Final Report

Rapid review of international peer-reviewed literature, and targeted environmental scan of the grey literature, to identify innovative service delivery models to support increased engagement of the peer workforce.

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Submitted to:

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Lived Experience Australia Ltd

Lived Experience Australia Ltd is a national representative organisation for Australian mental health consumers and carers, families and kin, formed in 2002. We provide services through our four pillars: advocacy; translational research; capacity building and partnerships. Our latest Annual Report highlights the extent of our work and the impact of our lived experience input. Our 'friends' include more than 9000 people with lived experience of mental health concerns, psychosocial disability, suicide and suicidality, across Australia.

All members of our Board and staff have mental health lived experience as either a consumer, family/carer/kin/supporter, or both. This includes lived experiences with all parts of the mental health care system, including public and private service options, and service provision in urban, regional, rural and remote Australia.

Lived experience is core to our advocacy, recognising that the impacts of policy and practice are felt not only by individuals, but also by families and whole communities. Our core business is to advocate for effective policies and systemic change to improve mental health care, services and support across the whole Australian health and social care system, including within State and Territory jurisdictions.

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Conflicts of Interest Declarations:

Professor Sharon Lawn is currently leading a Medical Research Future Fund (MRFF) Consumer-Led research project examining Peer work in primary care. Lived Experience Australia also provides training to, and partners with a range of organisations that may be delivering innovative models of peer work. Heather Nowak and Liz Asser undertake independent consultancy work focused on peer workforce. This includes delivery of capacity building training, mentoring, external supervision and Communities of Practice facilitation. They also undertake contracted part-time roles with Lived Experience Australia's training team.

These potential conflicts of interest will be managed by Lived Experience Australia declaring any relationships with organisations responsible for developing or delivering innovative peer work models included in the Final literature review and environmental scan.

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Abbreviations

AOD	Alcohol and Other Drugs
AUS	Australia
CPW	Carer Peer Worker
CBT	Cognitive Behavioural Therapy
COP	Consumer-led/Operated Program
CSI	Consumer Survivor Initiative
CALD	Culturally and Linguistically Diverse
Department	Australian Government Department of Health and Aged Care
ED	Emergency Department
FPA	Family Peer Advocate
FSS	Family Support Specialist
IPS	Individual Placement Support
LOS	Length of Stay
LE	Lived Experience
MHP	Mental Health Professionals
MHS	Mental Health Services
PAL	Parent Advocate with Lived Experience
PS	Peer Support
PW	Peer Worker
PICO	Population, Intervention, Comparator/Context, Outcome
QOL	Quality of Life
RCT	Randomised Controlled Trial
ROP	Recovery-Oriented Practice
RPS	Reciprocal Peer Support
UK	United Kingdom
USA	United States of America
YPSW	Youth Peer Support Worker

A Note on Language Used in Report

We acknowledge that the language surrounding mental health has historical and deeply felt impacts for many individuals and communities. It is powerful and, at times, contested. There is no single consensus on preferred terminology.

Many studies identified in this review were undertaken at different points in time and reflect their era. Many studies were undertaken in clinical settings; hence, many researchers in Australia and elsewhere have used predominantly clinical language (e.g., describing studies and program activities as 'interventions'). We have aimed to avoid this term where we could.

Various terms are used by the identified research sources to describe people receiving peer support (e.g., consumer, client, guest, patient, service user). In most cases, we have used terms reflected by the researchers and their studies; otherwise, defaulting to the term 'consumer' which is the predominantly recognised term within policy in Australia.

Peer workers also have varying titles across different countries and roles. We have used 'peer workers' as a generic term to cover these varied paid peer roles, to avoid confusion in this report. We have made one exception, distinguishing roles that entail peer support from a family/carer perspective for the purpose of identifying the nature of the gaps in this aspect of peer work evidence.

We recognise that the future may be one where Lived Experience Peer Work may be a broad and encompassing way of describing this workforce.

Background

Peer workers are an emerging and critical part of the broader mental health and suicide prevention workforce. Consumer peer workers were first employed in Australian public mental health services in the early 1990s with the establishment of 'consumer consultant' roles, particularly in inpatient settings, initially in New South Wales, and then rapidly adopted by other Australian States during this time. The introduction of the federally funded Personal Helpers and Mentors (PHaMs) program in 2006 is an example of reforms that saw increased investment in and recognition of peer work roles in the community sector. Throughout this period, National Mental Health Plans increasingly emphasised the role of consumer and family/carer participation. The National Standards for Mental Health Services (Australian Health Ministers, 2010), for example, required services to actively involve consumers and carers in the development, planning, delivery and evaluation of services.

The origins of peer work stem from the grass roots social justice and human rights movement coming from the voices of consumers and families experiencing mental illness, either as consumers or family members. Peer support grew out of a political and practical need to improve mental health service treatment across the world and is embedded in a "rights" movement around the shared experience of the consumer/survivor/patient movement (Jacobson & Curtis, 2000; Gallagher & Halpin, 2014).

The current National Mental Health and Suicide Prevention Agreement has identified peer workers as one of six priority professions requiring immediate action. Both the Productivity Commission's 2020 Inquiry into Mental Health and the National Mental Health Workforce Strategy (Strategy) also identified the potential to better utilise peer workers as part of the broader mental health and suicide prevention workforce. However, there remain ongoing concerns with service culture, literacy of the non-peer workforce, role clarity and understanding of boundaries and scope of the peer role, as well as issues with training, support, and supervision for peer workers. Despite the proliferation of peer work opportunities, the peer workforce continues to be largely misunderstood, unsupported and therefore underutilised in the mental health system.

The Strategy's Implementation Roadmap identifies a number of priorities and actions relevant to peer workers. This literature review and environmental scan will demonstrate progress against Pillar 1: Attract and Train of the Strategy, which includes an action to examine new and innovative service delivery models to support increased engagement of the Lived Experience (Peer) and Aboriginal and Torres Strait Islander mental health workforces in different contexts. This will support governments and the broader sector to identify opportunities to better utilise the peer workforce.

Purpose of the Review

Our purpose was to undertake a rapid review of the international published peer-reviewed literature, and targeted environmental scan of the grey literature, on innovative service delivery models to support increased engagement of the broad peer workforce.

This review included:

- Desktop review of existing peer workforce models in a range of contexts (See PICO).
- Analysis of evidence to support these models, where available.
- Workforce issues relevant to the peer workforce models.

The review did not include models specifically focused on Aboriginal and Torres Strait Islander workforce, except where broad themes may be applicable and useful to consider. We understand that the Department is exploring opportunities with Aboriginal and Torres Strait Islander organisations and stakeholders to address relevant actions under the Strategy.

Populations and Contexts Included in the Review

Evidence across these diverse settings and contexts are included in this review where peer support for mental health challenges are explicit components of the model being described and evaluated.

In this report, we have aimed to capture this diversity with specific groupings of the evidence according to their settings and contexts (**which we understand as 'Models'**).

A 'Model' broadly defines the way a service is delivered. It outlines best practice approaches and services for a person, cohort of people, or population group as they engage with that service. It aims to ensure people get the right support, at the right time, by the right team and in the right place.[1]

Peer work roles exist across diverse settings which include: hospital settings (inpatient units, emergency departments (ED), hospital avoidance/discharge/transition); community settings (clinical mental health, non-clinical mental health, psychosocial support); and online/digital (e.g. phone and webchat).

Peer work roles also exist across diverse contexts which include: within multi-disciplinary teams; user-led and operated services; peer-led and co-facilitated group programs; with diverse populations, e.g. adults, youth, forensic, families, drug and alcohol, suicide (prevention and postvention); and within related sectors such as housing and homelessness, education, and employment.

Summary of Findings

189 studies were identified for this review which included 148 peer-reviewed papers (including 24 systematic or other types of reviews), and 41 grey literature sources.

Similar to a review conducted by Akerblom & Ness (2023), most published studies arose from research conducted in the US, Australia, the UK and Canada, with a clear increase in research activity focus on the peer work role within the last 10 years (**see Appendix 1 graphs**). 53 published studies were Australian studies. The vast majority of grey literature reports were Australian (n=36) (as expected due to this positive bias within the Google search function):

Reviews (n = 24)
Inpatient settings (n = 30, three of which were Australian studies)
Community settings (n = 40, eight of which were Australian studies)
Carer Peer Models (n = 7, one of which was an Australian study)
Workforce Issues (n = 47, 18 of which were Australian studies)
Grey Literature (n = 41, 36 of which were Australian studies)

The emergence of a workforce of paid peer support workers identifies a range of implications that are consistently evidenced across the peer-reviewed and grey data collected in this study.

1. Informal peer support (existing for many years as an organic part of social relationships) result in considerable burden (negative effects on work and family life) placed on families.
2. There are current tensions between standardization (formalized peer work) and the loss of authenticity (informal peer work) impacting the effectiveness of the work.
3. Layers of peer work have emerged in recent years focussing on families, in particular, parents whose child(ren) or young adult(s) require access to mental health services, and carers providing informal, unpaid care to a family member or close friend who accesses mental health services.
4. The multiple types of peer work create much confusion about the terms used to define the work and the diversity of roles that exist across the various layers of peer work. This is also evident in the grey literature such as Hodges et al. (2022).
5. There is evidence of the effectiveness of trained volunteer peer work in aged care in reducing depression and increasing the quality of life of older people with mental health conditions.

[1] Adapted from the definition of 'Models of Care' used by NSW Agency for Clinical Innovation. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0009/181935/HS13-034_Framework-DevelopMoC_D7.pdf (p.5)

What innovative models of lived experience peer support are being utilised in mental health and suicide support service contexts?

There was significant heterogeneity in study designs. It is promising that the evidence included 14 RCTs (eight in inpatient/transition/hospital avoidance and six in community contexts) with relatively large samples. Overall, the evidence is strengthening and deepening.

Quality of studies was mixed, with more recently studies (those published since 2019) demonstrating stronger quality. It was apparent in the reporting of many studies that the authors sometimes blurred the boundary between advocacy for the peer role and evidence for effectiveness of the role. This reflects the commitment, passion and influence of the Lived Experience sector, emergence of LE Researchers, and the push for redress in more traditional structures of in what constitutes 'evidence' of impact in research.

Peer work roles were particularly well-established and showed the strongest evidence when delivered within Hospital Avoidance/Discharge/Transition support models. Research on non-clinical community models was conducted with greater quality and rigor than research on clinical community models. Consumer-led/operated models were also more highly rated for research quality.

Whilst the growth in peer work integration and evidence is growing, a number of gaps in evidence are apparent. These include studies examining peer work with the following populations and contexts: First Nations, women, men, refugees, suicide postvention, family/carers, and gambling. Many programs are likely not being evaluated and many have reports that are not in the public domain (e.g. The Lived Experience Telephone Support Service (LETSS) – a South Australian non-clinical service that is now being replicated in other jurisdictions as a result of its known success).

What outcomes are they achieving?

There was evidence across several published studies, reviews, and grey literature evaluations of positive impacts on hospital readmission rates, reduced length of stay, and psychosocial outcomes. A small number of studies reported outcomes that are no better or worse than those achieved by professional staff in providing care (e.g., review by Pitt et al, 2014).

Summary outcomes achieved include the following:

- Peer models demonstrate trauma-informed, person-centred care.
- Increased social and community connections and reducing isolation.
- Improved sense of belonging.
- Carer peer support - enhanced carers' capacity to manage their own wellbeing as well as their caring roles, improved advocacy with clinical staff.

Inpatient settings:

- Connection for individuals with lived experience.
- Successful care transitions, engagement and follow-up with community services and supports.
- Peer workers positively impacted cultural change within the inpatient setting.
- Witnessing peers' success influences patient outcomes (role-modelling recovery)

Eds/Transition & Hospital Avoidance models:

- Establishing empathy and building trust between the patient and the care team.
- Providing dignity in structures that traditionally take away dignity.
- Reduction in re-hospitalisation rates and LOS.

Consumer-led/operated models:

- lower levels of service utilisation and need, improved recovery and symptoms.

Community Clinical MHS

- Supported and empowered to understand and navigate a complex system.
- Increased engagement and willingness to reach out for help.
- Timely access to services, and improved mental health and recovery outcomes.

What barriers and enablers are identified in the operationalisation of these innovative models?

The evidence from this review indicates that a number of challenges to integration of the peer work role persist, particularly within clinical mental health settings, largely due to cultural resistance to and continued lack of understanding of the peer role by other health professional disciplines. Adequate supervision, training, mentoring and support were also consistently reported as needed to ensure peer workers work to their scope of practice, maintain their 'peer-ness' in navigating role boundaries and service cultures, and continue to develop their professional identity.

Barriers include the following:

- clinical dominance (in-patient settings), being accepted by non-peer staff.
- Boundaries with staff - struggle to retain role boundaries (peerness) resulting in narrowing of the role losing effectiveness and boundaries with consumers.
- ED is a challenging space to practice peer support work in, due to its physical environment and the deeply clinical culture.
- Role delineation and scope of practice was also a challenge, especially where consumers' support needs surpassed the role and ability of the peer navigator.
- Inconsistent peer staff/turnover and staff resourcing.
- Inadequate training for non-peer staff.
- Significant systemic workforce changes in a unique form of human service delivery.
- Limited understanding of the valued role peer workers play.
- Power imbalances and stigma.

Enablers include the following:

- Supports and resources to help peer workers navigate the emotional intensity of the ED.
- Creating safe workplaces for the emerging local peer workforce.
- Title used and remuneration recognition for the role.
- Championing of peer provision initiatives by organisational leadership.
- Whole of organisation commitment, culture and practice supporting peer work
- Quality supervision and Communities of Practice led by peers.

Summary Descriptions of Peer Support Models (Contexts & Settings)

The following are brief descriptions of the contexts and settings in which peer support models are currently delivered, according to the reviewed literature.

Hospital Inpatient Units: Models where peer workers are employed as a member of the multi-disciplinary team providing lived experience support through a range of roles (group programs, individual support, contributions to discharge planning, advocacy) alongside clinical staff.

Hospital Emergency Departments: Models where peer workers are located within emergency departments, working alongside clinical staff, and provide lived experience support, information, and engagement to people with mental health concerns who present in crisis (including distress, suicidality, self-harm, drug or alcohol intoxication), and/or their family, carers and kin.

Hospital Avoidance/Discharge/Transition: Peer support models that can be part of government-funded clinical service options or delivered by community psychosocial services that employ peer workers to provide alternatives to hospital admission, or in-reach to support as a person is leaving hospital, and in the days/weeks immediately after leaving hospital.

Community Clinical Mental Health Services: Government-funded services providing a range of community-based responses to people being provided with care coordination within a multi-disciplinary team that includes a paid peer work role alongside clinical mental health professionals.

Community Non-clinical Mental Health and Psychosocial Disability Support Services: Community-based programs that have a predominantly non-clinical approach to support. They can include individual and/or group programs, drop-in programs, psychosocial support such as employment, community connection and participation.

Suicide Prevention: These models can sit across both inpatient and community-based settings; hence, peer workers are located within clinical, non-clinical, community-driven, and consumer-led contexts.

Homelessness Services: These models are community-based, predominantly non-clinical and can include peers working in street-front programs, hostels, and non-government psychosocial support services.

Drug and Alcohol Community Support Services: These models can sit across both inpatient and community-based settings; hence, peer workers are located within clinical, non-clinical, community-driven, and consumer-led contexts, providing individual and/or group programs.

Primary Care Services / General Practice: Peer support workers either employed within the general practice setting or employed by clinical or non-clinical services receiving referrals from GPs.

Family and Carer Peer Support: These models can sit across both inpatient and community-based settings; hence, peer workers are located within clinical, non-clinical, community-driven, and carer-led contexts, providing individual, family and/or group programs.

Forensic and Prisons: These models can sit across both inpatient and community-based settings; hence, peer workers are located within clinical, non-clinical, and consumer-led contexts focus on transition and community reintegration.

Digital / Online: Models include predominantly phone or web-based individual and/or group-based interactions (including chat and forum modes, synchronous or asynchronous).

Education and Training: These can include specialist integrated youth services, school and university mental health services, employment, Recovery Colleges, Clubhouses.

Methodology

Reviews of research literature to guide translation of new approaches and models to the field of practice and service delivery require evaluation to be done in a systematic way. In preparing this review, we took an inclusive approach that reflects the relatively recent focus of research on peer support in the field of mental health. Therefore, we included all identified studies that met the inclusion criteria regardless of level of evidence.

The CASP Quality Rating Scale for systematic reviews (CASP, 2018), and the MMAT Scale (as applicable) for all other study designs (Hong et al, 2018), were used to evaluate quality of all peer-reviewed published sources. Grey literature was not assessed for quality.

1. Rapid Review

The decision to undertake a rapid review of the literature was based on the needs of the knowledge user (Department of Health and Aged Care) for rapid access to current knowledge on the topic. While rapid reviews are undertaken more quickly than systematic reviews, and limit aspects of the review process, they are reported to produce similar conclusions to systematic reviews of the literature (Khangura et al, 2012). We followed the rapid review process outlined by Khangura et al. (2012) to develop an 'evidence summary' - an overview of the available evidence about peer workforce models and the evidence to support these models. This involved: (1) Needs assessment (established by the Department); (2) Question development and refinement (negotiated by the Department in collaboration with the project team); (3) Proposal development and approval; (4) Systematic literature search; (5) Screening and selection of studies; (6) Narrative synthesis of included studies; (7) Report production; (8) Ongoing follow-up and dialogue with knowledge users.

The Rapid Review is registered with PROSPERO (CRD42024523029).

2. Research Questions

What innovative models of lived experience peer support are being utilised in mental health and suicide support service contexts?

What outcomes are they achieving?

What barriers and enablers are identified in the operationalisation of these innovative models?

3. Publication Sources

The decision was made to draw the information from evidence reported in published and grey literature given the diverse range of evidence gathering and the more recent expansion of research on this topic. This included:

1. Systematic, scoping and rapid reviews. This allowed us to consider the highest form of evidence available, and for the review to be undertaken in a timely manner, reflecting the nature and purpose of a rapid review and the needs of the Department.
2. Peer-reviewed publications reporting on empirical studies. The search was further limited to peer-reviewed journal articles published in English.
3. Grey literature reports to ensure the inclusion of evaluations, program reports and related analyses and sector guidance on peer work that may not have been reported in the published peer-reviewed literature.

4. Selection and Screening of Papers

Covidence Software (https://www.covidence.org/) was used to manage screening of published sources by the review team.

The initial search strategy was conducted in PubMed and Google Scholar using the following search terms to check that the parameters were successfully capturing relevant studies:

> (peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience OR self-help group OR Peer-to-peer support OR lived experience workers OR Recovery-oriented services OR consumer advocacy OR Empowerment-focused services OR Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program)
>
> AND (mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*)
>
> AND (models of care or primary care or secondary care or inpatient or hospital or healthcare service)

The search strategy was then formally applied to the following five databases (2000-Present), with the searches conducted on 21st February 2024 (**see Appendix 2 for Search Strategy Outputs**):

- Google Scholar
- Medline
- PsychInfo
- Emcare
- CINAHL

5. Inclusion and Exclusion Criteria

The expert medical and health sciences librarian undertook the database searches informed by the following PICO:

Population: Studies (in English) of lived experience (consumer or family/carer) peer workers in the mental health and suicide field, urban/regional//rural/remote locations, supporting adolescents/adults (≥18 years).
Intervention: Innovative service models of peer support for mental health (e.g., early intervention, recovery, psychosocial support, hospital avoidance, post-discharge) and suicide (prevention, early intervention or postvention).
Comparator / Context: Primary, secondary, or tertiary clinical or non-clinical services, in specialty treatment, medical/therapeutic, or psychosocial support settings, public or private. Quantitative, qualitative, mixed methods.
Outcomes: Innovative service delivery models to support increased engagement of the peer workforce (e.g., effectiveness, peer &/or client outcomes, identifying barriers and facilitators for peer worker recruitment, supervision and support, workforce retention, skill development, and job satisfaction).

Studies were excluded if they:

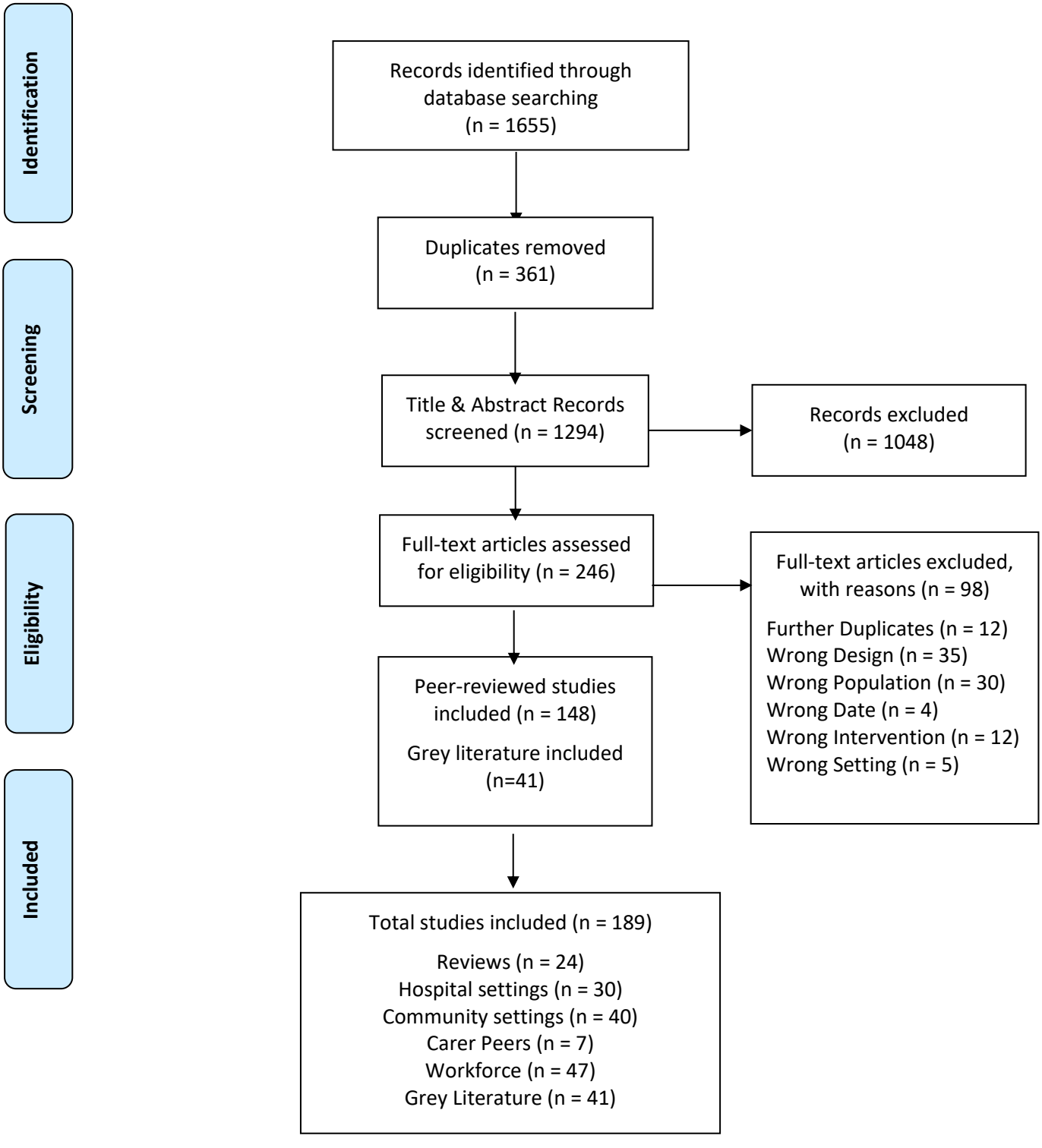
- Were discussion papers, editorials, study protocols, books or book chapters, conference abstracts.
- Examined informal peer support (e.g. peer support provided by friends, peer-to-peer as participants within groups or as fellow 'patients' within a setting).
- Examined peer support that did not also include mental health outcomes (e.g. focused only on social or occupational outcomes).
- Did not report peer support evidence as separate to support by other mental health service providers.
- Were papers that could not be accessed readily in full via Open Access, Internet, or University repository (i.e. were behind a journal paywall).
- Unpublished theses (Hons, Masters, and PhDs).

As recommended by Levac et al. (2010), reviewers met regularly throughout this screening process to resolve any uncertainties. A third reviewer was consulted, where a decision regarding inclusion could not be reached. Extraction and quality ratings were checked by a second reviewer.

Grey literature was identified through Google - English, Full report available, Jan 2000-April 2024 and ordered by relevance. The first 100 sources were searched with additional sources identified through website searches and research team advice. Search terms were: Peer Work, Mental Health, Evaluation, Review, Report, Outcomes, Barriers.

Thematic Content Analysis (Hsieh & Shannon, 2005) was used to identify themes across the peer-reviewed and grey literature. The PRISMA Framework was used for reporting results of the peer-reviewed search. Tables and narrative text summaries are used for reporting results, data quality, and relevant themes.

Figure 1. PRISMA 2009 Flow Diagram



Limitations of the Review

There are a few limitations to this review. As this was a rapid review with a short timeframe, we did not go through reference lists of reviews or papers to identify any further papers that may have been missed by the current database search. We did not include or chase protocol papers describing programs that are currently in progress. We did not include Honours, Masters, or PhD Theses. This decision was made following the full text screening of peer-reviewed papers, and sourcing of grey literature, when we recognised there would be ample published and unpublished studies identified for the purpose of this review in informing the Department. However, we acknowledge the growing number of Lived Experience researchers undertaking higher degrees on this and related topics.

Presentation of the Literature on Peer Support Models

The research evidence is provided in six sections:

1. The first section contains summary description from systematic and other types of reviews of the research on peer workforce and peer work models.
2. The second section contains summary description from the grey literature.
3. The third section contains the findings for research on the different models of peer work in the different hospital-based or related settings and contexts (inpatient, emergency department, hospital avoidance/discharge/transition) in which the role, feasibility, acceptability, impact and/or effectiveness of peer work has been examined.
4. The fourth section contains the finding from research on the diverse range of community-based peer work models in which the role, feasibility, acceptability, impact and/or effectiveness of peer work has been examined. It also includes findings of peer work applied to specific population groups.
5. The fifth section contains summary findings from research on carer peer work models.
6. The sixth section contains summary finding from research that examined barriers and enablers to peer work across various contexts, i.e. workforce concepts impacting effectiveness of models.

Section One: Summary of Existing Published Reviews

Summary

Twenty-four reviews were identified; 17 published in the past five years (2019-2024) (**see Appendix 3 for details**).

Thirteen reviews included studies of peer support involving varied mental health settings and models of peer support delivery. This heterogeneity of included studies was both a strength and limitation.

Nine reviews focused on specific contexts:

- One focused on studies of peer support and suicide prevention programs (Bowersox et al, 2021).
- Two focused on peer support within clinical mental health services (Gillard et al, 2014; Walker & Bryant, 2013).
- One focused on community models (Harvey et al, 2023).
- One focused on programs at the intersection of homelessness, drug and alcohol abuse, and mental health (Miller et al, 2020).
- One focused on specialist integrated youth services and school and university mental health services (Murphy et al, 2023).
- One focused on homelessness and mental health (Reif et al, 2014).
- One focused on rural communities (Luke et al, 2024).
- One focused on youth peer roles (de Beers et al, 2022)

Two reviews reporting on peer worker capacity building and mechanisms were also included: one reviewed the evidence of underlying alliance and role modelling mechanisms of peer support (Barker et al, 2020);

and one reviewed peer training manuals for content for suitability and deliverability via face-to-face, blended, or online formats (Charles et al, 2021).

Quality of Reviews

Nineteen studies were of high quality, receiving a score of 8-10/10 on the CASP quality rating scale for systematic reviews (CASP, 2018); four studies scored 6-7/10, and one study scored 5 (**see Appendix 9 for details**). Three elements accounted for lower ratings of quality:

- Whether all relevant studies were included (uncertain for 11 studies)
- Whether quality was assessed (didn't do/didn't report for 7 studies)
- Precision of reporting of results (not enough details for 6 studies)

NB. Rather than report the outcomes of literature reviews in detail here, we have included evidence from literature reviews below within the summaries of each setting/context type.

Section Two: Summary of the Grey Literature

Summary

We included a dedicated focus on grey literature given the likelihood of significant reports, service and program documents on this topic that sit outside of the peer-reviewed published literature. We found 41 such sources. Of these, 34 were Australian sources. We have chosen to focus on summarising these below (**see Appendix 4 for further details**). The grey literature was not assessed for quality.

Evidence

Reviews: Seven sources were reviews of the evidence for peer work:

- Two were general reviews (Health Workforce Australia, 2014; Kaine, 2019).
- One focused on Emergency Department peer roles (Minshall et al, 2020).
- One focused on forensic and prison populations across statutory and community contexts (Justice Action, 2024).
- One focused on Alcohol & Other Drugs inpatient and community contexts (Meumann & Allen, 2019).
- One focused on family/carer peer roles and programs (ARAFEMI, 2011).
- One focused the peer navigator role (Schweitzer, 2021).

Studies: Twenty-one sources were evaluations of specific programs or contexts/settings in which peer work is delivered. This included:

- Community integrated care (Maylea et al, 2022).
- Community Wellbeing Hubs (Steward, 2019).
- Digital/Online (Black Dog Institute, 2021; Boyle et al, 2023; Headspace, 2020).
- Eating Disorder (Butterfly Foundation, 2022).
- Family/Carers (Rising Together Action Group, 2022).
- Intentional Peer Support/Consumer-led Services (Australian Healthcare Associates, 2013)
- National Disability Insurance Scheme (NDIS) and other Community Managed Organisation psychosocial support (Mackay et al, 2019; Rutherford et al, 2022; Urbis et al, 2022).
- Peer development in the Northern Territory (Tari-Keresztes et al, 2022).
- Peer Navigators in the community (Mental Health Commission of NSW, 2023).
- Physical Health/Mental Health (SANE Australia, 2015).
- Safe Spaces and other hospital avoidance (NOUS, 2023; Wood et al, 2019).
- Various (SACHRU, 2008; Mental Health Lived Experience Peak Queensland, 2024).

Sector Guidance: Six sources were either national or state-based reports offering guidance to federal and/or state governments, and the sector, on the development of the peer work role. This included:

- The National Peer Workforce Guidelines (Byrne et al, 2021).
- A national census of peer workers and recommendations to support further development, including a National Association (McMahon et al, 2019).

- Peer workforce training and development guidance (Hodges et al, 2022; Western Australian Peer Supporters Network, 2018).
- A Website with guidance documents and resources on multiple aspects of peer workforce development (Lived Experience Leadership, 2024).
- Guidance for Eating Disorders and peer work roles (National Eating Disorder Collaboration, 2018).
- Guidance on improving evaluation of the peer work role (Paino et al, 2023).

Section Three: Peer Work Models in Hospital-related settings and contexts

Summary

Thirty (n=30) studies examined the evidence for peer work in hospital-related settings and contexts. This included their role in hospital inpatient units (n=9), hospital emergency departments (n=2), and hospital avoidance, discharge, and transition support programs (n=19). Table 1 below provides an accessible summary of the evidence for these models, drawn from exemplar evidence sources (reviews, studies, and grey literature).

Only three studies examined peer work in the Australian inpatient-related context (Lawn et al, 2008; Hancock et al, 2022; Van Zanden & Bliokas, 2022). However, a further eight Australian grey literature sources were identified:

- One review dedicated to evidence of the peer role in EDs (Minshall et al, 2020), and two reviews that included hospital-related studies (Health Workforce Australia, 2014; Kaine, 2018).
- Four evaluations of hospital avoidance/discharge/transition programs (Hancock et al, 2021; NOUS, 2023; Victorian Department of Health and Human Services, 2019; Wood et al, 2019).
- One evaluation of inpatient peer work roles (Gallagher & Halpin, 2014).
- Two evaluations of peer work roles that included these settings and contexts (Mental Health Lived Experience Peak Queensland, 2024; SACHRU, 2008).

Twelve studies examined peer work roles in the USA, seven in the UK, three in Canada, two from Germany, and one each from Ireland and Singapore. No studies explicitly sought the perspectives of family/carers/kin on the peer work role **(see Appendix 5 for details).**

Overall, peer work delivered in hospital-related settings and contexts was well-established, particularly in the hospital avoidance context. Effectiveness of peer work was grounded in their lived experience approach, being emotionally available and having time to support consumers in what are often otherwise busy and siloed mental health service systems. Peers were able to provide intensive support, help consumers to build self-worth and agency, identify strengths and support life goals, and provide person-centred alternatives to traditional care. They were viewed as critical in developing trust, role-modelling recovery, and engaging service-users with community supports (see Table 1 below).

Table 1: Hospital-Related Peer Work – Summary Evidence

Peer Model Type	Setting and target group	Outcome	Exemplar Evidence Sources #
Hospital Inpatient Settings	Forensic units Adults	Meaningful, genuine connections, positive impact in this disenfranchising setting.	Böhm et al. (2014) S Wolfendale & Musaabi (2017) S
	Inpatient units – Various populations	Facilitating successful care transitions Profound positive impact in earlier stages of recovery.	Smith et al. (2014) S
	Wellness Centre / hospital campus	Improved community reintegration Start forming beneficial and long-lasting supportive relationships.	Reinhardt-Wood et al. (2018) S
Emergency Departments	ED – people presenting in crisis, suicidal, distressed	Established trust, empathy, trauma-informed listening and accessible language, creating support for patient preferences on harm reduction, and facilitating self-acceptance and self-defined recovery. A challenging space to practice peer support work.	O'Neil et al. (2024) S Ashford et al. (2019) S Minshall et al. (2020) G
Hospital Avoidance, Discharge, Transition	Various – In-reach to inpatient units, transition support to community, or immediate contact post-discharge from hospital/ED. Varied timelines for follow-up support (most being up to 3 months). Various populations.	Reduced hospital re-admission rates.	Corrigan et al. (2022) R Pitt et al. (2013) R O'Connell et al. (2016) Hancock et al. (2021)
		Reduced hospital length of stay.	Corrigan et al. (2022) R Lam et al. (2020) Hancock et al. (2021)
		Improved symptoms. Improved functioning.	Pitt et al. (2013) R O'Connell et al. (2016) S Hancock et al. (2022) S
		Reduced financial costs of care.	Le Novere et al. (2023) S Hancock et al. (2021) G
		Positive impacts on recovery and hope.	Corrigan et al. (2022) R Hancock et al. (2022) S
		No better or worse than those achieved by professional staff in providing care. Peer support plus usual care was not superior to care.	Pitt et al. (2013) R Gillard et al. (2022) S
	Suicide Prevention ED presentation Post-Suicide attempt or Suicidality	Reductions in suicide risk. Highly feasible and acceptable to consumers. Facilitating connection, role modelling recovery and acted as a bridge. Building self-worth, strength, agency, trust, role-modelling recovery.	Bowersox et al. (2021) R Van Zanden & Bliokas. (2022) S

R= Review; S=Study; G= Grey Literature

Quality of Studies

Overall, many studies of peer support within hospital-related settings and contexts were of moderate to high quality, used rigorous designs and involved comprehensive analyses. Quality of more recent studies (those published within the last 5 years) was particularly high.

- Five of nine inpatient studies were of moderate to high quality.
- Two of two emergency department studies were of moderate to high quality.

- 16 of 19 hospital avoidance/discharge/transition studies were of moderate to high quality.

Quality of non-randomised and mixed methods study designs appeared to be better than other designs, though there was significant heterogeneity. More recent RCTs (Gillard et al, 2022; Le Novere et al. 2023) were of higher quality than earlier RCTs:

- 13 studies used qualitative designs. Eight studies examined peer work in inpatient settings (three moderately high or high, one moderate, and four low quality). Five qualitative studies examined peer work in hospital avoidance/discharge programs (four moderate to high quality).
- Eight studies used a randomised controlled trial design. Of these, one examined peer work in inpatient settings (moderate quality), with seven examining peer support in hospital avoidance/discharge programs (two high, five moderate, and one low quality).
- Three studies used a non-randomised quantitative design. All examined peer support in hospital avoidance/discharge programs (all moderate to high quality).
- Four studies used a quantitative descriptive design. One examined peer support in the emergency department setting (moderate quality), and three examined peer support in discharge programs (one high, one moderate, and one low quality).
- Two studies used a mixed methods design. One examined peer support in the emergency department (high quality) and one examined peer support in a discharge program (moderate quality).

Brief detail for each setting/context type is provided below. For each of these 'model' types, a consistent reporting structure is used:

- **An initial descriptive summary is provided.**
- **A brief statement about study quality.**
- **Key detail about the evidence, drawn predominantly from higher quality published studies and reviews (where available).**
- **Summary evidence from grey literature is provided, where available.**

Hospital Inpatient Settings

Summary

Of the nine studies in hospital inpatient settings, two examined peer support in forensic inpatient units (Böhm et al, 2014; Wolfendale & Musaabi, 2017), one examined suicidal patients' perceptions of peer support (Klim et al, 2022), one described a long-standing peer-run Wellness Centre on an inpatient campus (Reinhardt-Wood et al, 2018), and the remaining five studies examined the experiences and impact of peer support within mental health inpatient wards with a diverse range of populations. Several reviews (n=15) and three grey literature Australian sources (Gallagher & Halpin, 2014; Health Workforce Australia, 2014; SACHRU, 2008) included evidence from inpatient settings **(see Appendix 5 Table 1 for details).**

Quality of Studies

Three studies were moderately high to high quality (Böhm et al, 2014; Poremski et al. 2022; Smith et al, 2017), with the remaining studies of mixed quality **(see Appendix 10 for details).**

Evidence

Reviews: No reviews focused specifically on inpatient peer work studies. Fifteen reviews reported on the impacts of peer support across various settings, including inpatient settings; however, specific impacts were not disaggregated from overall findings. The general sense was that peer workers positively impacted cultural change within the inpatient setting, although clinical dominance often made the role challenging and isolating for peers.

Studies: A UK study by Böhm et al. (2014) involving focus groups with 17 male patients in a high secure forensic setting reported several challenges in the peer role which was complicated to deliver and sustain. They nonetheless concluded that peer worker contact could be experienced by these patients as a

meaningful, genuine connection and a unique opportunity for those at paradoxically the greatest risk of disenfranchisement and disconnection from the very system that is in place to help them.

Poremski et al. (2022) provides one of few longitudinal studies, followed a small sample of 10 peer workers in Singapore over a year, interviewing them at three points, starting approximately three months after commencing their peer role. They described integration changes and challenges for peers in inpatient roles that included struggles to retain role boundaries ('peerness'), and narrowing of the peer role over time, with consequent negative impacts on role satisfaction and retention of peers.

A US study by Smith et al. (2014) of the peer role in inpatient rehabilitation involved interviews with six peer workers and eight patients receiving peer support. Both peers and recipients strongly endorsed the role of peers in facilitating successful care transitions. Peers reported cultural challenges with being accepted by non-peer staff, and some peers and patients reported challenges in maintaining relationship boundaries with patients. The researchers concluded that simply witnessing peers' apparent successes may have a profound positive impact some recipients in earlier stages of recovery.

Grey literature: Gallagher & Halpin (2014) examined the impact of peer work in rehabilitation and acute inpatient units in South Australia, seeking feedback from consumers, carers, peers and clinical staff. Consumers reported that peers increased their sense of hope, helping them to identify coping strategies and to manage illness symptoms. Carers said carer peers helped them feel supported and to build strengths in their caring role. An early evaluation by SACHRU (2008) found peer support in inpatient settings was empowering to patients, humanizing for environment, and positively impacting cultural change. A review by Health Workforce Australia (2014) included inpatient peer work roles and found similar findings.

Emergency Departments

Summary

Two studies reported on peer support delivered in the ED; one from Canada (O'Neil et al, 2024) and one from the US (Ashford et al, 2019). No reviews were focused on the ED setting, though some reporting on various peer work settings, included peer work in ED settings. One Australian grey literature report was identified (Minshall et al, 2020) **(see Appendix 5 Table 2 for details).**

Quality of Studies

One study was of moderate quality (Ashford et al, 2019) and one was of high quality (O'Neill et al, 2024) **(see Appendix 10 for details).**

Evidence

Studies: A large survey of patients and interviews with peer workers (O'Neil et al, 2024) found peers were effective in establishing empathy and building trust between the patient and their care team through self-disclosure, facilitating a person-centered approach to patient care through trauma-informed listening and accessible language, creating support for patient preferences on harm reduction, and facilitating self-acceptance and self-defined recovery. The importance of supports and resources to help peer workers navigate the emotional intensity of the emergency department was noted.

A quantitative study of a large sample of patients presenting to rural EDs in the US with opioid overdose or substance-use problems (Ashford et al, 2019) found these patients had strong engagement with peer workers, though people who used benzodiazepine regularly were significantly less likely to engage.

Grey Literature: A recent report by mental health researchers at Melbourne University included a literature review, ED site visits, focus groups and a workshop with peer workers (Minshall et al, 2020). From their observations of the ED setting, that concluded that it was an unclear space for peer workers. Focus group themes emphasised peer workers' role in walking alongside, providing dignity, support, and person-centred care in an environment in which the nature of many structures readily took away dignity and privacy; peer workers were perceived as 'the human face of health services'. They concluded that the ED is a challenging space to practice peer support work in, due to its physical environment and the deeply clinical culture; both of these elements appear very rigid and difficult to change.

Hospital Avoidance/Discharge/Transition

Summary

Nineteen studies involved varied contexts and pathways for this peer work model type. These included: combined hospital avoidance and early discharge from inpatient units; hospital avoidance; short-term respite alternative to hospital admission; inpatient unit transition to discharge; discharge support immediately post-discharge from hospital; and ED postvention following a suicide attempt. Eight reviews and seven grey literature sources included evidence from hospital avoidance/discharge/transition peer work programs **(see Appendix 5 Table 3 for details).**

Quality of Studies

Eight studies were moderately high to high quality; six of these published within the past five years (Croft & Isvan, 2015; Forchuk et al, 2020; Gillard et al, 2022; Hancock et al, 2022; Lam et al, 2020; Le Novere et al, 2023; White et al, 2023). A further seven studies were of moderate quality, with only one of these published within the past five years (White et al, 2023). Three Australian studies were identified (Hancock et al, 2022; Lawn et al, 2008; Van Zanden & Bliokas, 2022). Of note, there were five RCTs - three from the US (Griswold et al, 2010; Sledge et al, 2011; O'Connell et al, 2016) and two from the UK (Gillard et al, 2022; Le Novere et al, 2023) across the more recent studies **(see Appendix 10 for details).**

Evidence

Reviews: Eight reviews included a focus on hospital avoidance/discharge/transition peer support.

Corrigan et al's (2022) systematic review included 13 studies of post-hospitalization programs. It included seven of 11 studies reporting a significant positive impact on readmission rates and/or number of hospitalization days. One study found significant negative effects of PS related to psychiatric hospitalization, and one found negative effects on crisis stabilization. Secondary outcomes were organized into six groups: (a) two studies assessing impact of peer support on arrests and incarcerations: neither found positive benefits; (b) three studies examined housing stability and homelessness: one had positive findings; (c) Symptoms were assessed in four studies: two reported positive benefits; (d) Two studies examined peer-supported self-management: neither found significant effects; (e) Four studies examined impact on recovery and hope; one showed positive benefits; (f) Three studies examined effects on quality of life; two found positive outcomes.

Pitt et al's (2013) Cochrane systematic review involved two key analyses:

1. Five trials (581 people) compared PS to professionals in similar roles within mental health services (case management roles (4 trials) and facilitating group therapy (1 trial)). They found no significant differences in client quality of life; depression, general mental health symptoms; client satisfaction with treatment, client or professional ratings of client-manager relationship; use of mental health services, hospital admissions and length of stay; or attrition. There was a small reduction in crisis and emergency service use for clients receiving care involving PS. Peers spent more time face-to-face with clients, and less time in the office, on the telephone, with clients' friends and family, or at provider agencies.
2. Six trials (2215 people) compared mental health services with or without the addition of consumer-providers. There were no significant differences in psychosocial outcomes (quality of life, empowerment, function, social relations), client satisfaction with service provision and with staff, attendance rates, hospital admissions and length of stay, or attrition between groups with PS as an adjunct to professional-led care and those receiving usual care from health professionals alone. None reported client mental health outcomes, data on adverse outcomes for clients, or the financial costs of service provision.

They concluded that PS achieves psychosocial, mental health symptom and service use outcomes that are no better or worse than those achieved by professional staff in providing care.

Chinman et al's (2014) systematic review found that peers were better able to reduce inpatient use and improve a range of recovery outcomes. Doughty and Tse's (2011) integrative review found a reduction in hospitalizations, and equivalent cost saving as non-peer initiatives. Gillard et al's (2014) narrative review

found potential reductions in hospital admissions. Repper and Carter's (2011) scoping review found reduced hospital bed days following peer support. Reif et al's (2014) systematic review found a moderate level of evidence for reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience. Shalaby et al's (2020) narrative review found inconclusive impacts on hospitalization, satisfaction, or overall symptoms.

Studies: (note – only studies of moderate to high quality are summarised here)

A UK RCT (Gillard et al, 2022) comparing peer support plus usual care after hospital discharge (n=294) with usual care (n=296) found that peer support plus usual care was not superior to care as usual alone in the 12 months after discharge. Engagement with a peer worker was low; however, people of any Black ethnicity receiving peer support were significantly less likely to be readmitted in the year post-discharge than those of any other ethnicity.

A further UK RCT (Le Novere et al, 2023) comparing peer support after crisis care discharge (n=221) with usual care plus workbook (n=220) found cost-effectiveness of the peer work role compared with the workbook plus usual care control at 12 months varied with the method used and ranged from 57% to 96%. The probability of peer support being cost-effective compared to control increases as the duration of follow-up increases.

A Canadian quantitative longitudinal study looking at 3 years of administrative data and impact of hospital transition peer support (Lam et al, 2020) found inpatient median Length of Stay (LOS) decreased significantly, while readmissions increased significantly and declined thereafter. The trend readmission rates differed between acute and tertiary care units in this study. Possible reasons include different patient needs and staff practices.

A Canadian study involving focus groups with 66 peer workers (Forchuk et al, 2020) found that they enhanced clients' autonomy and hope about their recovery, as well as established a safety net and reduced hospital readmissions. Several roles to facilitate clients' transition from hospital to the community included: assisting clients in building their capacity and developing healthy routines; attending regular on-ward and community meetings; accompanying to appointments; working with clients to set goals for recovery. Hindrances to effective implementation included: lack of understanding and appreciation of peer roles, lack of careful allocation of peer workers, and absence of appropriate protocols for ensuring safety and supervision of the peer workers.

A US quantitative study of respite/hospital avoidance peer support (Croft & Isvan, 2015) found the odds of using any inpatient or emergency services after the program start date were approximately 70% lower among peer respite users than non-respite users, and a longer stay in respite was associated with fewer hours of inpatient and emergency service use, but with diminishing returns beyond 14 respite days.

A US RCT (of moderate quality) comparing peer supported hospital avoidance for consumers who experienced more frequent hospital and crisis service contacts with usual care (O'Connell et al, 2016) found peer support resulted in them remaining out of hospital for significantly greater periods of time, and greater reductions in substance use and psychiatric symptoms and greater improvements in functioning compared with participants assigned to standard care.

Two Australian qualitative studies were of high quality. The first involved peer workers following people for up to 12 weeks post-hospital admission (Hancock et al, 2022) (**Note:** full Grey Literature report on outcomes is included in this review and noted below). Questionnaires and interviews with multiple stakeholders found positive impacts and outcomes for consumers that included: (a) a better, less traumatic inpatient experience; (b) felt understood, cared about and less alone; (c) easier to leave hospital; (d) easier to get back into life and daily routines; (e) built and re-established community connections; (f) gained new knowledge, strategies, and skills; and (g) felt more hopeful about my recovery. Peer workers were described as a 'bridge' enabling connections within, across, and beyond mental health services and to natural communities of choice.

The second Australian qualitative study involved a program in which peers followed people up for 12 weeks post-ED presentation with suicide attempt or suicidality (Van Zanden & Bliokas, 2022) peers and

psychologists noted that peers were effective in facilitating connection, role modelling recovery and acted as a bridge. Peers were emotionally available by bearing witness and providing intensive support, helping consumers build a life worth living, highlighting strengths and clarifying values and goals, encouraging agency and providing person-centred alternatives to traditional care. They were viewed as critical in developing trust, role-modelling recovery, and engaging service-users with community supports.

For the eight studies of moderate quality (Dermatis et al, 2006; Lawn et al, 2008; Mahike et al, 2017; Min et al, 2007; O'Connell et al, 2016; Shattell et al, 2011; Sledge et al, 2011; White et al, 2023), peer support hospital avoidance/discharge/transition programs were found to have an overall positive impact on re-admission rates, LOS, and improved self-efficacy and personal recovery outcomes.

Grey Literature: Seven studies were identified, including six Australian studies (Hancock et al, 2021; Health Workforce Australia, 2014; NOUS Group, 2023; SACHRU, 2008; Urbis, 2022; Victorian Department of Health and Human Services, 2019; Wood et al, 2019).

A recent large hospital avoidance peer program in NSW (Peer-STOC) (Hancock et al, 2021) found significant reductions in readmission rates and fewer days in hospital, a significantly higher number of community-based mental health service contacts in the follow up period, significant mental health services cost savings, but little change in ED presentations when comparing the 12 months before or 12 months after contact with Peer-STOC.

A recent evaluation of Safe Spaces in QLD (NOUS Group, 2023) found most 'guests' (86%) showed improvements in distress. A recent evaluation of the Resolve Social Benefit Bond in NSW (Urbis, 2022) found reduced number and length of hospital stays, and ED visits, with clients reporting improved confidence, social connections and participation, and relationships.

A review by Health Workforce Australia (2014) noted benefits to consumers included reduced admission rates, improved community tenure, empowerment, social inclusion, reduced stigma, hope. An early evaluation of Baptist Community Services Peer Support in SA (SACHRU, 2008) concluded that peer support was empowering and humanising, with peers reporting the role validated their self-worth and sense of purpose and improved their own recovery. A Victoria report on post-discharge peer support (Victorian Department of Health and Human Services (2019) noted benefits for peer workers for their own feelings of hope, purpose, connection, and recovery.

Section Four: Peer Work Models in Community settings and contexts

Summary

From 40 papers, 15 models were identified along with five papers dedicated to the general evaluation of community peer work (Gidugu et al, 2015; Gillard et al, 2015; Radigan et al, 2014; Swarbrick et al, 2016; Thomas & Salzer, 2017) (**see Appendix 6 for details**). Distinguishing clear lines between a model and a method, purpose and setting was often difficult as these features often overlapped and in some cases the terms 'model' and 'method' were used interchangeably. For example, the emerging focus on digital technologies in peer work is presented both as method and model, its purpose often recovery, but also preventative and emergency-based, and with mental health system-wide application. For this reason, digital technology was included as a broad model of peer intervention.

Recovery is identified in the systematic review literature as being the purpose of community-based peer work (Harvey et al. 2023, Gillard & Holly, 2014). As reflected in Table 2, recovery is not only an inherent feature across most community models but a formalised and overt focus in its own right through such programs as Partners in Recovery described by Hurley et al. (2018) and Lewis et al. (2012). There is extensive quality evidence pointing to these types of models across clinical, non-clinical and consumer-led/operated programs (COP). However, there are notable exceptions to recovery being *the* purpose of peer work as indicated in a range of more recent and emerging quality publications. Pfeiffer et al. (2019) present the 12-week peer intervention trial of Prevail for suicide prevention. Suicide prevention is also a key feature in digital technology models operated by peer workers such as shown in the use of peer operated hotlines (also known as 'warm lines') (Kerner et al. 2021) and in quality publications by Fortuna et al. (2022 & 2019) and grey literature such as Fortuna's 2024 presentation at the National Institute of Mental Health workshop titled Advancing the Science on Peer Support and Suicide Prevention and the use of smartphones. Studies such as these suggest that peer operated use of technologies may play important roles in suicide prevention.

While some model types are specific to a particular setting (e.g., COP appear isolated to community non-clinical settings), most are hybrid to community clinical and non-clinical settings, with some located across all parts of mental health community sector. An important feature of community peer work appears to be its capacity to work across multiple settings and to remain flexible to the needs of the healthcare recipient. This is both a strength and a challenge to cultural integration within systems that are largely siloed, and a challenge to improving workforce support and development issues for peer workers.

There were notable gaps in the community model evidence which we think may be indicative of the evolving nature of peer work. Several papers focus on the well-being of the peer worker in the undertaking of such work, however the evolving models targeting digital suicide prevention and emergency interventions (hotlines) appear to have not yet fully investigated the implications of service recipient suicide on peer workers. Another possible gap in the literature is that, while the resource implications of rural peer work in Australia is well noted (Byrne et al. 2017), there appears to be very few papers investigating the efficacy of peer-operated digital technologies for rural areas. A further gap appears to be the evaluation of peer work with specific demographic groups in the community, including for young people, culturally and linguistically diverse populations, and consumers with specific mental health diagnoses; noting only one study (Price, 2009) which focused on peer support for people with a diagnosis of personality disorder, and two studies (Jones, 2016 (Grey Literature); Watkins et al. 2020) which focused on peer support for people with early psychosis.

Quality of Studies

Overall, no community-based studies were rated as high quality. However, quality appeared to reach moderate to moderately high quality for the following types of community model types and settings (**see Table 2 below, and Appendix 11 for details**):

- Consumer-led/Operated Programs
- Digital/Online non-clinical groups
- Group programs for specific groups (hostel residents; physical health)

- Rural
- Shared Decision-Making & Advanced Care Directives
- Suicide Prevention

Table 2: Community Peer Work Models

Peer model type	Setting and target group	Outcome	Evidence *rating
Aged peer support	Community, non-clinical services. (elderly)	Contributes to the limited evidence base specific to peer work models for aged.	Coates et al. (2018) ***
		Support from peers can potentially influence health behavioural change in a combined peer and technology-based medical and psychiatric illness.	Fortuna et al. (2018b) **
Advanced care directives (mental health)	Community clinical services.	9 out of 10 (86.7%) of peer-facilitated psychiatric advance directives rated "very feasible and consistent."	Belden et al. (2022) ***
Consumer led/operated program (COP)	Clinical and community non-clinical and COP	Conducted by community for community; innovative approach to reducing suicide, self-harm, reliance on public health services.	Flegg et al. (2015) ****
	COP	Case literature emphasising the importance of long-term comprehensive consumer driven care.	Haertl (2007) *
		Positive outcomes for members of consumer-run services at 3-year follow-up suggest promise of consumer-run settings.	Nelson et al. (2007) ***
	Clinical and COP	Peer support is linked with developing a positive self-concept, participation in psychosocial groups and recovery.	Hoy, (2014) ***
Digital technology (phones, web, and hotlines)	COP and Community clinical services	Access to a virtual 'avatar' CBT therapist can be facilitated by trained peers in poor settings for maternal care.	Atif et al. (2022) *
	Clinical, non-clinical and COP	Telephone peer support can address diverse needs and provide diverse assistance and contact patterns.	Evans et al. (2020) ***
		Feasible and acceptable integrated medical and psychiatric self-management intervention for adults with serious mental illness.	Fortuna et al. (2022) ***
		Peer workers own their own smartphones and are willing to use them in peer work.	Fortuna et al. (2018a) ****
	Community clinical services	Adolescents increasingly utilize a peer-supported youth hotline to get help for mental health concerns including suicide.	Kerner et al. (2021) ***
		The main finding was the difficulties in conducting research with adolescents for technology-based mental health studies in the primary care setting.	Radovic, (2022) **
Disorder specific	Community clinical services. (Personality disorders)	Identified need to combine psychological treatments with social interventions and to establish clear boundaries which are shared by service users.	Price et al. (2009) ***

Employment and/or vocational.	Community clinical services (Youth, Severe MH)	Sixteen of 21 (76%) participants reported valuing or benefiting from peer mentoring.	Klodnick et al. (2015) ***
	Community clinical services (Youth)	The program achieved positive vocational outcomes and good fidelity to the IPS (individual placement model) e.g., approximately half of young people had employment placements.	Simmons et al. (2022) **
Statutory	Community clinical services	Only modest evidence of the effectiveness of individual peer support.	Rogers et al. (2016) *
Groups and networks	Community non-clinical and COP	Consensus that *Prosper* could strengthen social networks, improve individual well-being and impact how people use services.	Gillard et al. (2016) ****
	Community hostel residents	Clinically significant weight loss at 12-months. Despite changes in this setting, the peer-led program shifted their mindset about healthy living.	Stefancic et al. (2021) ****
	Community clinical	"Home Groups "model provides unique learning opportunities for peers and trainees and many potential benefits to group members.	Styron et al. (2018) *
		Keeping the Body in Mind (KBIM) peer support to 12-week group program for physical health, improves sense of belonging, empathy, respect, confidence, empowerment, social inclusion, coping skills, teamwork, shared learning, reduced social isolation and stigma.	Watkins et al. (2019) ****
Modelling and general evaluation	Community clinical and non-clinical services	Modelling helps address limitations by indicating a measurable set of outcomes.	Gillard et al. (2015) ****
	Community clinical	Individual peer support provided various practical, emotional, and social supports which were perceived as beneficial.	Gidugu et al. (2015) **
		A greater proportion of youth & caregivers with access to peer advocates compared to those without access responded positively.	Radigan et al. (2014) ***
		Key issues for the implementation/expansion of peer services are identified as defining the model, providing training to prepare the peer workforce, accessing funding for implementation, and establishing clear expectations.	Swarbrick et al. (2016) *
	Community clinical (serious mental health)	Found unique associations between the peer relationship and the outcomes of those who participated in a peer-delivered intervention.	Thomas & Salzer, (2017) *
Open dialogue	Across diverse healthcare settings	Although evidenced to hold promise as a framework it is yet to be determined if it can withstand hierarchal mental health structures.	Bellingham et al. (2018) ***
Outreach/rural	Community non-clinical	Maternal depression can be detected in non-clinical settings. Peers can administer outreach and educational interventions with appropriate training and supervision.	Acri et al. (2013) ***

	Community clinical and non-clinical (Rural)	Two key barriers transport and distance but with appropriate resourcing peer support work can make a significant contribution to Australian rural mental health.	Byrne et al. (2017) ***
	Community non-clinical (Rural)	Peers with lived experience valued by rural community; perceived to make mental health help-seeking easier in Australian rural health.	Cheesmond & Davies (2020) ****
Recovery oriented program (ROP)	Community clinical	Peer workers add lived experience and can contribute to clinician uptake and fidelity of practice in ROP.	Chisolm & Petrakis (2020) **
		Partners in recovery. Peer worker role appears underdeveloped across themed areas e.g., role variance, identity and role shaping etc.	Hurley et al. (2018) ***
		Evidence that subjects' recovery improved over time.	Kowalski (2020) **
		Peer worker recovery attributes may benefit service users' personal recovery.	Mak et al. (2021) ***
	COP	Partners in recovery. Mutual accountability from stable authentic relationships may act as capacity building toward recovery goals.	Lewis et al. (2012) ***
Resilience building	Community clinical (Men)	MINDS, significantly raised the perceived resilience of participants (men).	Robinson et al. (2015) *
Shared decision making	Community clinical	Core components/processes of shared decision making were observed more frequently in the intervention group and reported a significantly more positive relationship with their doctor.	Yamaguchi et al. (2017) ****
Substance abuse/harm reduction	Community clinical and non-clinical	Recovery community organizations are well situated and staffed to provide harm reduction services e.g., syringe exchange.	Ashford et al. (2018) ***
	Community clinical (serious mental illness)	High feasibility and acceptability of the intervention.	Dickerson et al. (2016) **
Suicide prevention	Community non-clinical	85% of peer specialist sessions demonstrated adequate fidelity to administering a conversation tool regarding hope, belongingness, or safety. Peer specialists' ability to relate, listen, and advise was highly positive.	Pfeiffer et al. (2019) ****

Brief detail for each community setting/context type is provided below. For each of these 'model' types, a consistent reporting structure is used:

- **An initial descriptive summary is provided.**
- **A brief statement about study quality.**
- **Key detail about the evidence, drawn predominantly from higher quality studies and reviews (where available).**
- **Summary evidence from grey literature is provided, where available.**

Consumer-Led / Operated Models

Summary

Ten studies reported on models that were either wholly consumer-led/operated or had an explicit consumer-led/operated component.

Quality of Studies

Most papers reporting on consumer-led/operated models were of moderate to moderately high quality. Quality was moderately high for a community program aimed at reducing suicide and self-harm (Flegg et al, 2015) and a group-based peer support network (Gillard et al, 2016). Digital models that included a consumer-led/operated component demonstrated moderate quality (e.g., Evans et al, 2020; Fortuna et al, 2022).

Evidence

Studies: A UK evaluation of the peer-to-peer best practices in the community (Flegg et al, 2015) found that it reduced suicide, self-harm, reliance on public health services, drug and alcohol misuse and criminal activity.

Grey Literature: Doughty and Tse's review (2005) found some studies that reported higher levels of satisfaction with services, general wellbeing, and quality of life while others reported no significant differences between service user-run services and mental health services run by non-service user providers. No studies reported evidence of harm to service users or that consumer services were less effective than the equivalent services offered within a traditional setting.

Smith-Merry et al's (2016) evidence review for the Sax Institute identified a number of user-led models, including drop-in programs such as Self-Help Agencies (SHA) in the US (mixed results for empowerment) and the Station in rural South Australia (found to be empowering and nurturing). Other models included The Friends Connection (also in US) offering peer-support for consumers involved in an Intensive Case Management (ICM) program (which showed reduced rehospitalisation rates) and US-based WRAP Group programs (RCTs which showed lower levels of service utilisation and need, improved recovery and symptoms). Clubhouses (found to be less successful as an employment intervention than other programs such as IPS, and difficult to evaluate) and Recovery Colleges (RCs) that originated in the UK and are now in many community mental health care settings across Australia (high satisfaction reported).

A psycho-social education intervention delivered by the Northern Territory Mental Health Coalition (Tari-Keresztes et al, 2022) empowered people with lived experience to establish the Northern Territory Lived Experience Network (NTLEN), and further local lived experience projects focused on psychosocial education and employment. Several recommendations are made, including to keep focusing on creating safe workplaces for the emerging local peer workforce.

Community Clinical Mental Health Services

Summary

Fourteen peer-reviewed studies examined peer work specifically in community clinical mental health service settings, and several more studies included community clinical services among various mental health service setting types. One grey literature report was identified.

Quality of Studies

All community clinical studies were rated as moderate to low quality. Reviews were moderately high to high quality.

Evidence

Reviews: Several reviews included examination of the peer worker role and its effectiveness in community clinical settings. Please refer to Appendix 3 Table 1 for details.

Studies: Given the number of community clinical specific studies, only those rated as moderate quality are summarised here. These included:

- Belden et al's (2022) US comparative examination of peer and clinical facilitated Advance Directives.
- Hurley et al's (2018) Australian study of the experiences of peer workers in the Partners in Recovery program.
- Kerner et al's (2021) US examination of a peer-delivered hotline for youth.
- Mak's (2021) examination of peer workers' impacts on recovery for consumers in a Hong Kong community clinical service.
- Price et al's (2009) UK examination of peer support provided to people diagnosed with personality disorder.
- Radigan et al's (2014) US examining clinical service consumers' satisfaction with youth and family advocates.
- See also Employment Section (Klodnick et al, 2015; Simmons et al, 2022).

Grey Literature: Evaluation of the NSW Peer Navigation project (Mental Health Commission of NSW, 2023) in four pilot sites found that consumers felt supported and empowered to understand and navigate a complex system, with increased engagement and willingness to reach out for help, timely access to services, and improved mental health and recovery outcomes. Challenges were the short pilot timeframes, which affected onboarding and upskilling of peer navigators, and their capacity to build rapport with consumers. Role delineation and scope of practice was also a challenge, especially where consumers' support needs surpassed the role and ability of the peer navigator.

Community Non-clinical Mental Health and Psychosocial Disability Support Services

Summary

Six peer-reviewed studies examined peer work specifically in community non-clinical mental health service settings, and several more studies included community non-clinical services among various mental health service setting types. Three grey literature reports were identified.

Quality of Studies

Most community non-clinical studies were rated as moderate to moderately high quality. Reviews were moderately high to high quality.

Evidence

Reviews: Several reviews included examination of the peer worker role and its effectiveness in community non-clinical settings. Please refer to Appendix 3 Table 1 for details.

Studies: Given the number of community non-clinical specific studies, only those rated as moderate quality are summarised here. These included:

- A US study (Acri et al, 2013) of peer workers supporting mothers with depression found that peers were effective in providing screening and educational support to them.
- A rural Australian study (Cheesman & Davies, 2020) concluded that peer workers may increase rural help-seeking for mental distress.
- An Australian study (Coates et al, 2018) of peers working with elderly consumers found that peers had a positive impact on service culture, consumers and carers.
- A UK study (Gillard et al, 2016) evaluating a peer worker supported group network built trusting relationships among community members with mental health challenges.
- A US study (Pfeiffer et al, 2019) of peer workers delivering suicide prevention support in the community found that they could deliver the 'Prevail' program with fidelity, and that they were effective in being able to relate, listen and advise people involved in the program.

Grey Literature: Mackay et al, (2019) evaluated the UnitingSA NDIS Peer Support Program in South Australia. Results of this pilot were that assertive, trauma-informed, recovery-oriented outreach support by a lived experience team assisting people to build their life skills and increase social and community connections. Service users were generally satisfied, but they were worried about the ongoing availability of this support within an NDIS environment. There were significant challenges to the capacity of programs to

continue to deliver recovery-oriented care and remain financially viable which directly impacted capacity to provide person-directed supports and facilitate community access.

Rutherford et al's (2022) evaluation of Queensland's non-clinical, holistic recovery-focused psychosocial wraparound support services (one to one and group programs) included a focus on individual recovery, group recovery, homelessness, up to 12 months community support for people transitioning from correctional facilities. They found a number of barriers impacting consumer outcomes that included inconsistent staff/turnover, under-resourcing, inadequate training, staff resourcing and management of consumer-staff boundaries.

An Australian Regional Mental Health and Wellbeing Hub initiative (Steward et al, 2019) employ peers to strengthening and embedding community awareness, understanding and capacity for improved individual and collective mental health and wellbeing have paid peers Hubs are located. Peers develop and deliver flexible and targeted activities that match the needs of specific communities and have created improved opportunities to get a wellbeing focus embedded in local planning (e.g., Local Councils).

Physical Health and Mental Health

Summary

Two peer-reviewed studies (Stefancic et al, 2021; Watkins et al, 2020) examined peer support for physical health for people with mental health challenges. Two Australian grey literature reports were also identified.

Quality of Studies

Both peer-reviewed studies were rated as moderately high quality.

Evidence

Reviews: Nil identified

Studies: A US peer-led group program focused on improving healthy lifestyle of hostel residents with SMI (Stefancic et al, 2021) found the proportion of study participants achieved clinically significant weight loss at 12-months (29%) was comparable to 12-month outcomes of other trials reporting non-peer-led healthy lifestyle interventions. Though there were several challenges, and change was often small, participants generally reported that the peer-led program shifted their mindset about healthy living. Support to sustain self-monitoring, meal planning, tailored physical activity, and advocacy was noted as needed.

A NSW multi-disciplinary model focusing on the physical health of younger people commencing anti-psychotic medications (Keeping the Body in Mind (KBIM) (Watkins et al, 2020) involves a 12-week lifestyle programme involving health coaching, dietetic advice, and exercise support, with peers working alongside clinical staff. The value of peer interaction was reported as giving people a sense of belonging, created empathy and respect between participants, increased confidence, empowerment, social inclusion, coping skills, teamwork and shared learning, and reduced social isolation and stigma.

Grey Literature: Evaluation of a Victorian Integrated Chronic Care (ICC) Pilot (Maylea et al, 2022) reported promising precursors to tangible health outcomes, such as changing attitudes to health, increased health literacy, and better connections to the healthcare system. There is some evidence of improved screening, though impact on wider embedding of screening was limited. The program was hampered by lack of a clear model for peer work, consumers' lack of awareness of the role, and staffing turnover.

SANE's (2015) Peer Health Coaching program, providing six one-hour coaching sessions, found positive but inconclusive results over its first 12 months due to the small sample.

Young People and Early Psychosis

Summary

One systemic scoping review (Murphy et al, 2023), three peer-reviewed studies (Klodnick et al, 2015; Simmons et al, 2022; Watkins et al, 2019), and two grey literature reports (Jones, 2016; Headspace, 2020).

Quality of Studies

Published studies ranged from moderate to high quality.

Evidence

Reviews: A review of peer support interventions within Integrated Youth Services, and school and university settings (Murphy et al, 2023) found that they had the potential for improving recovery related outcomes, including psychological wellbeing. Other improved outcomes related to managing mental health difficulties, including coping skills, autonomy, ability to manage self-stigma, self-efficacy, and decision making for mental health care. Peer support models included facilitating self-help support groups and internet support groups and providing one-on-one peer support. Seven studies reported programs within university settings, six programs were in integrated Youth MH services, and one was delivered in a secondary/high school in collaboration with a community mental health service.

A review of existing knowledge on YPSW roles in treatment settings, and the barriers and facilitators for youth peer support in practice (De Beers et al, 2022) found strong evidence for YPSW roles for: Engagement, emotional support, navigation and planning, advocacy, research and education.

Studies: See also Physical Health Section above (Watkins et al, 2019) and Employment Section below (Klodnick et al, 2015; Simmons et al, 2022).

Grey Literature: A number of US Early Intervention in Psychosis (EIP) peer models were identified by Jones (2016); however, evidence of impact was not reported. These models included:

- Peer Navigators who help clients troubleshoot in the transition from EIP to standard mental health and associated support services such as education.
- Vocational/educational peer specialists who help clients access services and establish relationships on-campus administrators, teaching staff, placement coordinators and future employers as part of providing holistic “wraparound” supports.
- Peer support groups across diverse settings, including clinical settings, Hearing Voices Networks, Work or School-Focused Support groups, Wellness Recovery Action Planning (WRAP) groups within community settings, Activities groups, and Community Events.

See also Employment Section below (Klodnick et al, 2015; Simmons et al, 2022) and Online section below (Headspace (2020).

Employment

Summary

Two peer-reviewed studies of peer support for employment and people with mental health challenges were identified (Klodnick et al, 2015; Simmons et al, 2022). Both studies focus on youth.

Quality of Studies

Both studies were of moderate quality.

Evidence

Reviews: Nil identified

Studies: A US study of peer support in a community clinical setting reported that 16 of 21 (76%) youth participants reported valuing or benefiting from peer mentoring. An Australian study, also involving peer workers in community clinical services providing employment support to youth found the program achieved positive vocational outcomes and good fidelity to the IPS (individual placement model) e.g., approximately half of young people had employment placements.

Grey Literature: Evaluation of a peer-supported employment program run by MIND in the UK (Kotecha-Hazzard et al, 2020) involved groups and one-to-one support, coaching, job search skills, interviewing skills, and other support to improve work readiness and matching people to vacancies and education/training opportunities. They found small improvements in supporting people to secure employment and engage in education/training. Staff turnover and inconsistent premises were common problems leading to groups finishing or pausing for long periods.

Drug and Alcohol Community Support Services (including Homelessness and First Nations Programs)

Summary

Three published reviews (Miller et al, 2020; Reif et al, 2014; Shalaby et al, 2020) and one grey literature review (Meumann & Allen, 2019) either focused explicitly on community-based peer work models for these populations or reported sub-group evidence for these populations.

Evidence

Reviews: A large systemic review of programs at the intersection of homelessness, drug and alcohol, and mental health (Miller et al, 2020) found overall reduction in harm related to drug and/or alcohol use, reduced use and relapse rates. Three studies reported improvements in homelessness status including decreases in the number of days spent homeless, improved housing retention, and improved health, return to work, and greater community engagement leading to improvements in quality of life.

A systematic review by Reif et al. (2014) of peer support for recovery from drug and alcohol abuse across the continuum of recovery, from pretreatment to maintenance services, community, walk-in, and inpatient settings found moderate level of evidence for reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience.

A broad narrative review of peer work (Shalaby et al, 2020) found that immersion in peer support groups and activities and active engagement in community were the two critical predictors of recovery for more than half the dependent substance users.

Studies: Nil identified.

Grey Literature: A review by Meumann and Allen (2019) described peer-delivered mutual support groups, such as Alcoholics Anonymous (AA) and SMART Recovery (limited and mixed evidence), web-based or eHealth models for peer support (promising evidence of impact on alcohol consumption), Peer-run and peer-operated services (effective for harm reduction activities), and peer workers in structured service delivery settings such as within mainstream alcohol and other drug (AOD) services. They noted a significant number of AOD workers identify as peers, and that mental health, homelessness, family violence and AOD issues are intrinsically linked as part of AOD peer work.

Community Support for Individuals formerly in Prison and Forensic settings (Including First Nations Programs)

Summary:

No reviews or peer-reviewed community studies examined the role of peer support for these populations. One Australian grey literature report was identified (Justice Action, 2024).

Evidence

Reviews: Nil identified

Studies: Nil identified

Grey Literature: Justic Action (2024), an Australian Lived Experience advocacy organisation, reviewed peer models in prison and forensic settings, identifying a number of programs, including the following examples:

- Women's Justice Network Adult Mentoring Program provides one-to-one social support for women and girls who have either exited custody or are at risk of involvement in the Criminal Justice System.
- Deadly Connections Youth Frontiers Project responds to Aboriginal children and young people, ages 10-17, who are entangled or at risk of being entangled with the criminal justice system or child protective services. Youth Frontiers are delivered by Aboriginal Youth Mentors who act as positive role models for the children.

Digital / Online Models

Summary

Six peer-reviewed studies (Atif et al, 2022; Evans et al, 2020; Fortuna et al, 2019; Fortuna et al, 2022; Kerner et al, 2021; Radovic et al, 2022 – five of these from the US) and 3 Australian grey literature sources (Black Dog Institute, 2021; Boyle et al, 2023; Headspace, 2020) examined peer work delivered digitally.

Quality of Studies

Four studies were rated as moderate to moderately high quality **(**Evans et al, 2020; Fortuna et al, 2019; Fortuna et al, 2022; Kerner et al, 2021) with the remaining two rated as low quality (Atif et al, 2022; Radovic et al, 2022)

Evidence

Reviews: Nil identified.

Studies: A US comprehensive mixed methods study of telephone-delivered peer support (Evans et al, 2020) concluded that it could address diverse needs of high-risk groups. Fortuna et al. (2019) found that a majority of peer workers owned smartphones and were willing and able to use them effectively in their role.

A further US study of digital peer support self-management support (Fortuna et al, 2022) found that it was acceptable and feasible to peers and was associated with statistically significant improvements in self-efficacy to manage chronic disease and personal empowerment. In addition, pre/post non-statistically significant improvements were observed in psychiatric self-management, medical self-management skills, and feelings of loneliness.

A US study examining utilization of peer-supported hotlines by a large sample of youth between 2010-2016 (Kerner et al, 2021) found that this was widespread and increasing over time, and should therefore also be a focus of prevention and early intervention mental health support for this group.

Grey Literature: An evaluation of the digital SANE Peer Guided Service (one-on-one telephone, online groups, forums, support lines) (Boyle et al, 2023) found peers were highly regarded for their ability to listen and convey respect, compassion and understanding. No significant improvements in psychological distress were reported, though QOL and recovery score improvements were significant, and there was some evidence of reduced acute service costs (ambulance, emergency departments, hospital).

An evaluation of 'eFriend' (3-15 telephone or video calls) (Black Dog Institute, 2021) involving a small sample of an evaluation of the first 12 months of 'Spaces Chat' (weekly group peer-led chat for young people) (Headspace, 2020) was well-received and reported high use (>37,000 young people had participated in 148 chats), and peer moderators felt highly supported and safe in their role.

Eating Disorders

Summary

No reviews or peer-reviewed studies were identified that focused on peer support for people with eating disorders. Two Australia grey literature reports were identified (Australian National Eating Disorders Collaborative, 2018; Butterfly Foundation, 2022).

Evidence

Reviews: Nil identified.

Studies: Nil identified.

Grey Literature: A rapid review (predominantly pilot studies with small samples) and interviews with key informants (Butterfly Foundation, 2022) reported eating disorder-focused peer workers increased consumers' empowerment, hope, acceptance and treatment attendance, and reduced feelings of isolation. The Australian National Eating Disorders Collaborative (2018) found evidence for peer work effectiveness in this area is limited; the evidence that does is comparable to general mental health settings. This includes

increased hope, improved engagement with treatment and sustained remission of symptoms. For families, benefits include a reduction in stress, overcoming isolation, and increased sense of agency and efficacy as partners in the treatment process. Key challenges include lack of understanding of the peer work role, unsupportive work environments and maintaining personal mental wellbeing, and funding.

Section Five: Family/Carer Peer Work Models

Summary

In community group programs, they enhanced carers' capacity to manage their own wellbeing as well as their caring roles. In inpatient settings, they enabled carers to voice their concerns without fear of alienating the clinical staff. In programs supporting young carers, there were significant reductions in depressive symptoms, risk of homelessness and stigma.

Quality of Studies

The studies were of moderate quality, one study (Wisdom et al. 2014) was deemed of low quality based on its limitations as a simulation pilot study (**see Appendix 12 for details**).

Evidence

Reviews: Nil identified, though studies were mentioned by Charles et al, (2021), Gillard & Holley (2014), and Zeng & McNamara (2021)

Studies: Table 3 provides an outline of the key themes beginning with the evidence of the tension between formalised and informal peer work. The table reveals evidence of the burden on families and carers of people with mental health conditions as well as the effectiveness of the intervention such as the Family Navigation Project and the introduction of specialised roles (Carer Peer Workers (CPW) and Family Support Specialists (FSS)). Rebeiro Gruhl et al. (2015) asks the question 'W*ho is the peer support worker in northeastern Ontario and what they do?*' They found most peer workers were identified in mainstream mental health services; in the focus group of 25 peer workers, they found 14 were paid for their work, with 11 functioning as volunteers. Rebeiro Gruhl et al. (2015) found that, as the role of peer worker moved beyond the urban centre, there was an increased likelihood of burnout, role blurring, unclear personal boundaries, fewer support networks, and an increased likelihood of volunteer versus paid peer work. Very little appears to be known about the background of volunteer family/carer peer workers. Unfortunately, in Chapin et al's (2012) study, a detailed description of the background of volunteers and their recruitment was not available.

Grey Literature: An evidence review by AREFEMI Victoria (2011) identified four main models:

1. Carer Peer Support Worker - carers paid to support mental health carers, often in community mental health settings.
2. Carer Consultant – carers paid to support mental health carers, primarily when they are in clinical mental health settings, usually attached to individual hospitals or community mental health facilities.
3. Carer Advocate – workers who provide individual advocacy for mental health carers; support system navigation; support where they need an independent advocate. Lived experience as a family/carer 'desirable' but not 'essential' criteria.
4. Carer Advisor – provide advice on mental health carer policy and related issues.

Their review did not include mental health carers in the following paid roles: Helplines, Family/carer peer education programs and workshops (e.g. 'Well Ways' and programs provided by non-government organisations), Family/carer researchers and facilitators of quality improvement activities, and family/carers sitting on Committees, Boards, Advisory Bodies.

A study exploring the experiences of carer peers in the Victorian mental health system (Rising Together Action Group, 2022) reported that they felt undervalued, isolated, and marginalised when attempting to work in a relational way within services focused predominantly on individuals in isolation.

Table 3: Family/Carer Peer Work Models

Theme	Setting and target group	Outcome	Evidence *rating
Peer support to families of children and young people with mental health needs	Families and parents with children and young people (Family Navigation Project and Parent Advocate with Lived Experience (PAL).	Peer work is just as important to support family members, particularly those supporting children and youth who access mental health supports. Found negative effects on work and social and family relationships because of the time and effort required to support the youth with mental health conditions.	Markoulakis et al. (2018) ***
	Families with young children with behavioural and MH needs.	Family partners with lived experience play a key role in engaging families in mental health services to build rapport and help families navigate services and build skills.	Nayak et al. (2022) ***
	Identifying what FSS do vs perceptions.	Perceptions of activities performed by FSS was found to be generally congruent with what FSS did.	Wisdom et al. (2014) ***
	Simulation pilot of 4 Family Peer Advocates (FPAs).	(Simulation pilot study). Variability in the range of services provided and identified challenges in aspects of service provision, such as boundaries of advocate roles etc.	Wisdom et al. (2011) **
Peer support to carers (providing informal and unpaid care to mental health service users).	Phone interviews with carers. Australia.	Carers were mostly positive about the support (emotional & practical) provided by CPWs. Carer peer support work should be tailored to the specific needs of the carers.	Visa & Harvey (2019) ***
Volunteer peer support	Test invention of pairing an older adult with an older adult peer "volunteer".	Peer support intervention has potential for reducing depression and increasing quality of life in low-income older adults who have physical health conditions.	Chapin et al. (2012) ***
	Broad survey targeting identifying PSW's. (Ontario Canada).	A challenge to calculating the exact population size of volunteer PSW.	Rebeiro Gruhl et al. (2016) ***

Section Six: Peer Workforce Issues

Summary

Forty-seven studies focused on the broad range of issues that impact the development of the peer workforce, and therefore inherently impact the effectiveness of the various peer work models. These are summarised below across six areas of interest (**see Table 4 below and Appendix 8 for further detail**).

Quality of Studies

Thirty-three peer workforce studies used qualitative designs and methods, two used quantitative descriptive methods, and 12 used mixed methods. There was significant heterogeneity across studies and this was also reflected in their quality (**see Appendix 13 for further details**).

Peer Workforce

As evidenced in the literature, successful mental health peer support work pivots on the understanding and collaborative co-management of its unique workforce. The enablers and barriers to peer work are rooted in workforce literature evidencing the types of inherent tensions that come with significant systemic workforce change in a unique form of human service delivery. Peer work is in a process of evolution and transition whereby it is subject to the nuanced perspectives of those helping to shape, explore and describe. For example, the phrase *peer work* comes with diverse titles; ranging from Hamilton et al.'s (2015) description of a 'consumer-provider' (on face value a contradiction in terms) to a 'lived experience practitioner.' (Byrne et al. 2016). There are also a range of common themes identified by this review which are listed below.

Workforce barriers & challenges

As reflected in the systematic review by Gillard and Holley (2014) where the peer work role is properly valued and supported, peer workers are a powerful resource in mental health services.

The overarching challenge, appearing in the literature, are the barriers to the establishment of a valued role for peer work. Recent Australian studies by Chisolm & Petrakis (2023, 2020) highlight the continuance of concerns raised by others (Adams et al, 2020, Byrne et al, 2016) about power imbalances, stigma and inequity faced by peer workers entering a traditional medical model of health service delivery. Common workforce challenges refer to pay and career progression barriers (Hagaman et al. 2023**,** Adams et al. 2020, Burke et al. 2018) and peer workers 'filling gaps' (Gray et al. 2017). Gaps in training (Asad & Chreim, 2016) and resourcing of peer work to rural areas are also highlighted.

Enablers, benefits & opportunities of peer work

The positive value provided by peer work is consistently documented across the literature. Peer status being authentic and stigma-opposing (Chisolm & Petrakis, 2020) contributing to greater levels of trust, empathy, and open communication in relationships with clients. (Stefancic et al. 2019).

A recent, high quality national survey from Switzerland (Burr et al. 2020) reports high satisfaction of peer work. The study notes its limitations which may have shaped the positive results, for example, the study was not subjected to formal psychometric testing and peer work is relatively new in Switzerland. However, there were notable differences in the Burr et al. (2020) study from the other reviewed works which, in addition to high job satisfaction responses, revealed detailed, active, oversight and reporting of the support related to PSS's health and wellbeing. Peer workers were referred to as peer support specialists (PSS) a valued title and with salaries appearing to be higher in Switzerland than in the US.

Other positive inroads include studies showing traditional mental health workers the positive value of peer workers (Meurk et al. 2019, Moore et al. 2020). A development of a fidelity instrument (Gillard et al. 2020) which measures the extent to which peer support is being delivered in a way that is demonstrably different from usual intervention; and recent literature reveals peer workers are not less satisfied, nor more burnt out than mental health professionals from other disciplines (Scanlan et al. 2020).

Integration of peer work

Several studies focused on the point of integrating peer work / peer workers into traditional mental health services wherein the challenges of barriers to integrating with traditional services are well documented. Noted too was the recent development and testing of an integrated staffing model described by Parker et al. (2022) for rehabilitation settings which may provide a pathway to facilitate the effective meaningful inclusion of peer support workers.

Support and leadership

As evidenced in the scoping review by Zeng and McNamara (2021) the championing of peer provision initiatives by organisational leadership is central to the success and sustainability of peer work. Emphasized is the importance of management exposure to peer work (Byrne et al. 2019) and whole-of-organisation commitment, culture and practice to supporting employment of peers in multidisciplinary environments. (Byrne et al. 2022). Wu et al. (2022) identifies organisational support resulting in increased work motivation, work engagement, organizational commitment, and job satisfaction. Similar examples of success are inherent to other, non-specific papers, which describe good outcomes in peer projects made possible due to strong leadership, competent co-ordination, and supervision. (Kern et al. 2013).

Training and supervision

The Delphi study by Charles et al. (2021) point to the consensus of 5 training topics (lived experience as an asset, ethics, PSW well-being and PSW role focus on recovery and communication), which were reflected across the individual studies. Recommendations for additional training for specific peer work are noted, for example, more structured primary health training for peer workers working with people with additional diagnoses in noted by Blixen et al. (2015).

In relation to supervision, variations were identified in the literature in accordance with the type of agency with community-run organisations indicating preference a more experienced peer support worker as a supervisor (Forbes et al. 2022).

Well-being (of peer workforce)

In addition to the earlier described focus on well-being in the Burr et al. (2022) study, well-being is an integrated topic across several of the reviewed papers. As noted by Gillard et al. (2020) peer workers in the UK largely stay well and experience a positive sense of self and growth in their work. Peer workers are reported to be no more likely to experience negative impacts of working than other healthcare professionals or mental health professionals from other disciplines (Gillard et al 2020, Scanlan et al. 2020). Holley et al. (2015) highlight specific risks to peers (e.g., relational/boundaries) and emphasise the importance of agency and peer-led risk management processes.

Table 4 Workforce themes

Workforce theme	Setting and target group	Outcome	Evidence *rating
Barriers & challenges.	Community clinical adult services.	Progress noted but institutionalization of peer support serves as a barrier to worker entry and retention; peer workers underpaid & barriers to professional advancement.	Adams, (2020) ***
	Community and hospital MH teams. USA.	Challenge of PW's setting boundaries with clients. Training gaps. Determining renumeration challenge.	Asad & Chreim (2016) **
	Delphi study UK – benefits/barriers.	Approximately half of the sample worked in public services and were more likely to have concerns regarding pay and career progression.	Burke et al. (2018) ****
	Interviews with 13 PW's Australia.	Current medical model approach requires critique to facilitate reform and avoid tokenism.	Byrne et al. (2016) ***

	LEP's and stigma. Australia.	LEP's can help reduce stigma provided they are not faced with discrimination in the workplace.	Byrne et al. (2016) ****
	Community, clinical, ROP. Australia.	Power imbalances, organizational structure, stigma and inequity.	Chisolm & Petrakis (2023) ***
	Clinical MH. ROP. Australia.	Key barriers include inequity between PW and MH practitioners. Medical model and stigma.	Chisolm & Petrakis (2020) ***
	PSW Perceptions of 'The Works.' Australia.	Power imbalance between facilitators. More development needed around the co-facilitation relationship between OT's and Peer-Support Workers.	Curtin & Hitch (2016) **
	Community, clinical rural MH Australia.	PSW's tended to 'fill service gaps' within services.	Gray et al. (2017) ***
	ROP. USA	PRSS report few professional advancement opportunities and that their role is frequently misunderstood.	Hagaman et al. (2023**) ***
	Diverse MH settings.	(a) direct and indirect expressions of prejudice; (b) relationship problems with co-workers; (c) lack of recovery environment; (d) being the only peer provider in the agency.	Moran et al. (2012) ***
Enablers, benefits & opportunities of peer work.	Community and hospital MH teams. USA.	Ambiguity in job description can also be an advantage as gives opportunity to customize PW role according to PW strengths and client needs.	Asad & Chreim (2016) **
	Hospital and community settings in Switzerland.	Very high job satisfaction amongst PSS's. Job descriptions with high proportion corresponding to the actual work which leads to increased role clarity & satisfaction. Salaries appear higher in Switzerland than in the US.	Burr et al. (2020) ****
	Clinical MH. ROP. Australia.	Staff being present, authentic and stigma opposing. Peer workers role itself forming acceptance by challenging perceptions.	Chisolm & Petrakis (2020) ***
	Community non-clinical (Clubhouse) Australia.	Four levels of peer support emerged: Social inclusion and belonging; shared achievement through doing; interdependency; and intimacy.	Coniglio et al. (2012) **
	Community, clinical rural MH Australia.	PSW's valued for their ability to build trusting connections with clients and to accept client choice in a non-judgemental way.	Gray et al. (2017) ***
	Community, clinical. USA.	PW potential to increase access to recovery-oriented services for people with mental and substance use disorders.	Myrick & Vecchio (2016) **
	Range of clinical and community clinical MH.	Appear to benefit the individual worker and may result in societal cost savings.	Salzer et al. (2013) ***
	Community, clinical. Australia.	Youth PW's are likely to experience similar benefits and barriers to those of adult peer workers.	Simmons et al. (2020) **

	Community, clinical. Australia.	PW's are not less satisfied, nor more burnt out than mental health professionals from other disciplines.	Scanlan et al. (2020) ***
	Community, clinical. USA.	PS's and supervisors indicated that "peer" status contributed to greater levels of trust, empathy, and open communication in client relationships.	Stefancic et al. (2019) **
Integration of peer work	Community and hospital MH teams. USA.	Role integration is facilitated by team understanding of the role, and the provider's ability to adjust to their new work environment.	Asad & Chreim (2016) **
	Multi-disciplinary MH services in USA.	Whole-of-organization commitment, culture and practice are essential to support employment of peers in multidisciplinary environments.	Byrne et al. (2022) ***
	Senior managers of MH services, Australia.	Management exposure to peer work and peer principles identified as critical in developing understanding and commitment to peer roles.	Byrne et al. (2019) ***
	Community, clinical, ROP. Australia.	Power imbalances, organizational structure, stigma and inequity prevented ease of implementation. Values that were identified were hope, inclusive practice, and collaboration.	Chisolm & Petrakis (2023) ***
	Community, clinical MH.	Successful integration in interprofessional teams was dependent upon the ability of clinical staff to focus on unique strengths PSW's bring, in addition to their lived experience.	Ehrlich et al. (2019) ***
	Community, clinical MH.	Systemic constraints limited the program's autonomy to uphold peer values. Challenges associated with peer leadership and peer staff perception of ideological differences in ROP.	Fletcher et al. (2020) ***
	Community, clinical MH.	Findings demonstrate that a strategy of training, goal setting and consultation can positively affect perceptions of inclusion, promote implementation.	Gates et al. (2010) ****
	Range of clinical and community clinical MH.	Fidelity index for 1:1 peer support in mental health services was produced with good psychometric properties.	Gillard et al. (2020) ****
	Clinical and community MH settings.	Implementation facilitators included site preparation, external facilitation, and positive, reinforcing experiences with the CPs. Challenges included role definitions & deficiencies in CPs' technical knowledge.	Hamilton et al. (2015) ***
	Clinical and community clinical settings.	PW good will/enthusiasm tempered by realism regarding the potential challenges of ROP.	Meurk et al. (2019) ***
	Multi-D MH professionals - different settings.	Mental health professionals valued PW's for the deeply empathic, relational approach they brought.	Moore et al. (2020) **
	Integration into hospital-based MH-care teams.	Challenges 3 themes 'Pioneers and the pressure to succeed'; 'a colleague, a rival or yet another patient?' and 'sharing of information, boundaries and professionalism'.	Otte et al. (2020) *

	Community Residential MH Rehabilitation. Australia.	The integrated staffing model shows promise in supporting clinical services to achieve ROP.	Parker et al. (2022) ***
	Clinical and community MH settings. Australia.	Barriers persist in the integration of peer support roles in MH.	Reeves et al. (2023) ***
	Newly Integrated MH and Primary Care Teams. USA.	PP's occupied a wide range of network positions, job responsibilities and varied according to their roles, backgrounds and service populations.	Siantz et al. (2019) **
Support and leadership	Multiple MH settings. Australia.	High rates of agreement on scale items measuring five co-designed peer support principles.	Otto et al. (2022) ***
	Clinical and community clinical USA.	Perceived organizational support increased motivation to work, work engagement, organizational commitment, and job satisfaction.	Wu et al. (2022) ****
Training and supervision	Peer educators with CM (SMI and diabetes).	Structured training in primary healthcare for PEs with SMI and DM may be helpful.	Blixen et al. (2015) **
	Community, clinical, MH USA.	Desire for a supervisor who was a more experienced peer support worker.	Forbes et al. (2022) ***
	Community, clinical, MH Australia.	Good evaluation result of IPW, but commitment and leadership within the organisation and supporting peer workers is crucial.	Franke et al. (2010) ***
	Community, employment MH.	Successful PW-supported employment program not possible without strong leadership of a highly competent on-site coordinator and supervisor.	Kern et al. (2013) *
	Hospital/clinical MH settings. Severe MH.	Need for ways to train peer staff in managing safely the vicarious trauma, frustrations, and inevitable setbacks involved in this work.	Mourra et al. (2014) *
	Youth with serious mental illness. Multiple MH, USA.	In Los Angeles having three or more peer specialist trainings (vs fewer trainings) was associated with lower use of inpatient services.	Ojeda et al. (2020)
	Community, clinical, MH settings. UK.	Training valuable, challenging, positive, good role preparation. Areas for improvement included emotional involvement/feelings PSWs had for their peers/ending the support relationship.	Simpson et al. (2014) **
Wellbeing	Range of clinical and community clinical settings.	PW's largely stay well and experience a positive sense of self and growth in their work - no more likely to experience negative impacts of working than other healthcare professionals.	Gillard et al. (2020) ****
	Range of clinical, community clinical and statutory settings.	Risks to peers e.g., relational/boundaries etc. Importance of agency and peer-led risk management processes.	Holley et al. (2015) ***

Concluding Remarks

The scarcity of high-quality targeted studies reveals much in terms of the Peer Work phenomenon as a priority for systemic reform and help seeker support - those studies which have been conducted give us more scope for the gaps revealed than for what they contribute to our understanding of effectiveness of peer work models. Paino et al's (2023) commissioned grey literature report concluded that most research and evaluation frameworks fail to capture the complexity and nuance of peer work. Similarly, Shalaby et al's (2020) recent narrative review summarises the current state of the evidence for peer support services (PSSs): "There is abundant literature defining and describing PSSs in different contexts as well as tracking their origins….The effects of PSSs are extensive and integrated into different fields, such as forensic PSSs, addiction, and mental health, and in different age groups and mental health condition severity. Satisfaction of and challenges to PSS integration have been clearly dependent on a number of factors and consequently impact the future prospect of this workforce" (e15576).

With regards to the training and support - supervision and organisational readiness issues - the diversity and inconsistency of models and implementation make it difficult to identify sound practice let alone the flow on effects. This deficit of clarity and understanding is even more apparent in Carer Peer Work settings - some targeted studies in specialist Peer Work including Suicide Prevention, Digital Service Delivery and AOD - again more gaps than there is evidence of close examination of these specialist settings. Barriers and Enablers remains a useful indication of better practice and vital elements for Peer Practice to take place.

Highlighting differentiation of service delivery with intention and peer staff wellbeing was refreshing and encouraging - as was the identification of championing as a pivotal factor for success and supported implementation. For this Lived Experience Practitioner and Mentor, the workforce themes resonated and captured the reality as reflected in current contexts - role clarity, Organisational Commitment and Culture - reminiscent of the Domains identified by Byrne et al 2019.

Even from what studies are available to us for review, indications suggest an as yet untapped resource in Peer Workforce which might realise significant benefit and reform if adequately understood, integrated and valued.

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Appendices:

Appendix 1: Distribution of Peer Work Research (by Country and Year)

Figure 1: Included studies per country, 2010–2021 (Source: Akerblom & Ness, 2023)

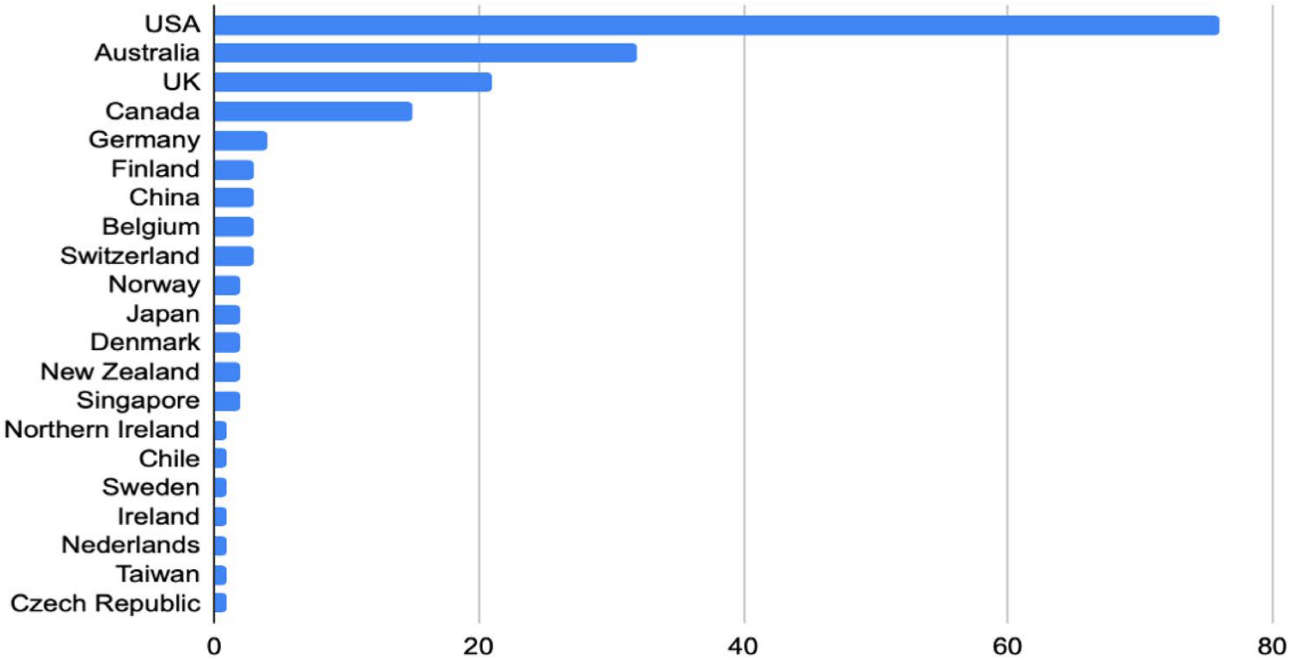
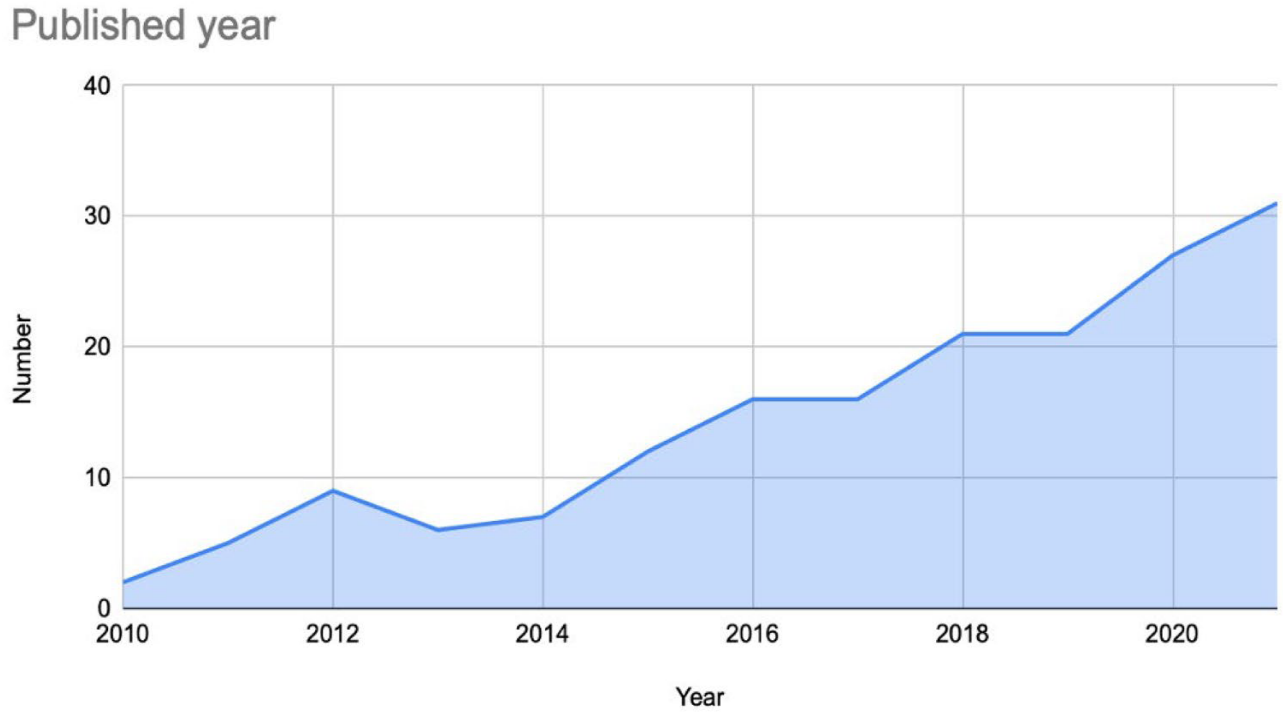


Figure 2: Number of studies by year, 2010–2021 (Source: Akerblom & Ness, 2023)



Appendix 2: Peer Workforce Literature search document

PICO

Population: peer workers in the mental health and suicide field

Intervention: Innovative service models of mental health peer support

Comparator / Context: Primary, secondary or tertiary clinical or non-clinical services, in specialty treatment, medical/therapeutic, or psychosocial support settings, public or private.

Outcomes: Innovative service delivery models to support increased engagement of the peer workforce

Potentially relevant keywords:

Peer support workers
lived experience workers
Peer-to-peer support
Consumer-run programs
Consumer specialists
Mental health peer support
Recovery-oriented services
Mutual aid
Lived experience
Peer mentoring
Client-run organizations
Community-based support
Empowerment-focused services
Family peer support
Consumer-driven services

Initial Search Strategy- conducted in PubMed and Google Scholar

(peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience OR self-help group OR Peer-to-peer support OR lived experience workers OR Recovery-oriented services OR consumer advocacy OR Empowerment-focused services OR Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program)

AND (mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*)

AND (models of care or primary care or secondary care or inpatient or hospital or healthcare service)

Search report and databases:

Databases	Number or results	Date searched
Google Scholar	70	21.02.2024
Medline	205	21.02.2024
PsycInfo	486	21.02.2024
Emcare	473	21.02.2024
CINAHL	421	21.02.2024
Total	1655	
Total - duplicates removed	1308	

Saved search login: peerworkers

Database(s): **APA PsycInfo** 2002 to February Week 3 2024

Search Strategy:

#	Searches
1	exp Peers/
2	(peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience or self-help group or Peer-to-peer support or lived experience workers or Recovery-oriented services or consumer advocacy or Empowerment-focused services or Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program).ti,ab,id.
3	Or/1-2
4	mental health/ or mental health services/ or preventive mental health services/ or public mental health/
5	mental disorders/
6	(mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*).ti,ab,id.
7	or/4-6
8	exp Primary Health Care/ or exp Health Care Delivery/ or exp Models/
9	("models of care" or service model or "healthcare delivery" or primary healthcare or secondary healthcare or hospitals or inpatient).ti,ab,id.
10	8 or 9
11	3 and 7 and 10
12	limit 11 to (english language and yr="2000 -Current")

Database(s): **Emcare Nursing & Allied Health Database** 1995-current

Search Strategy:

#	Searches
1	peer group/
2	(peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience or self-help group or Peer-to-peer support or lived experience workers or Recovery-oriented services or consumer advocacy or Empowerment-focused services or Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program).tw,kw.
3	1 or 2
4	mental health/ or community mental health/ or psychological well-being/ or mental health care/ or mental health center/
5	mental disease/

6	mental health service/
7	(mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*).tw,kw.
8	or/4-7
9	model/
10	health care delivery/
11	primary health care/
12	secondary health care/
13	hospital patient/
14	("models of care" or "service model" or "healthcare delivery" or primary healthcare or secondary healthcare or hospitals or inpatient).tw,kw.
15	or/9-14
16	3 and 8 and 15
17	limit 16 to (english and yr="2000 -Current")

Database(s): **MEDLINE(R) All including Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Daily and Versions(R)** 1946-current

Search Strategy:

#	Searches
1	Peer Group/
2	(peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience or self-help group or Peer-to-peer support or lived experience workers or Recovery-oriented services or consumer advocacy or Empowerment-focused services or Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program).tw,kw.
3	or/1-2
4	mental health/ or mental disorders/ or Mental Health Services/
5	(mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*).tw,kw.
6	4 or 5
7	("models of care" or service model or "healthcare delivery" or primary healthcare or secondary healthcare or hospitals or inpatient).tw,kw.
8	3 and 6 and 7
9	limit 8 to yr="2000 -Current"
10	limit 9 to english language

CINAHL:

#	Query
S15	S3 AND S8 AND S13 – limited to 2000-current English Language
S14	S3 AND S8 AND S13
S13	S9 OR S10 OR S11 OR S12
S12	TX ("models of care" or "service model" or "healthcare delivery" or primary healthcare or secondary healthcare or hospitals or inpatient)
S11	(MH "Inpatients")
S10	(MH "Primary Health Care")
S9	(MH "Health Care Delivery") OR (MH "Secondary Health Care")
S8	S4 OR S5 OR S6 OR S7
S7	TI ((mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*)) OR AB ((mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*))
S6	(MH "Mental Disorders")
S5	(MH "Mental Health Services")
S4	(MH "Mental Health") OR (MH "Mental Health Organizations") OR (MH "Community Mental Health Services")
S3	S1 OR S2
S2	TI ((peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience or self-help group or Peer-to-peer support or lived experience workers or Recovery-oriented services or consumer advocacy or Empowerment-focused services or Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program)) OR AB ((peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience or self-help group or Peer-to-peer support or lived experience workers or Recovery-oriented services or consumer advocacy or Empowerment-focused services or Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program))
S1	(MH "Peer Group") OR (MH "Peer Counseling")

Google Scholar

(peer support or peer workforce or peer consultation or peer mentoring or peer support workers or consumer specialists or lived experience OR self-help group OR Peer-to-peer support OR lived experience workers OR Recovery-oriented services OR consumer advocacy OR Empowerment-focused services OR Family peer support or Consumer-driven services or Client-run organisations or mutual aid or consumer-run program) AND (mental health service or mental health wellbeing or mental disorders or mental illness or suicide prevent*) AND (primary care or secondary care or inpatient or hospital or models of care or service model or healthcare delivery)

Appendix 3: Literature Reviews - Detailed Descriptive Table

Table 1: Systematic and Other Published Reviews (n=24)

Authors, Year	Design, Setting and Sample	Aims	Key Findings/Conclusions	Strengths & Limitations
Akerblom & Ness (2023) Peer Workers in Co-production and Co-creation in Mental Health and Substance Use Services: A Scoping Review	Scoping Review 172 articles 2010-2021: multiple contexts; adults 49 studies focused on the outcomes of peer worker involvement, 52 on the qualities that peer workers bring to services, and 71 on implementing a peer workforce.	To examine: How are peer workers involved in co-production and co-creation in mental health and substance use services, and what are the described outcomes?	**3 types of PS roles in terms of workers' degree of involvement:** 1. As providers of pre-determined services (21 studies) - some studies showed increased service effectiveness; that peer workers can perform a task with fidelity and achieve the same effect as non-peer workers; hence cost-effective. 2. As providers of peer support (145 studies) - effective as navigators, connectors and linkers who expand service users' access to resources and increase their involvement with the service system. 3. As partners in co-creation (6 studies) - involved in planning, delivery, and evaluation of services; employed as consultants, appointed to educate and train clinicians in implementing On-oriented praxis; service-level planning groups; input on the design of programs and services and advocating for changes in clinic policies and practices. Only 1 study focused on effectiveness and feasibility and that the outcomes were promising concerning the effects on providers' and service users' clinical outcomes.; other studies focused on implementation, and identification of challenges and opportunities.	**Limitations:** Did not include studies describing mutual peer support, self-help groups, consumer-driven services, peer-led education, or peer counseling programs. Youth services excluded, even if some articles included peer workers up to the age of 25. Many studies included can make the analysis less focused. May appear to positively portray peer workers, as only, to a small extent, present barriers and obstacles to involving peer workers - a consequence of a solid normative appeal of involving peer workers.

			Peer workers are rarely engaged as partners in co-creation. Identified peer worker roles have different potential to generate input and affect service delivery and development.	
Barker et al. (2020) Developing a Model of Change Mechanisms within Intentional Unidirectional Peer Support (IUPS)	Iterative Systematic Review 71 articles (Peer and Grey) Years not stated; Intentional Uni-directional Peer Support (IUPS – one-on-one mentorship relations that focus on being transformative and applied in an organised fashion) with various populations (mental health, physical health, addiction, criminal justice, and homelessness)	To identify and clarify concepts by examining change mechanisms that underlie IUPS that are potentially transferable across health areas and therefore useful to peer interventions with a homeless population. To provide testable concepts to assess the utility of an IUPS model that, once developed, can be tested and potentially modified /elaborated in different contexts to further understand IUPS interventions.	Model identified mechanisms of working alliances, role modelling, experience-based social support, and processes of becoming a peer-supporter. The model asserts that 1) the working alliance quality influences client/peer outcomes, 2) clients learn behaviours modelled by peers, 3) peer outcomes are mediated by being a role model, 4) peers provide social support (informational, companionship, emotional, instrumental and appraisal) impacting client/peer outcomes, and 5) training, supervision, and support are directly linked to peer supporters' effectiveness.	**Strengths:** Diversity and number of studies. Use of Realist Synthesis, completed with theoretical and empirical sources from multiple contexts, **Limitations:** Lack of randomisation and accounting for bias. Lit search conducted by one researcher and involved a significant interpretation. Studies not excluded based on poor quality. Very few randomised controlled trials. Review limited to peer support models that use IUPS - cannot be generalised to interventions involving other peer-led interventions.
Bowersox et al. (2021) Peer-based interventions targeting suicide prevention: A scoping review	Scoping Review 84 articles Inception-2019	To characterize the breadth of peer-delivered suicide prevention services and their outcomes to inform future service delivery and research.	Suicide prevention interventions utilized a diverse range of peer provider types and functions. Characteristics of peer services such as rapid access, low cost, availability outside of regular business hours, and enhanced privacy all likely contribute to greater acceptability. Gatekeeper training programs appear effective in enhancing awareness of suicide risk and confidence in intervening when faced with a person in crisis. Peer-based interventions associated with reductions in risk of suicide	**Limitations:** The majority of studies were program descriptions or uncontrolled trials; only three were RCTs - Lack of methodological rigor.

	Multiple contexts; adults and youth Suicide prevention service types included being a gatekeeper, on-demand crisis support, crisis support in acute care settings, and crisis or relapse prevention. Brief Gatekeeper training may include suicide risk identification, brief crisis intervention, and referral to advanced crisis support services (e.g., Mental Health First Aid, ASSIST, RUOK). Diverse contexts including general community, post-discharge from hospital, group programs, online forums, connection for older lonely, correctional facilities, workforce (police, firefighters, military).		within subgroups, though causality not firmly established. Peer-based support approaches allowed for targeted outreach to vulnerable groups who might otherwise be unwilling or unable to access mental health support through more formal channels. Peer-based suicide support services highly feasible and acceptable, especially as a complement or alternative to services provided by more formal mental healthcare approaches.	Effectiveness data were lacking for all but a handful of studies.
Charles et al. (2021) Initial Training for Mental Health Peer Support Workers: Systematized Review and International Delphi Consultation	Systematized Review & Delphi Synthesis 32 training manuals from 14 countries synthesized to develop a preliminary list of 18 topics.	To establish consensus levels about the content of initial training for mental health PSWs and the extent to which each identified topic can be delivered over the internet.	Delphi identified 20 training topics (18 universal and 2 context-specific). There was strong consensus about the importance of five topics: *lived experience as an asset*, *ethics*, *PSW well-being*, and *PSW role focus on recovery* and *communication.* There was no clear pattern of differences among PSW, manager, and researcher ratings of importance or by countries with different resource levels. All training topics were identified with strong consensus as being deliverable	**Strengths:** Number of participants from different countries. Low attrition. **Limitations:** Needed more representation from middle- / lower-income countries. Web-based

	Delphi consultation commenced with 110 participants (49 PSWs, 36 managers, and 25 researchers) from 21 countries (14 high-income, 5 middle-income, and 2 low-income).		through blended web-based and face-to-face training (rating 1) or fully deliverable on the internet with moderation (rating 2), with none identified as only deliverable through face-to-face teaching (rating 0) or deliverable fully on the web as a stand-alone course without moderation (rating 3).	consultation more difficult in poorer internet access environments - disproportionately affect PSWs. Only included PSW training manuals available in English or Arabic. Full systematic review not conducted (lacked PICO criteria; quality assessment/ reliability of manuals not explored; discrepancies between reviewers not reported).
Chinman et al. (2014) Peer Support Services for Individuals with Serious Mental Illnesses: Assessing the Evidence	Systematic Review 20 articles 1995 -2012 3 service types: peers added to traditional services, peers in existing clinical roles, and peers delivering structured curricula. Adults	To assess the level of evidence and effectiveness of peer support services delivered by individuals in recovery to those with serious mental illnesses or co-occurring mental and substance use disorders.	Moderate evidence of effectiveness found for each service type for the following: • Reduced inpatient service use • Improved relationship with providers • Better engagement with care • Higher levels of empowerment • Higher levels of patient activation • Higher levels of hopefulness for recovery Effectiveness varied by service type. Across the range of methodological rigor, a majority of studies of two service types - peers added and peers delivering curricula - showed some improvement favoring peers. Compared with professional staff, peers were better able to reduce inpatient use and improve a range of recovery outcomes; one study found a negative impact. Effectiveness of peers in existing clinical roles was mixed. Studies that better differentiate the contributions of the	Many studies had methodological shortcomings; outcome measures varied. Online peer support programs and consumer-operated services were not included in review. Most studies reviewed did not specifically evaluate impact of race, ethnicity, or sex on effectiveness of peer support services.

			peer role and are conducted with greater specificity, consistency, and rigor would strengthen the evidence.	
Corrigan et al. (2022) Formal Peer-Support Services That Address Priorities of People with Psychiatric Disabilities: A Systematic Review	Systematic Review 68 articles 1995-2020; Adults. Multiple contexts, settings and population groups	To make sense of 'outcome" in terms of four major life goals that reflect priorities for people choosing to engage in peer support: (a) Transitioning from a hospital back into the community; (b) Physical health and wellness; (c) Illness management and recovery; (d) Other goals frequently targeted by recovery-oriented systems, including employment, criminal justice involvement, and parenting.	**Posthospitalization release (13 studies)** - 7 of 11 reported significant positive impact on readmission rates and/or number of hospitalization days. One study found significant negative effects of PS related to psychiatric hospitalization, and one with negative effects on crisis stabilization. Secondary outcomes were organized into six groups: (a) 2 studies assessing impact of peer support on arrests and incarcerations: neither found positive benefits. (b) 3 studies examined housing stability and homelessness: One had positive findings. (c) Symptoms assessed in 4 studies: 2 reported positive benefits. (d) 2 studies examined peer-supported self-management: neither found significant effects. (e) 4 studies examined impact on recovery and hope; 1 showed positive benefits. (f) 3 studies examined effects on quality of life; two found positive outcomes. **Physical Heath (15 studies)** - only 1 indicated iatrogenic effects; 9 used individual peer coaches on health literacy and personal goals; 3 focused on peer navigation to help people engage in existing primary and specialty care; 3 were more specific to weight-related health goals, cigarette smoking, and assertive community support. Significant positive impacts for most studies. **Illness management and recovery (34 studies)** – 25 were manualized generic programs (eg. Wellness and recovery action plans (WRAP, n = 2), pathways to recovery (PtR, n = 5), and building recovery of individual dreams and goals (BRIDGES), Positive impacts for hope, quality of life, self-esteem, self-efficacy, personal empowerment, and symptoms across most studies. **Other: Employment, Criminal Justice, and Parenting (6 studies) -** parenting (n = 2): mixed – significant positive/no impact parental self-efficacy and parenting skills; criminal justice (n = 3): mixed – no impact on recovery /significant	**Limitations:** Took a parsimonious approach focusing on primary outcomes that does decrease power of analyses. Failed to include non-English studies. 55 o 373 records not included because could not be accessed through online methods. Nonsignificant or iatrogenic findings not published in many peer-reviewed journals thereby inflating positive benefits. Significant heterogeneity - measures, interventions, and methods. Focus on RCTs which discounts participant treatment preference and is counter to peer principles.

			positive impact on social support and alcohol use; employment (n = 1): iatrogenic effects due to PS.	
De Beers et al. (2022) A systematic review exploring youth peer support for young people with mental health problems.	Systematic Review 24 articles 2000-2022; Youth Peer Support Roles across a range of contexts and settings.	To systematically review current literature to identify what we know so far about the YPSW roles in treatment settings, and the barriers and facilitators for implementing and pursuing youth peer support programs in practice. To make practical recommendations for embedding YPWs in youth mental health services.	The roles included the: engagement role, emotional support role, navigating and planning role, advocacy role, research role and the educational role. The themes explored the needs of youth peer support workers (YPSWs) experiences of YPSWs, relationships between service users and YPSWs, the collaboration process between YPSWs and non-peer staff, and organizational readiness. **Strength of Evidence for YPSW roles by number of studies were as follows:** • Engagement role (n=21) - Consistent Very strong • Emotional support role (n=17) - Consistent Very strong • Navigating and planning role (n=11) - Consistent Very strong • Advocacy role (n=10) - Consistent Very strong • Research role (n=3) - Consistent Medium/strong • Educational role (n=6) – Mixed Strong Conclusion: We should be careful not to see valuable youth peer support as YPSWs that fit well within the traditional medical model commonly promoted by mental health services [47]. When we take youth peer support from the real world and mould it into existing mental health services, we risk YPSWs become another type of mental health worker there to fix the broken mind. **Recommendations:** 1: Set clear and realistic expectations for YPSWs. 2: Consider potential power imbalances in the collaboration process between YPSWs and (non)-peer staff. 3: Provide adequate time and resources to assist the personal and professional development of YPSWs. 4: Approach the implementation of YPSWs with a growth mindset.	**Limitations:** Excluded studies of youth PWs in adult mental health services, Those focused on prevention of mental illness, YPSWs for parents and/or relatives, and YPWs in digital environments.
Doughty & Tse (2011)	Integrative Review 29 articles	To examine the evidence from controlled studies for the effectiveness of consumer-led mental	27 were consumers participating within a traditional mental health service as peer supporters/specialists, health care assistants, case managers, advocates, educators or interviewers. 8 were of entirely consumer-run programs,	**Limitations:** Heterogeneity of studies and lack of power (due to sample size) to detect an

Can Consumer-Led Mental Health Services be Equally Effective? An Integrative Review of CLMH Services in High-Income Countries	1980-2008; multiple contexts All in high-income countries	health services.	including a crisis hostel, self-help programs, drop-in centers, peer support, advocacy, case managers or educators. Only 1 reported a consumer-led partnership within a traditional MHS. The majority of studies showed: • either no differences, or greater recovery for those in the consumer-led interventions compared to traditional services, across all three categories of emotional, social or symptomatic recovery. • a reduction in hospitalizations. • cost savings. • greater improvements in practical outcomes, including employment, finances, education, living arrangements, and transport. Found equally positive outcomes for clients as traditional services, particularly for practical outcomes such as employment or living arrangements, and in reducing hospitalizations and thus the cost of services. More inclusion of recovery-oriented outcome measures needed.	effect. Majority of the reviewed articles were written by health professionals, with or without input from consumers. Included studies only in high-income, English-speaking countries. Focus on effectiveness studies meant descriptive or qualitative studies were not included.
Gillard et al. (2014) Peer workers in mental health services: literature overview	Narrative Review Years not stated; multiple contexts Focus on existing reviews, and evidence from NZ, US and UK.	To appreciate the origins of the peer worker role and how the role has been introduced into mental health services to date. To understand the evidence for the benefits of peer worker roles, for patients, peer workers and mental health service delivery.	**Benefits for patients** • Decreased social isolation • Improvement in quality of life • Increased independence and confidence **Benefits for peer workers** • Development of skills • Personal discovery • Improved financial situation • More likely to seek and sustain employment **Benefits for mental health services** • Improved information-sharing	**Limitations:** Trials to date have not indicated definitive effectiveness or cost-effectiveness of the role, in part because of quality of studies, and lack of definition of what peer workers do that is different to roles of the mental health professionals they work alongside.

		To demonstrate awareness of the organisational and team-level barriers to and facilitators of introducing peer workers into, or alongside, existing multidisciplinary mental health teams.	• Better understanding of the challenges faced by patients • Potential reduction in hospital admissions Careful definition of the intervention is necessary to properly evidence the effectiveness of PS. Where the role is properly valued and supported, peer workers are a powerful resource for the multidisciplinary team, offering different, experiential knowledge and insight, and the ability to engage patients in their treatment through building relationships of trust based on shared lived experience. The peer worker is an important potential partner in supporting the recovery of people using mental health services.	
Harvey et al. (2023) Community-based models of care facilitating the recovery of people living with persistent and complex mental health needs: a systematic review and narrative synthesis	Systematic Review and Narrative Synthesis 59 articles 2016-2021; high-income countries Models of Care included: goal-focused; integrated community treatment; intensive case management; partners in recovery care coordination; rehabilitation and recovery-focused; social and community connection-focused; supported	To assess the effectiveness of community-based models of care (MoCs) supporting the recovery of individuals who experience persistent and complex mental health needs.	Beneficial MoCs ranged from well-established to novel and updated models and those explicitly addressing recovery goals and incorporating peer support. Outcomes focused on clinical, functional, and personal recovery. Overall, 10 studies reported incorporating peer work: 4 integrated community treatment; 3 social and community connection-focused MoC; 1 each for rehabilitation and recovery-focused (intensive case management, and supported accommodation MoCs. The clubhouse model was particularly successful in enabling a recovery-oriented environment. Greater emphasis on the inclusion of lived and living experience in the design, delivery, implementation, and research of MoCs is needed, to enhance MOCs' relevance for achieving individual consumer recovery outcomes. More research requires evaluation of why and how PS works, how it adds value, and when and how it is appropriately included.	Far more quantitative studies than qualitative, quality of studies was not consistently strong. Studies were often small-scale, lacked comparison group, had high drop-out rates, and did not report on the sustainability of changes longitudinally, or on between-group differences. Potential for response bias. Limitation timeframe for search.

	accommodation; and vocational support.			
King et al. (2018) A Systematic Review of the Attributes and Outcomes of Peer Work and Guidelines for Reporting Studies of Peer Interventions	Systematic Review 37 articles 1995-2018 Predominantly adults; multiple contexts Randomized and nonrandomized controlled trials of peer work.	To describe key attributes and outcome measures reported in controlled trials of peer work, identify outcome measures likely to report significant change as a result of peer work, assess the quality of reporting and formulate guidelines for the design and reporting of future trials.	Peer programs delivered in a range of settings: consumer operated (N=8) and those linked to outpatient (N=22), inpatient (N=7), and residential (N=5) services. 17 were in clinically operated services with limited peer control of how programs were run. Outcome measures were limited to measures of individual clinical improvement and recovery rather than social and structural impacts. Outcomes that more often showed significant differences as a result of PS were patient activation, self-efficacy, empowerment, and hope. Gaps in reporting of the attributes of PS programs were identified to formulate guidelines for the design of future trials. Lack of attention to fidelity to core PS principles and aims in the design and reporting of effectiveness trials limits the utility of research to policy and practice.	**Strengths:** Review limited to RCTs or controlled trials involving equivalent sample groups. **Limitations:** Many studies had small sample sizes, and many excluded individuals with inadequate spoken language or literacy skills.
Luke et al. (2024) A systematic review of effective local, community or peer-delivered interventions to improve well-being and employment in regional, rural and remote areas of Australia.	Systematic Review 19 articles Rural, any age. Evaluated effectiveness (wellbeing, employment, satisfaction) of local, community or peer delivered, well- being or employment (or both) interventions.	To identify, systematically review, and synthesise studies assessing the effectiveness of local, community or peer-delivered interventions to improve well- being and employment in regional, rural and remote areas of Australia.	Interventions that appeared effective in improving well-being tended to focus on addressing social connectedness and self- determination. Unexpected employment outcomes were evident across many of the studies, which high-lighted the reciprocity between well- being and employment. Indigenous communities studies involved the following: suicide prevention; social and well- being services; digital skills training and mentoring; aged and disability clients, staff and carers; drug and alcohol rehabilitation services; youth programs involving sports mentoring, driver training for employment opportunities and school- based learning. Interventions addressing the needs of older community members focused on: information technology training; Men's Sheds; financial counselling; an Indigenous Australian community training program for carers of ageing family.	**Strengths:** 10 studies had explicit Indigenous community focus. **Limitations:** Overall level of evidence for the interventions was low due to mostly descriptive studies. Significant heterogeneity of interventions.

			Community well-being studies focused on building social capital via community gardens.	
Miller et al. (2020) Provision of peer support at the intersection of homelessness and problem substance use services: a systematic 'state of the art' review	Systematic Review 62 articles 2000-2019 Multiple contexts; adults US, Canada, UK, Portugal and France	To search and synthesis of literature examining use of peer support models within services for people impacted by homelessness and problem substance use.	PS programs included: homelessness (N=15), Physical health including Tuberculosis, Hepatitis; and HIV (N=12), criminal justice involved/experienced individuals (N=6), needle exchange programmes (N=3), safe consumption sites (N=5), smoking cessation (N=4), abstinence programs including AA/12 Step; relapse; and recovery (N=12). Found overall reduction in harm related to drug and/or alcohol use. Half of the included studies reported reductions in drug and alcohol use and relapse rates, with 2 studies finding statistically non-significant changes related to problem substance use, specifically the amount of money spent on drugs or alcohol, and the number of days using drugs or alcohol. 3 studies reported improvements on homelessness, including decreases in the number of days spent homeless, a reduced return to homelessness, and reports of an overall improvement in housing environment. Only 1 study found no improvements. Improvements in homelessness status including housing retention; and psycho-socioeconomic benefits such as improved health, return to work, and greater community engagement leading to improvements in quality of life. The review identified considerable challenges and risks for SP roles. Five themes relating to the challenges faced by peers were: vulnerability, authenticity, boundaries, stigma, and lack of recognition.	**Limitations:** Only 23 of the 62 papers clearly focused on peer support, homelessness and substance use together. Many studies did not report whether peers were paid or not. Majority of studies (N= 47) were conducted in the USA and Canada. Mental health not explicitly noted.
Murphy et al. (2023) A systematic scoping review of peer support interventions in integrated primary youth mental health care.	Systematic Scoping Review 15 articles Primary care, schools and universities; youth	To identify, collate and synthesise the available evidence on key aspects of peer support interventions within Integrated Youth Services, and school and university settings.	This review supports previous research indicating that peer support has potential for improving recovery related outcomes. A variety of interventions (n=13) and PW roles were reported: facilitating self-help support groups and internet support groups; one-on-one peer support. 3 papers reported on The Choice Project. 7 studies reported programs within university settings, 6 programs were in integrated Youth MH services, and one was delivered in a	**Limitations:** Studies could be strengthened by providing more in-depth information on intervention/model content. Of the 13 different interventions, six (40%)

	2005-2022	(1) What mental health outcomes have been reported? (2) What are the core characteristics of PSWs and their subsequent roles in these settings? (3) What are the barriers and facilitators to implementing peer support interventions in integrated primary youth care mental health care?	secondary/high school in collaboration with a community mental health service. 4 studies reported improvements in psychological wellbeing, and 1 study reported an improvement in overall mental health as measured by the Strengths and Difficulties Questionnaire; however, when scores were analysed separately no change was reported. 2 studies reported improvements in social support, 1 reported a reduction in loneliness; 2 studies reported decreased anxiety, while one reported no change. Although 1 study reported a reduction in depressive symptoms, 3 studies did not reveal a significant effect; 1 study reported an improvement in resilience, while another reported no significant change. Studies aimed at specific mental difficulties, including social anxiety and body dissatisfaction reported improvements. Other improved outcomes related to managing mental health difficulties, including coping skills, autonomy, ability to manage self-stigma, self-efficacy, and decision making for mental health care. Examples of barriers to implementation included staff concerns around confidentiality of peer support relationships as well as PSWs' confidence in their roles. Facilitators included positive support from staff members and role clarity.	required PSWs to have a lived experience of mental health difficulties.
Mutschler et al. (2022) Implementation of Peer Support in Mental Health Services: A Systematic Review of the Literature	Systematic Review 19 articles Inception-2019 Multiple contexts; adults	To synthesize the existing literature on the implementation of peer support interventions and identify barriers and facilitators using an implementation framework (Consolidated Framework for	The review highlighted a number of important elements for implementation within the CFIR domains, including clear role definition, a flexible organizational culture, and education for peer and non-peer staff. Implementation barriers included an organizational culture without a recovery focus, allied practitioners' beliefs about peer support, and an unclear peer role. The review provides a summary of best practices for the implementation of peer support in mental health services that can be used by researchers and service providers in future implementation.	**Strengths:** Inclusion only of studies that examined implementation in sufficient detail for organisation with the CFIR Framework. **Limitations:** Most studies from the US and Australia, both with existing government and organizational-mandated

		Implementation Research (CFIR))	Peers were found to relate better to clients than non-peer staff in many cases. Strong organizational leadership and commitment to the peer support role was the most important factor for successful PS integration in both community and health organizations. An accepting culture was critical to success of the PS role. Nonpeer staff worry about boundaries, confidentiality, and use of disclosure by peer workers, hence need for education about the role. Regular supervision was also important. Clarity in roles and responsibilities was among the most important factor influencing effective integration into existing programming.	policies on the integration of the peer role. Use of CFIR framework solely for post hoc evaluation, rather than for development and process of implementation of the intervention, has been criticized.
Pitt et al. (2013) Consumer-providers of care for adult clients of statutory mental health services (Review)	Systematic Review (Cochrane) 11 articles (2796 people); adults Inception/ various dates by database – 2012 RCTs of current or past consumers of mental health services employed as providers ('consumer-providers') in statutory mental health services.	To assess the effects of employing current or past adult consumers of mental health services as providers of statutory mental health services. Comparing either: 1) consumers versus professionals employed to do the same role within a mental health service, or 2) mental health services with and without consumer-providers as an adjunct to the service.	**1. 5 trials (581 people)** compared PS to professionals in similar roles within mental health services (case management roles (4 trials), facilitating group therapy (1 trial)) - no significant differences in client quality of life; depression, general mental health symptoms; client satisfaction with treatment, client or professional ratings of client-manager relationship; use of mental health services, hospital admissions and length of stay; or attrition. There was a small reduction in crisis and emergency service use for clients receiving care involving PS. Peers spent more time face-to-face with clients, and less time in the office, on the telephone, with clients' friends and family, or at provider agencies. **2. 6 trials (2215 people)** compared mental health services with or without the addition of consumer-providers. There were no significant differences in psychosocial outcomes (quality of life, empowerment, function, social relations), client satisfaction with service provision and with staff, attendance rates, hospital admissions and length of stay, or attrition between groups with PS as an adjunct to professional-led care and those receiving usual care from health professionals alone. None reported client mental	**Limitations:** Moderate to low quality - unclear risk of bias in terms of random sequence generation and allocation concealment, and high risk of bias for blinded outcome assessment and selective outcome reporting.

			health outcomes, data on adverse outcomes for clients, or the financial costs of service provision. **Conclusion:** PS achieves psychosocial, mental health symptom and service use outcomes that are no better or worse than those achieved by professional staff.	
Reif et al. (2014) Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence	Systematic Review 11 articles 1995-2012: Across the full continuum of recovery, from pretreatment to maintenance services; community, walk-in, inpatient.	To assess the evidence base for Peer recovery support services delivered by individuals in recovery from substance use disorders to peers with substance use disorders or co-occurring mental disorders.	Moderate level of evidence for reduced relapse rates, increased treatment retention, improved relationships with treatment providers and social supports, and increased satisfaction with the overall treatment experience. Methodological concerns included lack of consistent or definitive outcomes, and lack of any or appropriate comparison groups.	**Limitations:** Inability to distinguish the effects of peer recovery support from other recovery support activities, small samples and heterogeneous populations.
Repper & Carter (2011) A review of the literature on peer support in mental health services	Scoping Review 38 articles 1995-2010; Statutory mental health services; adults	To review the literature on Peer Support Workers employed in mental health services to provide a description of the development, impact and challenges presented by their employment and to inform implementation in the UK.	Found reduction in admissions, reduced hospital bed days, improved empowerment scores, increased sense of independence and empowerment, improved community integration for those involved in longitudinal PS programs, improved social support, enhanced social skills and better social functioning, greater feelings of being accepted, understood and liked, less likely to identify stigma as an obstacle for getting work and were more likely to have employment, improved sense of hope. Challenges: boundaries of the role, power dynamic, stress, maintaining role distinction. Peer Support Workers have the potential to drive through recovery-focused changes in services. However, many challenges are involved in the development of peer support. Careful training, supervision and management of all involved are required.	**Limitations:** Excluded studies of peers working in a consumer-led service. Lack of a framework to critically analyse the included articles. General level of analysis given the wide scoping aims.
Schlichthorst et al. (2020)	Scoping Review	To provide an overview of peer support programs that aim to	7 programs in a variety of settings (schools, communities,	**Limitations:**

Lived experience peer support programs for suicide prevention: a systematic scoping review	8 articles 2000-2019: multiple contexts; adults and youth	reduce suicidality and are led by people with lived experience of suicide.	rural and online). Only 3 of the 7 programs contained data on effectiveness. Areas of greatest improvement were increased sense of community, and a better understanding of why suicidal thoughts may come up. Participation in online peer support forums decreased the intensity of suicidal thoughts but did not increase help-seeking outside the forums.	Small set of programs. 84 records were excluded due to either not providing enough information on nature of lived experience of peer supporter workers or because lived experience was defined more broadly and not specific to suicidality.
Shalaby et al. (2020) Peer Support in Mental Health: Literature Review	Narrative Review Number of articles not stated.	To examine the literature, exploring the evolution, growth, types, function, generating tools, evaluation, challenges, and the effect of Peer Support Services (PSSs) in the field of mental health and addiction.	**Severe/Series Mental Illness:** • Adding PSSs to intensive case management teams improves activation (knowledge, skills, confidence, and attitudes) for managing health and treatment. • Some evidence of positive effects on measures of hope, recovery, and empowerment. • Inconclusive impacts on hospitalization, satisfaction, or overall symptoms. **Addiction and Drug Use:** Immersion in peer support groups and activities and active engagement in community are the 2 critical predictors of recovery for more than half the dependent substance users. **Forensic:** Multiple initiatives have been introduced to facilitate a re-entry process for people recently released from incarceration. **Older Adults:** Peer support undertaken by older community volunteers is effective in improving general physical health, QOL and social functioning, and depression and anxiety, especially in socially isolated, low-income older adults. **Youth:** Limited evidence. **Physical Health:** peer support is associated with improvements in psychiatric, medical self-management skills, QOL, and empowerment.	**Limitations:** Not systematic; no meta-analysis; no well-defined inclusion or exclusion criteria of studies; study design heterogeneity.

			People with Disabilities: Peer support has helped in decision making and facilitating communication. **Families:** Many peer workers have been engaged in family psychoeducation, especially for those with the first episode of psychosis. **Online:** Social media useful for allowing people with SMIs to feel less alone, find hope, support each other, and share personal experiences and coping strategies with day-to-day challenges of living with mental illness through listening and posting comments. Overall, online peer support is feasible and acceptable; evidence is still emerging. **Conclusion:** Feasibility/maintenance of robust PSS are only possible through collaborative efforts, ongoing support and engagement from all stakeholders.	
Watson & Bryant (2013) Peer Support in Adult Mental Health Services: A Metasynthesis of Qualitative Findings	Qualitative Metasynthesis 27 articles 1990-2010: Adult Mental Health Services	To synthesize findings from qualitative reviews on the effectiveness of peer support. The experiences of peer support workers, their nonpeer colleagues, and the recipients of peer support services were investigated.	People in recovery experienced increased hope, increased motivation, increased social networks, built rapport with peer support workers more easily as a result of working with PSWs. Some papers reported that PSWs are not role models for people in recovery. (See Table 2 Summary of findings – Frequency Effect Size calculation) **Conclusion:** Training, supervision, pay, and nonpeer staff/ peer staff relationships are important factors for statutory mental health peer support programs.	**Limitations:** Only four studies investigated the experiences of people receiving peer support services. Limitation of the frequency effect size calculation is equal weight given to each study regardless of how many participants a study has.
Watson (2019) The mechanisms underpinning peer support: a literature review	Scoping Review 13 articles Inception-2017; multiple contexts; adults	To review the published research literature relating to the process of peer support and its underpinning mechanisms to better understand how and why it works.	Five mechanisms were found to underpin peer support relationships (lived experience, love labour, the liminal position of the peer worker, strengths-focussed social and practical support, and the helper role). 8 studies focused on the liminal role, with 3 of these examining the powerful and challenging process of entering mental health services as a provider and service user. 6 studies highlighted the peer's role in offering social and practical support as core components of the role.	**Limitations:** Potential for bias due to 1 researcher completing all steps in the review.

	Plus 10 leading researchers in the field of recovery and peer support provided additional relevant research papers.		5 studies noted a range of positive effects to the adoption of a helper role, including feeling useful to others, reducing internal stigma, feeling looked up to and the requirement to shift focus away from oneself, onto others.	
Yin et al. (2023) Umbrella review on peer support in mental disorders	Umbrella Review of systematic reviews and meta-analyses 15 articles Inception-2020	To provide a unified perspective of the effectiveness of peer support in mental health.	Many of the reviews found improvement in recovery-oriented outcomes compared to clinical and psychosocial ones. For example, out of 13 reviews that presented recovery-oriented outcomes, 8 showed PS to be beneficial for hope and empowerment. No major adverse effects were associated with peer support.	**Strengths:** AMSTAR 2 instrument used to assess quality of included reviews. **Limitations:** Many studies low quality.
Zeng & McNamara (2021) Strategies Used to Support Peer Provision in Mental Health: A Scoping Review	Scoping Review 28 articles 2001-2020 Multiple contexts	To examine what strategies mental health organizations use to support peer provision.	24 or 28 studies emphasised the importance of leadership support for the PS role. 18 studies emphasised organisational preparedness. 14 studies emphasised a range of recruitment, training and induction strategies as important. 13 studies emphasised support and development of peers as crucial. **Conclusions:** Championing of PS by organizational leadership is central to its success and sustainability. Leadership undergirds three strategies that were discussed: organizational preparation, recruitment, training and induction, and support and development. When peer provision is championed by organizational leadership, measures can be undertaken to prepare the organization for peer provision; recruit, train and induce peer providers successfully into the organization; and support peer providers on the job.	**Limitations:** Excluding quantitative studies reduced the strength of numerical evidence. There was a dearth of co-produced research with peer

Appendix 4: Grey Literature - Detailed Descriptive Table

Table 1: Peer Work Grey Literature (n=41 sources)

Source (Author, publication date, country, setting/context)	Resource Summary Information
ARAFEMI Victoria (2011) Australia Carer Peer Workers Independent Evidence Review	**Best Models for Carer Workforce Development.** This resource outlines a project designed to review the literature for evidence and investigate best practice models and the body of knowledge around carer needs, peer support, participation, advocacy and mentoring models. 4 main models identified: • Carer Peer Support Worker - carers paid to support mental health carers, often in community mental health settings. • Carer Consultant – carers paid to support mental health carers, primarily when they are in clinical mental health settings, usually attached to individual hospitals or community mental health facilities. • Carer Advocate – workers who provide individual advocacy for mental health carers; support system navigation; support where they need an independent advocate. Lived experience as a family/carer 'desirable' but not 'essential' criteria. • Carer Advisor – provide advice on mental health carer policy and related issues. Examples of Carer peer program models for NSW, QLD, SA and VIC are provided. These include the following activities: Education and training packages which teach families and carers about mental illness and its management, and help to build coping skills and resilience, Individual support and advocacy services for families and carers, and Assistance to establish peer support groups. Carer Peer models are diverse and include inpatient and community settings, clinical and non-clinical services, and are particularly noted as relevant for work with Aboriginal and Torres Strait Islander, CALD, and rural and remote communities. **Summary of evidence for Carer Peer Workers:** • In community group programs - Enhanced the carers' capacity to manage their own wellbeing as well as their caring roles. • In inpatient settings - Enabled carers to voice their concerns without fear of alienating the clinical staff. • In programs supporting young carers - significant reductions in depressive symptoms, risk of homelessness and stigma. **NB.** This review did not include mental health carers in the following paid roles: Helplines, Family/carer peer education programs and workshops (e.g. 'Well Ways' and programs provided by non-government organisations), Family/carer researchers and facilitators of quality improvement activities, and family/carers sitting on Committees, Boards, Advisory Bodies.

Australian Healthcare Associates (2013) Queensland, AUS Intentional Peer Support and Consumer Operated Services Independent Research Report	**Evaluation of the Community Mental Health Intentional Peer Support Training and Consumer Operated Services.** The Intentional Peer Support (IPS) training program and the Consumer Operated Services (COS) program are initiatives of the Queensland Government Department of Communities, Disability and Community Care Services (Department of Communities). **Summary of findings about workforce development issues:** • Because there is no mandatory qualification for community mental health workers, IPS workers are likely to continue to suffer from the perception that they are part of an unprofessionalised workforce. • Course participation patterns indicate that the IPS courses may not always be adequate to equip workers for the IPS worker role. • There was no evidence provided that the IPS training has resulted in workforce growth. • Manager training is reported to have had a significant impact on organisations in the areas of internal process (i.e. changes to how teams are structured, how supervision is conducted, and series are delivered) and understanding of recovery. • Organisational change related to IPS manager training is likely to have improved organisational readiness to effectively employ peer support workers. • COS programs are a key employer of IPS workers in Queensland, and as such, they are an important training ground that is helping to build the IPS workforce. • Without exception, the COS programs were viewed positively by all stakeholders involved in the evaluation. Service users reported high levels of satisfaction with the COS program. In particular, they valued the responsiveness of the COS, the time and understanding that IPS workers put into understanding them, and the hope that this engendered. Positive outcomes included improvements in ability to manage daily life, better relationships, improved ability to manage emotions, improved social interaction and reductions in hospitalisations.
Black Dog Institute (2021) Australia Online peer support Independent Commissioned Research Report	**eFriend Evaluation.** eFriend is a virtual platform that provides support and connection to people over the age of 18 who are feeling down, lonely, isolated, or worried, implemented by Independent Community Living Australia (ICLA). eFriend provides a minimum of three and maximum of fifteen peer support calls, either over the phone or on video call, that participants can book online. Phase 1 Evaluation period was July 2020 and March 2021. Methods included an electronic survey: with participants in the eFriend Program (n=34 respondents, 41% response rate); a survey with eFriend peer workers (n=7, 78% response rate); and interviews with eFriend peer workers (n=5). Engagement with eFriend across a diversity of age groups, gender and locations/Australian States and Territories. **Summary of findings:** Outcomes for eFriend participants: (feelings of confidence, empowerment, hopefulness, and self-concept - on a scale of 1 (not at all) to 10 (completely)) • Eighty-five percent of responses were between 7 and 10 for feeling more hopeful and optimistic

	• 79% were between 7 and 10 for feeling more confident • 70% were between 7 and 10 for feeling more empowered Facilitators to implementation included: the great team culture of the peer workers; the excellent rapport developed with program participants; and specific training programs that were useful to the skills needed to perform the role of peer worker. Barriers to implementation included: inconsistent quality of the communication technology; the variable support provided by ICLA; and the lack of professional supervision in the form of a trained psychologist.
Boyle et al. (2023) Australia Online Peer Support Independent Research Report (University of Queensland)	**Evaluation services for the SANE pilot for people with complex mental health need.** The SANE Guided Service is a digital guided psychosocial support service for people over 18 years of age with complex mental health needs and their families and carers. The model of service involves a free, flexible, goal-orientated, tailored recovery plan through its online platform including regular one-on-one telephone sessions with counsellors and/or peer support workers, peer-led online group support, access to SANE's drop-in services including online community Forums and Support Line services, connection with local social services and coordination with health professionals and other supports. The evaluation period was from December 2021 to June 2023. **Summary of findings:** • There have been significant implementation challenges including waitlists and pressure points along the service journey. A lack of communication about waiting times and service changes was a source of frustration and distress for some participants. • SANE counsellors and peer support workers were highly regarded and valued for their ability to listen and convey respect and understanding. • One of the best things about the services as reported as the compassion, empathy and understanding from the support workers. • There was no statistically significant change in psychological distress (K10+) scores or in the number of days out of role due to psychological distress. • There was significant improvement in quality of life and recovery between baseline and first follow-up survey (~12 weeks) for CALD, LGBTQIA+ and rural/regional priority groups. • The mean cost of acute services used by participants involving ambulances, emergency departments, hospital and residential care decreased by an average of $400 between baseline and first follow-up survey at approximately 12 weeks. • There was no significant change in QALYs (quality-adjusted life years) from baseline to follow-up.
Burden et al. (2018) USA Various settings	**Supervision of Peer Practice.** There are a variety of roles that peers play within PRSS programs. Two that have become most prominent are peer recovery coach and peer recovery support specialists. Benefits and positive outcomes of peer support are presented briefly for broad setting types: peer-led services, drug and alcohol services and prison services. These are broadly stated as improvement in engagement with services and treatment programs, though detail of how these outcomes were measured is not stated. Currently, many peer practitioners face obstacles due to inadequacies of supervision, organizational policies that impact the nature of support, and/or the setting where support is offered. Further obstacles encompass a general sense of feeling devalued: lack of policy

Independent report (Altarum Institute)	regarding transportation, workload, lack of clear expectations, lack of clear job description, lack of funding for professional development, lack of communication, and unreasonable expectations on outcomes for peer practitioners.
Butterfly Foundation (2022) Australia Peer worker for Eating Disorder Sector Needs Assessment Report	**An eating disorder-focused peer workforce: Needs assessment.** The research comprised a rapid literature review and 38 qualitative interviews with a range of key informants. **Aim:** to understand the full scope of eating disorder peer work currently being delivered in Australia, explore barriers to access, identify unmet needs and gaps in delivery, and identify key requirements for expansion of ED peer work in Australia. **Summary of findings:** Benefits to service users included increased empowerment, hope, greater acceptance and attendance at treatment and reduced feelings of isolation. Benefits for peer workers included aiding reflection and validation of their own recovery and experience, and upskilling. However, the existing evidence base is limited and relied on small pilot programs, with small sample sizes, no control groups, and limited timeframes. Barriers to expansion of the ED peer workforce include existing infrastructure for ED peer work in Australia is severely limited and exists primarily at a jurisdictional level only. There is a need for centralisation with a single coordination body which oversees and regulates quality of care, underpinned by a standardised practice framework that sets out best practice guidelines, and outlines a structure for how and when peer work should be provided.
Byrne et al. (2021) Australia National Guidelines Government Document	**National Lived Experience Workforce Guidelines.** The National Guidelines were the result of extensive consultation and a co-production process to ensure national standards for Lived Experience workforce development grounded in the expertise of lived experience. Stakeholders included people with personal or direct lived experience (consumers), families/carers, designated Lived Experience workers, people working for government departments, mental health commissions, managers/employers, and non-designated colleagues. 787 people participated. As a national document, the National Guidelines bring together key issues from state, territory, and organisational policies and guides, with the expertise of lived experience to create a single overarching framework for consistent national development of the Lived Experience workforce. **Agreed Principles to guide lived experience workforce development are:** • **Co-production**, engaging all stakeholders in equal and respectful partnership for all aspects of workforce development is essential for Lived Experience workforce development to be effective and meaningful. • **Maintain the integrity of Lived Experience work** ensuring that all work is consistent with the values, and principles of Lived Experience work and develops from its strong foundations in the consumer movement.

	• **Create the conditions for a thriving workforce**, developing flexible, recovery-oriented workplaces where Lived Experience workers are enabled to achieve in their professional roles with flow-on benefits for the whole workforce and for service users and their families. • **Respond to diversity**, engaging with diverse communities to ensure that all aspects of service delivery meet their needs and engaging a Lived Experience workforce that reflects the diversity of service users and their families and supporters. • **Reduce coercive and restrictive practice**, ensuring that Lived Experience workers are not placed in positions where they are expected to support coercive or restrictive practices, and working to co-produce more effective alternatives to restrictive practices. **Support systemic change and professionalisation** of the Lived Experience workforce, identifying areas for prioritisation in funding, policy, planning and service commissioning.
Doughty & Tse (2005) New Zealand, International Review Varied Peer Models Government Report / Systematic Review	**The effectiveness of service user-run or service user-led mental health services.** Systematic review of evidence based on 26 primary data studies and 2 systematic reviews: This review of effectiveness found some studies that reported higher levels of satisfaction with services, general wellbeing and quality of life while others reported no significant differences between service user-run services and mental health services run by non-service user providers. No studies reported evidence of harm to service users or that consumer services were less effective than the equivalent services offered within a traditional setting. (Later update appears as peer-review publication)
Gallagher & Halpin (2014) South Australia, AUS Inpatient and Rehabilitation Services Government Report	**The Lived Experience Workforce in the SA Public Mental Health Services.** **Aim:** To evaluate the lived experience workforce within South Australian government mental health services to assess the impact of the Mental Health Directorate's (MHD) Lived Experience Workforce (LEW) Program (carer consultants and peer specialists) in rehabilitation and acute inpatient units in South Australia in order to explore program strengths, challenges and future developments. Evaluation methods: 29 consumers surveyed, 5 carers interviewed, 58 clinicians and 12 peer workers surveyed, focus groups with 5 peer specialists and 4 carer consultants. **Summary of findings:** "The incorporation of the peer work role has been very well received by consumers and carers in South Australia. Consumers feel that peer specialists increase their sense of hope for recovery, assist them in identifying their own coping strategies and assist them to manage their symptoms". (p.6)

	An earlier evaluation of the impact of introducing peer specialists and carer consultants in acute mental health units in South Australia was published in 2008. Consumer, carer and staff questionnaires were developed and administered to ascertain perspectives of peer specialists or carer consultants. Overall, results were positive; most consumers felt that peer specialists helped the consumer feel supported, identify coping strategies and increase their sense of hope for recovery. Carers had a positive appraisal for carer consultants saying they made carers feel supported and helped carers build on their strengths in the caring role. (p.16) Several recommendations are made, focused into four areas: Role clarity, Training and development, Resourcing, and Supervision.
Hancock et al. (2021) New South Wales, AUS Peer Delivered Hospital Avoidance Program Commissioned Research Report (Australian National University/University of Sydney)	**Independent Evaluation of NSW Peer Supported Transfer of Care initiative (Peer-STOC).** Findings from analysis of data from 987 Peer-STOC participants and a comparison group of 4,122 individuals who were similar but had not received Peer-STOC support. **Summary of findings:** • Peer-STOC participants were significantly less likely to be readmitted to hospital within 28 days of discharge. Peer-STOC participants were 32% less likely to be readmitted than individuals in the comparison group (1 in 10 Peer-STOC participants were readmitted within 28 days following discharge; 1 in 7 people in the comparison group). • Peer-STOC participants had significantly fewer admissions to hospital over the 12 months after discharge. They spent 8.6 fewer days in hospital than people in the comparison group (average of 14.8 days Peer-STOC; average of 23.4 days comparison group). • There was no real change in the number of emergency department presentations from the 12 months before or 12 months after contact with Peer-STOC in either the Peer-STOC participant or comparison group. • Peer-STOC participants had a significantly higher number of community-based mental health service contacts in the follow up period than individuals in the comparison group (77 Peer-STOC; 52 comparison group). • Peer-STOC was associated with net savings in mental health service costs of at least $12, 211 per participant per year. Over the first three years of Peer-STOC, NSW Health invested $7.92M in the program. Over the same three-year period, Peer-STOC saved the system at least $9.77M (equivalent to the release of 7,904 hospital bed days); a net saving of $1.85M over the first 3 years.
Headspace (2020) Australia Online Peer Support to Young People	**Community Spaces Evaluation Report.** This report summarises an evaluation of 'Spaces Chats' over the first year of the program (Oct 2019- Sept 2020). Spaces Chats sit within Community Spaces - a shared area of the headspace website that allows service users to engage with each other on high level topics; weekly chats which are peer-led. Evaluation methods: feedback on experiences of Online Peer Support Moderators and users. **Summary of findings:**

Sector Evaluation Report	• The service has been well received by young people and is helping to expand access to mental health support. 37,473 young people have participated in 148 Spaces sessions; 84,766 messages sent and 21,268 views of Spaces transcripts. • Moderators are highly satisfied with their role (average 4.7 at mid-point and 4.2 at end-point on 5-point scale), felt supported in their role (average of 4.5 at mid-point, 4.7 at end-point) and in sharing their lived experience safely (average of 4.7 at mid- and end-points), agreed that they could both effectively manage Spaces Chats (average of 3.8 at the mid-point and 4.2 at the end-point) and support young people in Spaces Chats (average of 4.0 at mid- and end-points). The majority of Community Spaces users who completed a feedback survey (n=51) were satisfied or very satisfied with the service (77%) and felt that their needs were either completely or somewhat met (63%).
Health Workforce Australia (2014) Australia Various Peer Contexts Government Report / Literature Scan	**Mental Health Peer Workforce Literature Scan.** Review of the evidence for the benefits of mental health peer work and challenges experiences in implementing the role. Lists the wide variety of titles assigned to peer work roles (n=33) and notes the confusion that this creates when considering how to understand the diversity of roles and measure their impact and effectiveness. **Summary of Benefits:** Benefits for consumers: reduced admission rates, improved community tenure, empowerment, social inclusion, reduced stigma, hope. Benefits for peer workers: mental health and wellbeing, acceptance, skills and employment. Benefits for carers: empowerment and knowledge, improved relationships, social support. Benefits for mental health services and the service system: engagement of consumers, more inclusive organisational culture, cost effectiveness, improved response to crisis and reducing coercive practices. **Summary of Challenges:** Poorly defined jobs; Negative attitudes from non-peer workers; Role conflict and confusion; Lack of clarity regarding confidentiality; Limited opportunities for networking and support. Solutions to these challenges are summarised. A summary of the variety of peer roles in the USA, UK and New Zealand are provided.
Hodges et al. (2022) Australia	**Pathways for Supporting the 'Not Negotiable' Lived Experience (Peer) Workforces to Thrive.** The report provides recommendations for improving existing training options, career opportunities and support structures to strengthen the lived experience (peer) workforces. Recommendations were derived from the following methods: 22 semi-structured individual/group interviews with 36 people across the lived experience community, service providers, organisations and higher education sector. Review of policies and literature related to

Peer Workforce Development Independent Commissioned Research Report	lived experience (peer) workforces, roles, training options and supports. Online survey (n=213). Interactive workshop (n=40). Environmental scan of 259 identified training programs and learning options. Online Roundtable to present/verify findings and refine draft recommendations. Five Broad Recommendations (with further detail within each): 1. Endorsement of and investment in lived experience as a discipline and critical workforce 2. Tiered training options accounting for diverse roles, responsibilities, communities, settings and entry points 3. Visible career pathways and progression opportunities 4. Workplace supports that enable safe, effective and thriving lived experience (peer) workforces A professional body providing oversight, development opportunities and advocacy
Jones (2016) USA Substance Abuse and Mental Health Administration (SAMHSA) Guidance Manual	**Peer Involvement and Leadership in Early Intervention in Psychosis Services.** **Aim:** To provide a range of different stakeholders with information and best practices for peer support and leadership in early intervention for psychosis (EIP) services. **Peer Navigators in EIP:** help clients troubleshoot in the transition from EIP to standard mental health and associated support services, used to help current clients succeed in specific non-healthcare domains e.g., help a client who is a prospective student register for classes, meet with student disability services staff, fill out a financial aid application and negotiate specific accommodations with faculty. **Vocational/educational peer specialists:** help clients access services and establish relationships with key administrators and offices on campus, provide more holistic "wraparound" supports including facilitating study groups, organizing or arranging extra tutoring, and directly liaising with school- campus-based staff, and local employers or internship program administrators. **Peer support groups:** in clinical settings, Hearing Voices Networks, Work or School-Focused Support groups, Wellness recovery Action Planning (WrAP) groups within community settings, Activities groups. **Examples:** Coming Out Proud (COPp) is an innovative three-session group program run by peer facilitators. The program is premised on the idea that secrecy about a psychiatric diagnosis has negative impacts both on the individual and his/her relationships with others (for instance degree of relational honesty). The Transition Aged Youth (TAY) "UnConvention" or "UnCon" is a semi-regular (recurring) all-day event that brings together youth with lived experience, peer advocates, and TAY providers.
Justice Action (2024) Australia	**Peer Mentoring in Mental Health [Prisons and Forensic Populations].** In the environment of imprisonment, violence to the self and to others occur almost on a daily basis. There is also a lack of physical and social interactions leading to isolation and other maladaptive coping mechanisms. Traumatic conditions of prison and lack of inside support can foster a negative environment for individuals.

Peer work with criminal justice populations (including women and Aboriginal and Torres Strait Islanders) Independent Evidence Review Report	**Examples of peer models:** 1. The Women's Justice Network takes a gender-responsive approach, with mentorship programs provided by women for women. The **Women's Justice Network Adult Mentoring Program** provides one-to-one social support for women and girls who have either exited custody or are at risk of involvement in the Criminal Justice System. 2. **Deadly Connections Youth Frontiers Project** responds to Aboriginal children and young people, ages 10-17, who are entangled or at risk of being entangled with the criminal justice system or child protective services. Youth Frontiers are delivered by Aboriginal Youth Mentors who understand the challenges Aboriginal people face. Therefore, they can form deep connections with the children and young people, as they share the sentiment of being inextricably connected to the land, Aboriginal community and culture. Once the mentor and mentee are matched, the mentors are positive role models for the children, showcasing the possibility of healing, learning and opportunity. They do this by encouraging prosocial skills and activities and participation with external services to develop personal and professional skills. **3.** Justice Action also has published a **Mentor's Handbook** on the JA Mentor Project to establish practical mentoring strategies with a focus on criminal justice.
Kaine (2018) Australia Various Peer Contexts Independent Evidence Review / Advocacy Organisation	**Toward Professionalisation: Exploration of best practice models in mental health peer work.** Review focused on peer reviewed journal articles and grey literature published between 2011-2017 (30 peer-reviewed sources; 34 grey literature sources). **Summary of findings:** Six themes are identified to inform professionalisation of the mental health peer workforce in Australia and the development of a professional membership organisation for mental health peer workers: 1. The importance of recovery-oriented practice within services offering peer support, and exploration of organisational culture to support the successful integration of peer support services. 2. Issues of stigma and discrimination and the impact this can have on the peer support workforce, effecting integration and delivery of peer support services. There is an identified need for education of non-peer staff on the functions, values and role of peer support workers. 3. The need for role clarity and a clear identity for peer support workers and to support broader organisational and consumer understanding of the peer support worker role. 4. Exploring boundaries and self-disclosure in the peer worker role. 5. Supporting the ongoing health and wellbeing of peer support workers. 6. Training, development, certification and professionalisation of peer support workers.
Kotecha-Hazzard et al. (2020)	**Evaluation of a Peer Support Employment Group Project.** This employment project run by Mind UK aimed to provide peer support groups and one-to-one employment support to people with mental health challenges (Jan 2017-March 2020). Support provided included psychoeducational approaches, coaching, job search skills,

UK Peer support for Employment Independent Research Report	interviewing skills, and peer support employment groups, to improve participants' work readiness and match them to vacancies and education/training opportunities. Evaluation methods: interviews with a sample of participants (n=17), employment advisors (n=6), and project stakeholders (n=3); progress data from all participants, and baseline and follow-up questionnaires from participants who attended peer support (n=201). **Summary of findings:** • Of the 201 participants, 31 (15%) had secured employment, and 27 (14%) were engaged in education/training. Most participants never attended peer support and engaged only with one-to-one support. Of the 67 participants who attended peer support, 10 (15%) were employed upon leaving the project (5 had sustained employment), and 14 (21%) were engaged in education or training. • The peer support groups encountered significant difficulties in delivery. All sites attempted to run groups at the outset, but they were reliant on paid project staff to set them up and facilitate the groups. • The funders' reporting requirements were extensive, leading to excessive paperwork and project staff spending time completing administrative tasks. This negatively impacted the development and sustaining of peer support. • Staff turnover and inconsistent premises were common problems leading to groups finishing or pausing for long periods. Groups offered participants a chance to make friends, meet people and share common experiences, exchange stories and frustrations relating to their journey with mental health and employment, though improvements were small.
Lived Experience Leadership (2024) Australia Peer Workforce Integration and Capacity Building Independent Lived Experience Research and Consultancy Group	**Lived Experience Leadership Website [Multiple Reports]** Website with multiple resource materials (documents and videos), and published research reports, as follows: • Effective Employment of Peers • Management Perspectives • How much Lived Experience is Enough? • Lived Experience & COVID-19 • The Global Need for Leadership • Professionalisation of Lived Experience • Challenges for lived experience roles • Peer Workers & Safe Disclosure • Role Titles & Descriptions • Management Exposure, Understanding & Commitment • Lived Experience and the Medical Model • Recovery as a Discipline • Developing Inclusive Organisations • Differences between Consumer and Carer roles

	• The Mental Health Advocate Role **Exemplars:** **'Developing Inclusive Organisations'** reports on a survey conducted across the mental health sector in Queensland. 327 responses from diverse perspectives, including 116 in Lived Experience roles and 211 in non-Lived Experience roles (e.g., psychiatrists, psychologists, mental health nurses, social workers, among others). Key findings: Leader commitment to Lived Experience roles allows the entire workforce to develop better and clearer understand about these roles. Better understanding about Lived Experience roles resulted in employees feeling as if they could be their true selves at work and led to a perceived improvement in service delivery. **'Differences between Consumer and Carer roles'** reports on a survey conducted across Australia. 558 peer workers (including both consumer and carer peer workers), and 324 mental health staff who were not peer workers. Key findings: Differences in Perspectives, Priorities, Work Practices. Similarities in Values: "*Both roles involve sharing lived experiences to build rapport, validation, and hope, while assisting the people they are working with to look at strengths, goals, and healthy coping strategies to enhance self-care, advocacy, and resilience." Risks and challenges in combining roles are described.*
Mackay et al. (2019) South Australia, AUS Psychosocial support community, NDIS Commissioned Research Report (University of South Australia)	**The UnitingSA NDIS Peer Support Program: Sustaining recovery-oriented psychosocial services in a National Disability Insurance Scheme funding environment.** The pilot service provides assertive, trauma-informed, recovery-oriented outreach support by a lived experience team, assisting people to build their life skills and increase social and community connections for people with severe mental illness, with complex comorbidities including acquired brain injuries and other physical and psychosocial disabilities. **Summary of findings:** • Service users were generally satisfied with this model, but they were worried about the ongoing availability of this support within an NDIS environment. • There were areas where the program was notably exceeding requirements (engagement with lived experience, peer work and an embedded attitude towards person-centred recovery-oriented support and language). Significant challenges to the capacity of programs to continue to deliver recovery-oriented care and remain financially viable (being unable to bill transport mileage, and insufficient on-costs to cover supervision) which directly impacted capacity to provide person-directed supports and facilitate community access.
McMahon et al. (2019) Australia	**Towards Professionalisation Final Report.** National research to determine the current state of peer work roles, and the feasibility of establishing a national member-based organisation to support peer workers. A consultative process included workshops conducted in all Australian capital cities (n=184 attendees) and an online survey (n=165 respondents) which sought to further distil the key issues highlighted from the workshops.

Peer Professionalisation Independent Commissioned Report	These consultations and reference to national and international literature, informed a series of recommendations for the National Mental Health Commission to consider. This centred around the recommendation for the establishment of a national member-based organisation for the peer workforce. Current accurate data on the numbers of peer workers employed within clinical mental health service and community managed sector roles proved difficult, due to diversity of roles, conditions of employment, reporting on staffing, service cultures and challenges in embedding peer roles, and lack of clarity about the peer role with multi-disciplinary teams and services frameworks.
Maylea et al. (2022) Australia Community integrated care Independent Commissioned Research Report / University Consortia	**Evaluation of Integrated Chronic Care Pilot.** The ICC program focused on improving physical health for people with mental health conditions. Two ICC sites were established in outer Melbourne locations, and they employed one registered nurse and one mental health peer worker. Methods used for the evaluation involved interviews and focus groups with 52 stakeholders (27 consumers, 2 carers, 10 ICC staff and 13 external professional stakeholders). **Summary of findings:** Overall, the ICC model appears well adapted to improving physical health of people using mental health services. Tangible outcomes were difficult to identify, but many of the precursors to tangible health outcomes, such as changing attitudes to health, increased health literacy, and better connections to the healthcare system, were evident. There is some evidence of improved screening, but the data do not indicate widespread action resulting from that screening. Neither pilot program had a clear model for peer work, making evaluation challenging. Peer work was appreciated when consumers were aware of it, but consumers were often unaware of the peer worker or what they did. Staffing turnover compounded this issue.
Mental Health Commission of NSW (2023) New South Wales, AUS Community Peer Navigator role embedded within mental health services	**Insights Report: The role of Peer Navigators.** The project had 2 phases. Phase 1 aimed to examine the potential role of peer navigators, who can draw upon their personal lived experience of mental health issues and connection to communities and familiarity with local services, to help individuals access the right care and supports. Phase 2 aimed to test the model with several communities and organisations across NSW through 4 pilot sites that trialled the peer navigation model between 2021-2023. **Summary of findings:** For consumers, key benefits of peer navigators included feeling supported and empowered to understand and navigate a complex system, increased engagement and willingness to reach out for help, timely access to services, and improved mental health and recovery outcomes. For staff and providers, the visibility of the peer navigators, was central to understanding and valuing the peer navigator model. Education and training was also essential. Staff improved their knowledge of mental health and related services, and peer navigators filled a gap in support and service provision, particularly in areas with limited clinical staff. Challenges were the short pilot timeframes, which affected onboarding and upskilling of peer navigators, and their capacity to build rapport with consumers prior to

State Government Report	engaging in navigation work. Role delineation and scope of practice was also a challenge, including where the level of support required by a consumer surpassed the role and ability of the peer navigator.
Mental Health Lived Experience Peak Queensland (MHLEPQ) (2024) Queensland, AUS Varied Peer Contexts Queensland Lived Experience Workforce Network	**Psychosocial Hazards in the Lived Experience (Peer) Workforce.** Project involved 3 focus groups (n=21 peer workers) and a statewide survey (n=43 peer workers) to explore peer workers experiences and perceptions of psychosocial hazards within their peer work roles. Seven recommendations are presented for workplaces to consider in managing psychosocial hazards. These included: adequate training, adequate supervision, training for non-peer staff to understand the peer work role, Lived Experience representation at all levels of the organisation, monitor workplace culture closely with particular focus on interdisciplinary engagements and hierarchical barriers to collaboration, promote and encourage a positive and fair work environment.
Meumann & Allen (2019) Australia Peers in diverse Alcohol and Other Drug settings Independent Evidence Review Report	**Peer Workforce Models in Alcohol and Other Drug Treatment.** The report defines and describes the scope of peer roles in AOD. AOD peer support services and models include the following: Mutual support groups, such as Alcoholics Anonymous (AA) and SMART Recovery; Web-based or eHealth models for peer support; Peer-run and peer-operated services; Consumer engagement and support; Peer workers in a structured service delivery setting such as within mainstream alcohol and other drug services. While there are limited peer support roles within AOD structured service delivery organisations, they comprise a significant number of AOD workers who openly identify as being a peer. Mental health, homelessness, family violence and AOD issues are intrinsically linked as part of AOD peer work. **Summary of evidence:** • The research evidence on the effectiveness of AA is mixed and is of poor quality (12-step programs delivered by peers also adapted for Narcotics, Gambling, Families). SMART Recovery has limited evidence about its effectiveness. • Aboriginal mutual support groups for men and women provide a culturally safe space where substance use can be discussed along with other relevant issues such as health issues, stigma and discrimination, and are effective in reducing drug and alcohol harms across the community.

	• Web-based models - advantages are that they are anonymous, convenient, accessible, cost-effective, private, and can provide support while clients investigate other face-to-face options. They are also perceived to improve access to care in rural and remote locations. (e.g. Hello Sunday Morning web program evaluation found participants reported a significant decrease in alcohol consumption 4 months following program commencement. • Peer-run services (e.g. NSW Users and AIDS Association (NUAA) and Queensland Injectors Health Network (QuiHN) and their Needle Syringe Programs and peer education programs) evaluation has found peer networks are effective for harm reduction activities. **Challenges for AOD Peers:** Role clarity; Personal issues with health and stress; Boundaries; Inadequate training and supervision; Workload; Inadequate remuneration.
Minshall et al. (2020) Australia Emergency Departments Commissioned Research Report / Melbourne University	Research included a literature review, site visits, focus groups and workshop with peer workers. Observation of the ED setting - The clinical spaces gave a sense of "authority" and "urgency"; unclear space for peer workers. Focus Group themes included peer workers role in walking alongside, providing dignity, support, and person-centred care in an environment in which the nature of many structures readily took away dignity and privacy, hampered also by the ED culture, physical environment of 'hustle and bustle' time issues, in contrast to slow and long waiting in the waiting room. Peer workers were perceived as 'the human face of health services'. The workshop with peers identified skills, knowledge and values peer workers need in the ED environment, optimal roles for peer workers in the ED context, and what peer workers need from the organisation. **Conclusion:** This research concluded that the ED is a challenging space to practice peer support work. In part, this is due to its physical environment and the deeply clinical culture; both of these elements appear very rigid and difficult to change.
National Alliance of Mental Illness (NAMI) (2023) USA Peer Work Resources Lived Experience Peak / Clearing House	**Certified peer specialists: an untapped opportunity.** Provides links to multiple published and grey literature resources and project reports. **Exemplar pages:** **'Workforce: Peer Support Workers' -** Peer support is an evidence-based mental health model of care. Considerable research demonstrates that PSWs help improve patient outcomes, including reducing the need for inpatient and emergency services and the frequency of recurrent psychiatric hospitalizations. PSWs can help improve an individual's sense of recovery and hopefulness, and they can help people improve their skills and abilities in desired areas. Peer support services are more frequently being integrated into mental health, substance use and physical health services as a meaningful part of multidisciplinary health care teams, due to an increased recognition of their value. ***'Certified Peer Specialists: An Untapped Opportunity' -*** *Evidence-based courses and/or tools that can enhance peer specialist skills: Building Recovery of Individual Dreams and Goals, Emotional CPR, Health and Recovery Peer program, Honest, Open, Proud, Illness*

	Management and Recovery. *Intentional Peer Support*, *Pathways to Recovery*, *Psychiatric Advance Directives, Shared decision-making, Wellness and Action Recovery Plan, Wellness in Eight Dimensions* and *Whole Health Action Management*.
National Eating Disorder Collaboration (2018) Australia Peer Support and Eating Disorders Sector Specific Report	**Developing a Peer Workforce for Eating Disorders Exploring the Evidence.** The implementation of peer work strategies in eating disorders has been relatively slow by comparison with other areas of mental health and evidence is limited. The evidence that does exist, however, indicates that the experience and outcomes of peer work are comparable to those found in general mental health settings. Identified benefits include increased hope, improved engagement with treatment and sustained remission of symptoms. For families, benefits include a reduction in stress, overcoming isolation, and increased sense of agency and efficacy as partners in the treatment process. Key challenges included: lack of understanding of the peer work role, unsupportive work environments and maintaining personal mental wellbeing. The most persistent barrier to implementing a peer workforce in eating disorder services appears to be funding.
NOUS Group (2023) Queensland, AUS Peer Delivered Alternatives to Emergency Departments Commissioned Research Report	**Safe Spaces Evaluation**. Brisbane North Primary Health Network. Safe Spaces provide an alternative to emergency departments for people in distress through a non-clinical service. Key findings • Establishment of the Safe Spaces was well paced and collaborative. • The Safe Spaces model is meeting local needs and aligns with peer-led co-design principles. Demand for the Safe Spaces has been strong and increasing over the program. Most guests (86%) showed an improvement in distress levels between the start and the end of their Safe Space visit. • Repeat visitors constitute a significant proportion of service activity, which highlights the need for the service. The model of care needs to adapt to accommodate repeat visitors and different presentations of distress. There is a need for clearer guidance on the service model, and to crystalise guidance and messaging on the target cohort without creating rigid exclusion criteria. Peer work is intensive and workforce structures need to accommodate for this. Expanded and standardised training and supports which recognised the intensity for peer workers are required.
Paino et al. (2023) Australia	**Towards a Meaningful Evaluation Framework for Peer Work.** **Aim:** To provide training and skill development in Meaningful Evaluation Frameworks to peer work leaders, and to create a space for a deliberative dialogue about the possibility and value of a peer-specific meaningful evaluation framework. Participants: 10 peer workers attending a series of reflective workshops.

Peer work role evaluation Commissioned Research Report (Centre for Social Justice and Inclusion University of Technology Sydney)	"…the current focus on linear outputs and de-contextualised explanations for the efficacy of peer work, or on 'hard' tangible and monetised outcomes, means that most research and evaluation frameworks fail to capture the complexity and nuances of peer work. Additionally, evaluation frameworks tend to treat community members as though they are passive recipients of care, which is not in line with peer workers' commitments to solidarity, mutuality, dialogue, and power-sharing." (p.4) A resource providing a suite of question options for evaluation within a 'Meaningful Evaluation Framework'.
Rising Together Action Group (2022) Victoria, AUS Carer Lived Experience Workforce Development Commissioned Research Report	**Rising Together-Lifting the lid on the experiences of family/carer lived experience workers.** The study sought to investigate the experiences of family/carer lived experience (LE) workers within the Victorian mental health system. Aim: To better understanding what is needed to ensure the safe and sustainable development of this workforce. Evaluation methods: • An online survey with 62 Family/carer LE workers asking about their perceptions of support, inclusion, workload, and training, and perceptions of how families and carers were included in mental health service delivery. • A photovoice process - participants selecting up to three images that represented their experiences as family/carer LE workers. • A workshop to discuss these images (n=10 participants). • Focus Group participants (n=16) brainstorm solutions to issues identified which then informed a series of recommendations. **Summary of findings:** Participants reports feeling undervalued and poorly understood, isolated and marginalised, with inherent tensions when attempting to work in a relational context within mental health services that focused on individuals. Recommendations: 1. Mental health organisations need to change to better incorporate Family/Carer Lived Experience Workers 2. The family/carer LE workforce needs to be developed and sustained 3. The mental health system needs to better incorporate relational orientated practice into standard models of care 4. Authentic co-production must guide all work involving the family/carer LE workforce.
Rutherford et al. (2022)	**Mental Health Community Support Services Evaluation.** Evaluation of Queensland's non-clinical, holistic recovery-focused psychosocial wraparound support services delivered either one to one, peer to peer or within a group, based on an individual's recovery needs. The four core programs evaluated were: • The Individual Recovery Support Program (IRSP) - an individualised psychosocial support program.

Queensland, AUS Community Psychosocial Support Programs Commissioned Research Report	• The Group Based Peer Recovery Support Program (GBPRSP) - group-based peer-led activities. • The Individual Recovery Support -Transition from Correctional Facilities Program (TCFP) - non-clinical psychosocial wraparound support to a person at least 2 weeks prior to release from the correctional facility and for up to 12 months post-release. • The Individual at Risk of Homelessness Program (IRHP) - non-clinical psychosocial wraparound support for individuals residing in a boarding house, crisis accommodation or hostel; focused on breaking the cycle of homelessness and supporting development of skills enabling individuals to transition to secure and stable tenancy and housing. In evaluating the implementation of the MH CSS program across the NGOs it was found that there were common barriers related to the NGO staff that negatively impacted the recovery journey for consumers. These included inconsistent staff/turnover, inadequate training, staff resourcing and management of consumer-staff boundaries. Consumers often noted that their support workers were extremely busy and under-resourced, which was identified as a barrier to receiving adequate supports.
SANE Australia (2015) Australia Peers as Health Coaches for Physical Health Non-Government Report	**Physical Health Peer Education Improving Physical Health and Preventing Chronic Health Conditions in People Living with Mental Illness.** The aim of the Peer Health Coaching program was to develop, implement and pilot a physical health peer support program (referred to as Peer Health Coaching) to address the physical health needs of people living with a mental illness. Trained Peer Health Coaches provide six one-hour coaching sessions to support eligible consumers in reaching their identified physical health goal. Methods: qualitative and quantitative data is being collected over a two-year period (this evaluation covered the first 12 months). Whilst the results to date are positive, the sample size (n=37) is too small to draw definitive conclusions about Peer Health Coaching being an effective method of improving the physical health of consumers. Despite these results, learnings from implementation and recommendations for further development are provided.
Smith-Merry et al. (2016) Australia Review of various MH Recovery Programs, including PS	Reports on many Recovery-focused program that are clinician delivered, delivered with a peer support component, or are peer-led. Many mentioned a peer support component did not disaggregate outcomes of peer support from the overall outcomes. Therefore, only examples where the outcomes of peer support were clear have been noted here. **Consumer-Driven Peer Support Models:** Self-Help Agencies (SHA) in the US allow consumers to **drop-in** and receive services when needed and participate in the running of the organisation, which is entirely peer-run as a "participatory democracy" of peer workers. The Friends Connection (also in US) offers peer-support for consumers involved in an **Intensive Case Management (ICM)** program (discussed above). Consumers are paired with peers who support involvement in community-focused social activities such as self-help groups and recreation activities. A mixed methods evaluation of the program implemented with people who had been hospitalised for mental ill-health in the previous 24 months (67% with schizophrenia related diagnoses, 23% with depression, etc) showed reduced rehospitalisation rates compared to those ICM clients not enrolled in the program.

Sax Institute Report	Evaluation of consumer operated service programs in the US offering "**drop-in**, peer support and mentoring, and education and advocacy" showed that, while there was a negligible increase in empowerment over all sites, empowerment was significantly increased in some programs but not in others, and organisational setting therefore makes a significant difference in consumer outcomes, even within consumer-run services. Two separate RCTs of **WRAP Group programs** by Cook et al. in the US showed lower levels of service utilisation and need compared to control, while improving an individual's recovery and lessening symptoms. **Clubhouses** - "intentional recovery communities" focusing on psychosocial rehabilitation in a peer support environment, found to be less successful as an employment intervention than other programs such as IPS, and is difficult to evaluate as a concrete model because its functioning is dependent on how it has been devised in local contexts. 'The Station' – a consumer-driven in **rural** South Australia for consumers and their families who come to the centre for peer support, formal and informal activities. A realist evaluation found that the service was nurturing and empowering for consumers. **Recovery Colleges (RCs)** – originating in the UK, RCs have been developed in many community mental health care settings across Australia. A core focus is on co-production where consumers take on all facets of running the college and designing courses, with the support of some paid staff and, in some cases, clinicians. Satisfaction with this model is generally reported as high, as the underlying premise is that RCs allow 'students' to move out of the patient-practitioner mode of learning and take on their own learning, drawing on peer-relationships to discover new possibilities for moving forward in managing their lives and ill- health. **Family Peer Support Models:** Family Peer workers in Intensive Family Support Services in the US provide carers and family members with education about mental ill-health, instructions about personal coping strategies and communication; report very high satisfaction.
South Australian Community Health Research Unit (SACHRU) (2008) South Australia, AUS Peer support community non-clinical	**Baptist Community Services Peer Support Project Evaluation.** South Australia non-government peer services integrated with different workplace and organisational settings such as acute care facilities and supported residential facilities (45%), and step-down hospital to community settings and community support settings (55%). Evaluation methods: 24 interviews with peer workers, their managers and colleagues in mental health service settings across SA. Summary of findings: • Managers and non-peer colleagues - mix of expectations • Peers - mix of expectations of their acceptance within teams • Service user/peer relationships - seen to be empowering, honest, humanising, relevant, and a valid addition to existing clinical teams. • Peer workers are seen to have enacted significant cultural change in many workplaces. • Peers reported the role validated their self-worth and sense of purpose, and many felt it had improved their own recovery.

Independent Research Report	
Steward et al. (2019) Queensland, AUS Regional Community Mental Health Promotion Independent Research Report (Griffith University)	**The evaluation of the Mental Health and Wellbeing Hubs.** The Regional Mental Health and Wellbeing Hub initiative was established to develop, deliver and evaluate a coordinated and evidence-based approach to strengthening and embedding community awareness, understanding and capacity for improved individual and collective mental health and wellbeing. Though not explicitly measured, significant paid roles are performed by peers with lived experience drawn from the communities in which the Hubs are located. The Hubs are able to develop flexible and targeted activities that match the needs of specific communities. The Hubs have substantially developed their capabilities to transfer knowledge to the wider communities in which they are located. Improved opportunities to get a wellbeing focus embedded in local planning process (in particular with Local Council) were identified.
Schweizer (2021) NSW, AUS Peer Navigators Commissioned Review for the NSW Mental Health Commission	**Peer Navigation: Desktop Review.** Aim: To inform the project to codesign a joined-up wellbeing and mental health supports in NSW, which may include peer navigation as a key feature. **Summary of Findings:** • Improvement in self-reported indices of physical and mental health. • Peer navigators may offer a promising solution to barriers in utilizing the healthcare system for people with SMI, especially those who may be homeless or from minority racial groups. • Peer navigators are committed to time and relationships and can aid with such tasks as helping people get to appointments and engagement with providers; accompanying people into the examining room; helping people access entitlements and prescriptions; and connecting health problems to issues of shelter, nutrition, and personal safety. • Patients more likely to follow through with primary care. Peer-STOC and Partners in Recovery peer navigation roles are noted. This report also reviewed peer navigation in broader contexts beyond mental health, including HIV and chronic disease.

Tari-Keresztes et al. (2022) Northern Territory, AUS Various community contexts and populations / especially Aboriginal and Torres Strait Islander & CALD Commissioned Research Report (Flinders University)	**Evaluation of the "Professionalising the NT Peer Workforce and expanding peer supports for Territorians who experience mental health challenges" Project.** The Peer-Led Education Pilot (PLEP) was a unique and innovative psycho-social education intervention delivered by the NT Mental Health Coalition that empowered people with lived experience of mental health concerns to support others with similar experiences. As a result, they established the NT Lived Experience Network (NTLEN). PLEP also encouraged the implementation of further local lived experience projects which include the Two Ways Mentoring program (TeamHEALTH), the ADF Family and Friends Recovery support program (NTLEN and Flinders), and the current NT Peer Workforce project led by the Top End Mental Health Consumer Organisation (TEMHCO). **Summary of findings:** This project was crucial in filling a critical gap in psychosocial education and employment, providing an avenue for opportunities such as employment, personal recovery, peer work skills, experience in group-based, supported learning and building the evidence base of the pilot. Many challenges were identified in relation to the mental health challenges students may face—for instance, low self-confidence, poor self-esteem, minimal self-reflection, struggles with communication, lack of confidence with self-advocacy, delayed help-seeking and limited problem-solving skills. Also, fear of failure, feeling overwhelmed, the influence of triggers and stigma were also mentioned. These challenges were also reportedly exacerbated by individual circumstances, literacy and numeracy levels, and previous bad experiences with studies. Several recommendations are made, including to keep focusing on creating safe workplaces for the emerging local peer workforce.
Urbis (2022) New South Wales, AUS Community non-government program Commissioned Evaluation Report	**Evaluation of the Resolve Program.** The Resolve Social Benefit Bond (SBB) is a social impact investment developed by Flourish Australia, Social Ventures Australia (SVA), the NSW Ministry of Health (NSW Health), and NSW Office of Social Impact Investment (OSII). The program blends psycho-social and clinical services to support people living with severe and persistent mental health issues; established in 2017 in Orange and Cranebrook, NSW. **The model:** people who have been admitted for mental health care (e.g. a mental health unit or a 'general ward' bed) for between 40 and 270 days in the preceding 12 months. Provided with access to community-based services to support their recovery journey for up to 2 years. Evaluation methods: interviews with 48 stakeholders (including clients, staff, program partners and external service providers), 10 program partners (including Flourish, NSW Health, and OSII); review of aggregated program data (Oct 2017-June 2021; n=319 clients). **Summary of findings:** • Clients had reduced their engagement with the health system (reducing number and length of their hospital stays, and Emergency Department presentations when compared with the year prior to Resolve enrolment).

	• Clients reported included improved confidence, social connections, participation in community life, and relationships. • Recovery-oriented practice is being inconsistently implemented by staff and across sites. While residential stays appear to be valued by those who participate in them, uptake of the stays has been low.
Victorian Department of Health and Human Services (2019) Victoria, AUS Community Post-Hospital Discharge Support Government Report	**Expanding Post Discharge Support Initiative.** This support includes at least three contacts with a peer support worker within the first 28 days following discharge from a mental health inpatient hospital stay. **Benefits:** Benefits for organisations included: enhancing recovery-oriented approaches and promoting an organisational culture that treats people with mental illness with dignity and respect. Benefits for peer support workers included: Feelings of hope, purpose and connection that flowed from their work; Valuing the opportunity to contribute to improvements in mental health services and treatment; The powerful impact of modelling recovery for consumers and clinical staff on their own recovery. **Challenges:** The research suggests that when organisations carefully prepared for the introduction of a lived experience workforce, benefits were more likely to be realised. Without this preparation, the peer support workers themselves were likely to feel uncertain about their role, unsupported and even unsafe. The most significant practical challenges for peer support workers were: • Lack of access to Intentional Peer Support training. • Inadequate supervision, particularly discipline specific supervision. • Poorly resourced working conditions, lack of space, and access to standard office equipment, such as computers and stationery. • Finding the language and culture of clinical environments personally disempowering and disrespectful. • Feeling that being in a clinical environment creates pressure to 'become clinicalised' which can inhibit authentic peer support. • Being re-traumatised by their working environment, particularly when working on or around wards. • For those providing carer peer support, feeling as if their role is 'tacked on' to a clinical system oriented around the consumer. • Insufficient time to prepare for the introduction of the Initiative and the new lived experience workforce. • The availability, timing and scheduling of training. Operationalising the Initiative's requirements around number of contacts (at least 3) and timing (in the 28 days after discharge).
WA Peer Supporters' Network (2018) Western Australia, AUS	**The Peer Workforce Report [Western Australia]** The report provides an overall picture of demand, benefit, supply and sustainability factors to inform peer workforce investment and peer development requirements in Western Australia, outlining factors that drive or impede peer workforce growth and retention, and it makes industry recommendations for peer workforce growth and development.

Peer Workforce Development Lived Experience Peak Independent Report	154 stakeholders completed a survey (26 agency/organisational representatives (persons with a role in establishing and/or overseeing a peer workforce; 58 peer workers; individuals, families and carers). **Summary of findings:** • Around 9 in 10 of individuals, families and carers surveyed reported peer support would benefit them and supported having choice of access to a peer worker in services. 83% of individuals, families and carers who had accessed a peer worker had a positive experience. • 3 in 4 peer workers were satisfied in the workplace overall and view peer work as a greatly fulfilling vocation. However, peer workers are facing job shortages, remuneration problems and poor career progression options. • Peer workers are also exposed to significant psychosocial health and safety risks in the workplace. 42% were dissatisfied with levels of stigma and discrimination in the workplace, a majority had taken sick leave for work-related reasons, and 1 in 5 had resigned for work-related reasons, which strongly corresponded to peer workforce management problems, such as workplace bullying.
Wood et al. (2019) Western Australia, AUS Peer Supported Hospital Avoidance Commissioned Research Report (University of WA)	**Choices Post Discharge Project.** The Program was established at Royal Perth Hospital, Rockingham General Hospital and Perth Magistrates Drug Court to recruit clients who are discharged from Emergency Departments (EDs) or attending justice services. Through peer support and case management Choices is a short-term program that works to coordinate and facilitate access to primary and secondary care and community support services in order to address underlying, unmet needs in the post-discharge period. 392 people received support (Nov 2017-March 2019); 54% were male; 31% identified as Aboriginal and/or Torres Strait Islander. Main Issues: Mental health (66%), alcohol and other drug use (62%), and accommodation (55%). **Summary of findings:** In the year following support, there was a 35% reduction in the number of clients presenting to ED and overall the number of ED presentations declined by 18%. The number of inpatient admissions also decreased by 7% in the year following support. In the six-months following support there was a 37% decrease in ED presentations and 38% decrease in inpatient length of stay, equating to a hospital use cost reduction of over $1 million across 392 clients (or $3,462 per person) in this period. In the 12 months post Choices, there was an 18% reduction in number of people offending and 44% reduction in the proportion of clients who had been victims of offences.

Appendix 5: Hospital-related Setting and Contexts - Detailed Descriptive Tables

Table 1: Hospital Inpatient Units

Author(s), Year, Country	Design, Setting and Sample	Aims	Key Findings/Conclusions	Strengths & Limitations
Böhm et al. (2014) Patient Focus Group Responses to Peer Mentoring in a High-Security Hospital. UK	Qualitative Study Focus Groups 17 male patients in high secure forensic inpatient unit (average length of stay 4.67 years - 4 months to over 16 years). Adults	To investigate patient perspectives on peer mentoring in high security.	Considerations of power and risk need to be balanced with care in high secure units, against the possible benefits of providing mentoring opportunities. The development of a mentoring scheme in a high-security hospital would benefit from involvement of patients in the development process and operationalization. Establishing a clear mentor role was difficult. A mentor in close cooperation with staff was seen to compromise the distinct quality of the relationship. It is potentially complicated to deliver and sustain but nonetheless could be experienced as a meaningful, genuine connection and a unique opportunity for those at paradoxically the greatest risk of disenfranchisement and disconnection from the very system that is in place to help them.	**Limitations:** Focus groups were too large (up to 9 participants), which silenced some and favoured dominant voices. Selection bias.
Klim et al. (2022) Characterizing suicide-related self-disclosure by peer specialists: a qualitative analysis of audio-recorded sessions. USA	Qualitative Study (sub-study of RCT) 10 Recorded interactions between 4 peer support specialists trained in suicide-related self-disclosure and 10 study participants who were admitted to inpatient	To examine peer specialists' use of suicide-related self-disclosure in encounters with individuals hospitalized for recent suicidal ideation or behaviors, how they shared their stories around suicide, and	Three themes: 1. Peers mentioned suicide-related aspects of their histories briefly, often as part of introductions, without participants responding specifically to those aspects. 2. In more detailed disclosures by peer specialists and in participant responses, suicide is a part of the mental health challenges and life stressors discussed, not the focus.	**Limitations:** Trial context may limit generalizability of the findings to routine care. Findings based on spoken conversation which may not represent participants' state of mind. Did not measure effect of disclosure on suicide

	psychiatry units with suicidal ideation or a suicide attempt. Adults	how study participants reacted.	3. “Let’s focus on my recovery and what I’ve learned” reflects that peers steered their self-disclosures away from suicide and towards what was helpful in their recovery. These findings suggest that, with practice and preparation, peer specialists can convey shared lived experiences related to suicide while maintaining a message of recovery.	risk. Analyzed only initial sessions - peer disclosure characteristics and participant responses may change with greater familiarity/trust between individuals.

Otte et al. (2020) Challenges faced by peer support workers during the integration into hospital-based mental health-care teams: Results from a qualitative interview study. Germany	Qualitative study 9 interviews with PSWs. Inpatient unit. Adults	To explore the challenges faced by PSWs during their integration into hospital-based mental health-care teams.	3 themes: 1. 'Pioneers and the pressure to succeed' - burdened with an immense pressure to succeed with no room for failure; feared would be no opportunity for other PSWs to be hired in future; 2. 'a colleague, a rival or yet another patient?' - lack of acceptance by clinical staff; 3. 'sharing of information, boundaries and professionalism' - feeling of not being competent enough to support patients. All themes relate to several concrete challenges on different systemic levels and have the potential to impede the PSWs' integration process.	**Limitations:** Only reports PSW perspective. Small sample.
feiffer et al. (2019) Development and Pilot Study of a Suicide Prevention Intervention Delivered by Peer Support Specialists USA	RCT plus Qualitative 70 inpatients at high risk for suicide randomized to usual care (n=36) or to a 12-week PREVAIL peer support intervention (n=34) incorporating motivational interviewing and psychotherapies targeting suicide risk into recovery-based peer support. Adults	To assess the acceptability, feasibility, and fidelity of the peer specialist intervention (PREVAIL) to reduce suicide risk in mental health inpatients.	Peer specialist sessions demonstrated adequate fidelity to administering a conversation tool regarding hope, belongingness, or safety, and 72.5% of general support skills (e.g., validation) were performed with adequate fidelity. Qualitative responses (n=23) were highly positive regarding peer specialists' ability to relate, listen, and advise, and to provide support specifically during discussions about suicide. Findings demonstrate that a peer support specialist suicide prevention intervention is feasible and acceptable for patients at high risk for suicide.	**Limitations:** Small sample, at one medical centre, and study not adequately powered to compare differences between treatment arms or changes over time. Many patients were ineligible to participate, many due to judgments by psychiatrists who may have been overly conservative.
Poremski et al. (2022)	Qualitative study Inpatient unit.		Peers appear to pass through 4 phases over the course of their employment: early beginnings, establishing the role, role narrowing, and role sustainability. Services wishing to integrate new peers must be aware of the time required for	**Limitations:** Small peer pool. Those most likely to be dissatisfied were least likely to participate.

A Longitudinal Qualitative Analysis of the Way Peer Support Specialist Roles Change Over Time in a Psychiatric Hospital Setting in Asia. Singapore	Followed 10 peer support specialists over a year, interviewing them at 3 points, starting approx. 3 months after becoming peers in the role. Adults		integration. Without role clarity, peers may struggle to find their place. Pairing new staff with mentors may limit this burden. As roles consolidate, boundaries may emerge. If these boundaries narrow the role of the PSS, they may no longer find the role appealing. They may then choose other caregiver roles with wider or different spheres of influence (issues of tenure/sustainability),	Variety of departments in which PSS were integrated introduced significant heterogeneity. A more conventional implementation research framework might have produced clearer results but not have led to discovery of negative impact of role narrowing.
Reinhardt-Wood et al. (2018) Inception of a Peer-Run Wellness Center at a State Psychiatric Hospital. Ireland	Qualitative study/ case study Peer-run wellness center on the grounds of a state psychiatric hospital. Adults	To explore the establishment of the centre, challenges and impacts for inpatients.	The peer role and center model involves provision of individualized peer support; information, referral, and linkage to community resources and community wellness centers; computer access and computer literacy education; and completion of personalized recovery plans. By accessing the center, individuals are able to begin the community reintegration process while still hospitalized, start forming beneficial and long-lasting supportive relationships that may carry forward into the community outside of the confines of the institution. Challenges: cultural acceptance by non-peer staff. Exponential growth in attendance at the centre has been recorded over its years of operation.	**Limitations:** None stated.
Rooney et al. (2016) Patients' views: peer support worker on inpatient wards.	Qualitative study 7 interviews with inpatients	To explore patients' experiences of intentional mental health peer support.	Overarching theme of communication with patients, and 6 main themes: person centredness, practical support, building connections, emotional support, modelling hope and recovery	**Limitations:** Small scale qualitative research

UK	Adults		interventions. There were no negative comments expressed by interviewees.	
Smith et al. (2017) The implementation of a peer support scheme in an assertive rehabilitation ward in high secure forensic services. USA	Qualitative study 14 interviews with peer support providers (N=6) and individuals who initially received peer services (N=8) during an inpatient stay. Adults	To clarify the potential role and impact of behavioral health peer support providers on community hospital acute inpatient psychiatric units.	Recipients described inpatient experiences as disempowering and humiliating and reported powerful positive initial reactions to peers who had had similar experiences but who also displayed competence and professionalism. Peers and recipients described strong emotional connections that differed from traditional attitudes and relationships with clinical staff. Peers described challenges and obstacles related to interactions with the clinical treatment team, and both peers and recipients strongly endorsed the role of peers in facilitating successful care transitions. Peers and clients both spoke about the structural limitations of peer relationships, and several recipients mentioned conflicts with individual peers that had to be resolved over the relationship. Findings suggest that simply witnessing peers' apparent successes may profoundly impact some recipients in earlier stages of recovery.	**Limitations:** Potential for selection bias; circumstances and snowball recruitment limited interviews to peers and recipients who had positive experiences; not able to interview recipients who refused peer services. Lack of hospital clinical staff members' perspectives.
Wolfendale & Musaabi (2017) The implementation of a peer support scheme in an assertive rehabilitation ward in high secure forensic services. UK	Qualitative study Interview with peer, focus groups with inpatients, questionnaires during implementation. Forensic Rehab inpatient unit. Adults	To provide an overview of the implementation of a peer support volunteer scheme in a high secure setting and to explore the peer support volunteer's experiences conducting this role, based predominantly on an assertive rehabilitation ward.	There are challenges introducing this particular scheme into mental health service teams e.g. establishing appropriate boundaries and dilution of the role due to power imbalances, both between the peer support volunteer and the service recipient, but also between the clinical team that supervises the overall peer support scheme.	**Limitations:** Only 1 peer involved. Data analysis process not described.

Table 2: Hospital Emergency Departments

Author(s), Year, Country	Design, Setting and Sample	Aims	Key Findings/Conclusions	Strengths & Limitations
O'Neill et al. (2024) "Whatever journey you want to take, I'll support you through": a mixed methods evaluation of a peer worker program in the hospital emergency department. Canada	Mixed methods Survey of characteristics of patients (n = 555) and type of supports provided to them. Interviews with 7 PSWs. Emergency Department. Adults experiencing mental health, homelessness and/or drug and alcohol issues.	To outline the role of Peer Workers in the care of a marginalized populations in the emergency department. To characterize the impact of Peer Workers on patient care. To describe how being employed as a Peer Worker impacts the Peer.	Support primarily consisted of friendly conversations (91.4%), discharge planning (59.6%), tactics to help navigate emotions/ mental wellbeing (57.8%) and sharing lived experience (50.1%). In 38.9% of interactions, PSWs shared new information about patients with health care team (e.g. obtaining patient identification). 5 themes: (1) Establishing empathy and building trust between the patient and their care team through self-disclosure. (2) Facilitating a person-centered approach to patient care through trauma-informed listening and accessible language. (3) Support for patient preferences on harm reduction. (4) Peer worker role facilitating self-acceptance and self-defined recovery. (5) Importance of supports and resources to help Peer Workers navigate the emotional intensity of the emergency department.	**Strengths:** Rigour of the mixed-methods approach. Sampling of PSWs. **Limitations:** Focused on how Peer Workers perceive their impact on patients' care experience -patients and health professionals may have differing views. Patient Interaction Survey was by proxy (i.e., the Peer Worker) not self-reported by patient. Small sample precluded sex/ gender analysis.
Ashford et al. (2019) Utilization of Peer-Based Substance Use Disorder and Recovery Interventions in Rural	Quantitative Descriptive study Peer support data (patient interviews and self-report)	To analyze archival data collected during the first year of the pilot program to characterize and describe (a) the utility of Peer Recovery Support Services (PRSS),	Only a small percentage of participants declined referrals to further support. Relationship between participant response to the initial peer engagement and regular benzodiazepine use was significant, 2 (1, 205) 6.911, p .33 (99% CI, [.033, .034]) – i.e. this group were less likely to engage with PSW.	**Limitations:** Exploratory study only. Administrative data meant many variables of interest not collected or available. Data collected via participant

Emergency Departments: Patient Characteristics and Exploratory Analysis. USA	from Community Connections Program captured at 3 rural EDs. Patients (N = 205) for people who presented with opioid overdoes or substance-use disorder. Adults	(b) the engaged patient population, and (c) relationships between services provided and patient characteristics.	This study demonstrated that peer interventions can be beneficial for all types of drug use, not just for individuals who experience accidental opioid drug poisoning (i.e. overdose).	self-report (less robust than e.g. urinalysis lab testing). Referral to local resources, but no data on whether they were followed up. Lack of clinical assessment data to determine referral appropriateness.

Table 3: Hospital Avoidance / Early Discharge / Post-Discharge Programs

Author(s), Year, Country	Design, Setting and Sample	Aims	Key Findings/Conclusions	Strengths & Limitations
Croft & Isvan (2015) Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services. USA	Quantitative study Peer-delivered Respite / hospital avoidance. 89 individuals who used any inpatient or emergency services. Propensity score matching to create matched pairs of 139 users of peer respite and 139 non-users of respite with similar characteristics. Adults	To examine the relationship between peer respite and use of inpatient and emergency services among adults receiving publicly funded behavioral health services.	After controlling for relevant covariates, the odds of using any inpatient or emergency services after the program start date were approximately 70% lower among peer respite users than non-respite users, although the odds increased with each additional respite day. Among individuals who used any inpatient or emergency services, a longer stay in respite was associated with fewer hours of inpatient and emergency service use. However, the association was one of diminishing returns, with negligible decreases predicted beyond 14 respite days.	**Limitations:** Propensity score matching can account for only observed characteristics and cannot account for unobserved factors that might influence a decision to use respite services.
Dermatis et al. (2006)	Controlled Trial	To determine, for both non-chronic and chronic	The peer-led self-help program was associated with a higher rate of acceptance of aftercare	**Strengths:**

Evaluation of a model for the treatment of combined mental illness and substance abuse: the Bellevue model for peer-led treatment in systems change. USA	Mental illness and chemical abuse inpatients 461 consecutive inpatient admissions were evaluated to compare the peer-led self-help unit with two standard psychiatric units. Adults	mentally illness and chemical abuse patients, whether the peer-led self-help treatment program is associated with greater engagement in aftercare treatment relative to conventional psychiatric treatment.	referral (93% vs. 74%) and aftercare attendance (52% vs. 30%) among patients with no prior psychiatric hospitalizations (N = 111). In addition, the program appeared to benefit chronically impaired patients (N=350) or those with a history of prior psychiatric hospitalizations, more likely to accept referral to aftercare compared with similar patients discharged from standard psychiatric units (96% vs. 81%).	While random assignment was not feasible, constant referral base produced equivalent characteristics across groups. **Limitations:** Chronicity defined only by prior psychiatric hospitalizations. Measure of retention was limited to attendance in professional treatment and did not incorporate a measure of attendance at self-help meetings. Evaluation as a whole precluded any assessment of specific ingredients.
Forchuk et al. (2020) An ethnographic study of the implementation of a transitional discharge model: peer supporters' perspectives. Canada	Qualitative Study Evaluation of implementation of transitional discharge model (TDM) across 9 hospitals. 66 PSWs Focus groups, held at 6 months and 1-year post implementation. Adults	To examine peer supporters' perspectives on the implementation of a transitional discharge model, an intervention for the community integration of people with mental illness.	PSW reported their involvement enhanced clients' autonomy and hope about their recovery, as well as established a safety net and reduced hospital readmissions. Several roles to facilitate clients' transition from hospital to the community included: assisting clients in building their capacity and developing healthy routines; attending regular on-ward and community meetings; accompanying to appointments; working with clients to set goals for recovery. Hindrances to effective implementation included: lack of understanding and appreciation of PSW roles, lack of careful allocation of PSWs, and absence of appropriate	**Limitations:** None stated

			protocols for ensuring safety and supervision of the peer supporters.	
Gillard et al. (2022) Peer support for discharge from inpatient mental health care versus care as usual in England (ENRICH): a parallel, two-group, individually randomised controlled trial. UK	RCT Patients assigned to intervention (peer support plus care as usual) or control (care as usual). Peer support focused on building individual strengths and engaging with activities in the community, beginning during index admission and continuing for 4 months after discharge. Usual care was follow-up by community mental health services within 7 days of discharge. Adults	To establish the effectiveness of a peer worker intervention to reduce psychiatric readmission following discharge.	590 recruited - 294 allocated to peer support (287 after withdrawals and loss to follow-up), and 296 to care as usual (291 in analysis). In the peer support group, 136 (47%) of 287 patients were readmitted at least once within 12 months of discharge. 146 (50%) of 291 were readmitted in the care as usual group. Engagement in the peer support intervention was low, with a mean of 1·8 face-to-face contacts (SD 2·9) per patient before discharge in the peer support group, and 4·4 contacts (4·6) after discharge (compared with a total planned 14 contacts). Patients of any Black ethnicity receiving peer support were significantly less likely to be readmitted in the year post-discharge than those of any other ethnicity. Conclusion: Peer support plus usual care was not superior to care as usual alone in the 12 months after discharge.	**Strengths:** Superior trial - robust procedures for concealment of allocation from assessors, complete reporting of outcomes, and low attrition. **Limitations:** The peer intervention had high flexibility in activities that took place, i.e. might not have been sufficiently structured to maintain engagement or meet the high level of need of this high-risk group.
Griswold et al. (2010) Access to primary care: Are mental health peers effective in helping patients after a psychiatric emergency? USA	RCT 175 Peer worker and primary care navigator roles examined. 1-year follow-up.	To examine access to primary care after a psychiatric crisis and the role of peer workers and navigators.	Study participants were recruited from ED as part of RCT examining access to primary care after a psychiatric crisis. The intervention group worked with primary care navigators, versus the control group who received usual care. All patients were offered mental health peers and were followed for 1 year. **Results:** People receiving support from PWs were statistically more likely to follow through with primary care, and patients who had both a navigator and a PW connected to primary care	**Limitations:** Non-blinded.

			at even higher rates. Peer work may be one essential ingredient of a coordinated and person-centered mental health and primary care system.	
Hancock et al. (2022) Peer Worker-Supported Transition from Hospital to Home-Outcomes for Service Users. Australia	Qualitative Study 82 questionnaires (12 consumers, 20 PSWs, 50 clinicians) and 58 interviews (17 consumers, 22 PSWs, 19 clinicians). Across NSW, 17 Peer-STOC programs, each with 1-2 full-time equivalent PSW positions. Model involved hospital in-reach to collaboratively identify transitional supports needed. Transitional support of 6 weeks post-discharge (referrals, connecting with services, social connection, getting things organized, getting out of the house). Adults	To understand the impacts and outcomes of the Peer-STOC program on service users from three stakeholder perspectives: service users themselves, peer worker service providers, and other mental health workers and clinicians interfacing with the program.	All stakeholders described positive impacts and outcomes of the program for service users. These included: (a) a better, less traumatic inpatient experience; (b) felt understood, cared about and less alone; (c) easier to leave hospital; (d) easier to get back into life and daily routines; (e) built and re-established community connections; (f) gained new knowledge, strategies, and skills; and (g) felt more hopeful about my recovery. Repeatedly PSWs and program were described as a 'bridge' enabling connections within, across, and beyond mental health services and to natural communities of choice. Conclusions: The Peer-STOC program had a positive impact. It enhanced people's experience in hospital, eased their transition from hospital and assisted with people recovering community-based relationships, activities, and routines.	**Limitations:** Recruitment was via program managers. Low service user rates of completing interviews and questionnaire.
Lam et al. (2020)	Quantitative Descriptive Study	To compare temporal trends in psychiatric health services use before and after	Among acute care units, median LOS decreased significantly below the projected historical trend following TDM implementation, while readmissions increased significantly and	**Strengths:** Use of time series design, and availability of multiple

Evaluation of the transitional discharge model on use of psychiatric health services: An interrupted time series analysis. Canada	Used health administrative databases (monthly discharges from psychiatric units 3 years prior to 2 years after TDM implementation). Median inpatient length of stay (LOS), psychiatric readmission rates and mental health-related emergency department visit rates were compared. Acute units and tertiary care units. Adults	Transition Discharge Model (TDM) implementation within acute and tertiary care psychiatric units in Ontario, Canada.	declined thereafter. No significant changes were found for tertiary care units. The trend readmission rates differed between acute and tertiary care units in this study. Possible reasons include different patient needs and staff practices.	years of data before and after the intervention. **Limitations:** Application of TDM may have differed from site to site e.g. Due to higher discharge rate of acute care units, it would be difficult to organize follow-up with a specific inpatient team, but it could be more easily accommodated in tertiary care units. Some people already had a working relationship with a community care provider or a peer supporter.
Lawn et al. (2008) Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. Australia	Mixed Methods Public mental health service consumers, peer workers, mental health clinicians. Hospital avoidance / early discharge support packages of up to 3 months post crisis/acute phase provided in home & community. In-reach into EDs and inpatient units, following referral	To report evaluation of the first 3 months of operation of an Australian mental health peer support service providing hospital avoidance and early discharge support to consumers of adult mental health services.	In the first 3 months of operation, 49 support packages (12% avoidance/88% early discharge) were provided with 300 bed days saved, equating to $93,150 AUS saved after project set up, delivery and administration costs of approximately $19,850. Feedback from all stakeholders (clients, peers, referring mental health professionals) was overwhelmingly positive. Low grade yet promising evidence for positive impact on hospital re-admission rates was also found. [12-month Grey Literature Report showed further similar savings and outcomes – 230 packages (36% avoidance/64% early discharge), 1178 bed days saved, with $393,468 savings to	**Limitations:** Poorly powered trial. Lack of recovery and other standardised outcome measures beyond self-reported satisfaction ratings and qualitative feedback. Bed days saved was estimated by subjective feedback by MHS staff and clients' previous admission patterns.

	from inpatient and ED MHS staff and GPs. Adults		the system after service set up, delivery and administration costs of approximately $52,638.	
Le Novere et al. (2023) Cost-effectiveness of peer-supported self-management for people discharged from a mental health crisis team: methodological challenges and recommendations. UK	RCT 441participants who had received at least 1 week of Crisis Response Team case management (hospital avoidance/early discharge recruited from 6 NHS Trust MHS crisis services; 221 randomized to PSW intervention and 220 to usual care plus workbook. Adults	To report the 12- month cost-effectiveness of CORE, a peer-provided self-management intervention, compared with the control, where data were collected over 12 months for resource use and 18 months for health-related quality of life.	The probability that the PSW intervention was cost-effective compared with the workbook plus usual care control at 12 months varied with the method used and ranged from 57% to 96% at a cost-effectiveness threshold of £20,000 per QALY gained. At a cost-effectiveness threshold of £20,000 per QALY gained, the probability that the intervention was cost-effective compared to the control was 65% based on 12-month QALYs calculated using linear interpolation. The probability of the intervention being cost-effective compared to control increases as the duration of follow-up increases	**Strengths:** Had relatively complete follow-up for mental health service use data. **Limitations:** The cost perspective was limited to specialist mental health services. Hence, unable to cite impact on wider healthcare service use, employment and productivity. 18-month cost-effectiveness analysis is potentially a conservative given incomplete. The EQ-5D is not as sensitive in serious mental illness.
Mahlke et al. (2017) Effectiveness of one-to-one peer support for patients with severe mental illness - a randomised controlled trial. Germany	RCT People recruited via inpatient and community (n=216) Adults	Comparing one-to-one peer support with treatment as usual.	People in the intervention group had significantly higher scores of self-efficacy at the six-month follow-up. There were no statistically significant differences on secondary outcomes in the intention to treat analyses.	**Strengths:** Good sample, size, rigor. **Limitations:** Low rate of clinician ratings, dropout rate of 67% in control group, making results of clinical outcomes very difficult to interpret. Hence, lack of

				detailed assessment of patient experiences.
Min et al. (2007) Peer support for persons with co-occurring disorders and community tenure: a survival analysis. USA	Longitudinal comparison group study Mental health and drug and alcohol. Participants paired with a peer; meet approx. once a week for 2 to 5 hours and engage in a variety of community-based activities, including leisure and recreational activities, attend self-help groups, or just spend time talking. Adults	To examine the effect of participation in The Friends Connection, a peer support program for individuals with co-occurring disorders, on 3-year rehospitalization patterns.	Program participants have longer community tenure (i.e., periods of living in the community without rehospitalization) than a comparison group. Significantly more people in the comparison group (73%) are re-hospitalized in a 3-year period versus those in the Friends Connection group (62%) (x2 = 4.374, p=.04).	**Limitations:** Non-randomized study cannot definitively account for these unmeasured characteristics. Hospitalizations occurring outside of study area were not captured. Potential for case manager selection bias when referring to the program, and individuals who agreed to participate may have been more motivated.
O'Connell et al. (2016) Outcomes of a Peer Mentor Intervention for Persons with Recurrent Psychiatric Hospitalization. USA	RCT 76 individuals who were diagnosed as having a major psychotic or mood disorder and who had at least two psychiatric hospitalizations or more than three emergency department visits within the 18 months prior to the index hospitalization;	To explore the relationship between a peer mentor intervention and improved clinical outcomes and increased community tenure among a sample of individuals with serious mental illness and a history of multiple hospitalizations.	Participants assigned to receive peer mentor support reported significantly greater reductions in substance use and psychiatric symptoms and greater improvements in functioning compared with participants assigned to standard care. Moreover, participants in the peer mentor program remained out of the hospital for significantly longer periods of time compared with those assigned to standard care.	**Limitations:** 50% of control group did not have a follow-up interview (reasons unknown). Limited to one setting, small sample (N=93); participants represent a small proportion (30%) of eligible participants. No quantitative data about program

	randomly assigned to: standard care or a peer mentor plus standard care. Adults			effectiveness i.e. may have benefitted simply from spending more time with an interested person.
Ostrow & Croft (2015) Peer respites: a research and practice agenda. USA	Open Forum [Similar to Urgent Mental Health Centres in AUS]	To present an agenda outlining implementation and research issues faced by peer respites.	Support mental health service users in preventing and overcoming psychiatric crisis by providing peer support in a setting intended to be supportive and enhance community connections. Peer respites may enhance availability of community self-help resources such as WRAP, suicide or hearing voices support groups, and wellness-oriented activities. Some peer respites require guests to have stable housing prior to admission, while others accept individuals experiencing homelessness. Organizational structures range from fully peer-run and autonomous to peer-operated and embedded within the traditional mental health system. 16 peer respites operating nationwide and more planned.	**Strengths:** Proposes shift in focus on what is measures, with clinical measures (e.g. Hospital costs saved as secondary to more holistic consumer-focused outcomes
Reynolds et al. (2004) The effects of a transitional discharge model for psychiatric patients. UK (Scotland)	Pilot RCT Transitional discharge model intervention (N=8): (1) peer support (friendship understanding and encouragement); (2) overlap of inpatient and community staff in which inpatient staff continue to work with discharged patients until a working	To test the discharge model designed to assist patients discharged from acute admission wards to adjust to community living.	Both the control and the experimental group demonstrated significant improvements in symptom severity and functional ability after 5 months. Usual treatment subjects in the control group were more than twice as likely to be re-admitted to hospital.	**Limitations:** Small sample. Study underpowered.

	relationship is established with community care provider. Vs Usual care (N=11) Adults			
Short et al. (2012) The Impact of Forensic Peer Support Specialists on Risk Reduction and Discharge Readiness in a Psychiatric Facility: A Five-Year Perspective. USA	Descriptive Study Quarterly Consumer Care Satisfaction Surveys Adults	To evaluate the impact of the Community Living, Education and Recovery Program (CLEAR) to people in transition from a Forensic Hospital.	Peers are based in the hospital and work on goal-focused recovery plans with patients from admission and follow-up in the community. The goal is facilitate the earliest possible discharge and appropriate residential placement for forensic residents while simultaneously identifying and managing risk factors. Benefits reported: • Role Models for Risk Free Effective Behaviors • Unique Communicators between Consumers and the Professional Staff • Identifiers and Innovators for Improved Consumer Care Procedures • Mediators during Complaint or Grievance Resolutions • Mentors and Teachers for Self-Advocacy Skills	**Limitations:** None stated.
Sledge et al. (2011) Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. USA	RCT Patients had been hospitalized 3 or more times in the prior 18 months. 74 patients randomly assigned to usual care (N=36) or peer mentor plus usual care	To examine the feasibility and effectiveness of using peer support to reduce recurrent psychiatric hospitalizations.	Participants who were assigned a peer mentor had significantly fewer rehospitalizations (.89 ± 1.35 versus 1.53 ± 1.54; p=.042 [one-tailed]) and fewer hospital days (10.08 ± 17.31 versus 19.08 ± 21.63 days; p<.03, [one tailed]).	**Limitations:** Small sample. Didn't have verifiable data on whether patients were hospitalized at other facilities during the follow-up period. Cannot conclude that differences in outcome were attributable to the peer mentors rather than

	(N=38) and assessed at nine months. Adults			to the presence of other informal supports. Did not have strict separation between supervisory and study's evaluative functions i.e. supervisors participated in some follow-up evaluations and weren't blind to participants' treatment status. Couldn't estimate cost savings from the peer mentor intervention.
Shattell et al. (2014) A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: "the living room" USA	Qualitative study using in-depth interview with 18 participants (9 guests, 5 peer counselors, and 4 clinical staff). Adults	To describe the lived experience of guests (persons in emotional distress) and staff (counselors, psychiatric nurses, and peer counselors) of a community, recovery-oriented, alternative crisis intervention environment—The Living Room (TLR).	Themes included: A Safe Harbor, At Home with Uncomfortable Feelings, and It's a Helping, No Judging Zone. Non-clinical care settings are perceived as helpful and positive.	**Strengths:** Study findings are trustworthy and dependable because the researchers adhered to the phenomenological approach. **Limitations:** Small convenience sample.
Van Zanden & Bliokas (2022) Taking the next step: A qualitative study examining processes of change in a suicide prevention program	Qualitative Study using in-depth interviews with 6 peer workers and 5 psychologists. Adults	To examine the processes facilitating change in an aftercare suicide prevention program featuring peer-workers from the perspective of clinicians and peer-workers employed in the service.	Next Steps is a CMO-based follow-up aftercare service for people over the age of 16 who have presented to local Emergency Departments (ED) following a suicide attempt or because of high risk for suicide. Contact with peer workers occurs over phone and face-to-face, and is initially 3–4 times per week, eventually tapering down to weekly across a time period of up to 12 weeks.	**Limitations:** Small sample that relied on peer worker and clinician reports. Did not include service-user perspectives. Results are specific to the Next Steps program and are therefore

incorporating peer-workers. Australia			Within themes, the following peer outcomes were noted: • Lived experience - Facilitates connection, role modeling recovery and peer-worker as a bridge. • Emotional availability of peers - Bearing witness and providing intensive support. • Building a life worth living - Highlighting strengths and clarifying values and goals. • Consumer-driven care - Encouraging agency and person-centred alternatives to traditional care. Participant responses indicated that lived experience was viewed as critical in developing trust, role-modeling recovery, and engaging service-users with community supports. Consultation in the context of risk was an important aspect of suicide prevention work for peer workers.	not generalizable to other approaches.
White et al. (2023) Predictors of engagement with peer support: analysis of data from a randomised controlled trial of one-to-one peer support for discharge from inpatient psychiatric care. UK	Quantitative Study Data analysed for 265 participants randomised to peer support who had a known peer worker. Two outcomes were considered: (1) a measure of engaged with PSW (2) number of face-to-face contacts with PSWs post-discharge. Adults	To examine if strength of relationship is predictive of the effectiveness of peer support. To examine the potential association between outcomes and 'matching' of PSW and participants.	Longer duration of first contact with PSW (*OR* = 1.03, 95% CI: 1.00, 1.04, $p < .001$) and more relationship building activities in the first contact (*OR* = 1.4, 95% CI: 1.13, 1.85, $p = .004$) were associated with greater odds of engaging with PSW. Non-heterosexual participants had increased odds of engaging with peer support compared to heterosexual participants, *OR* = 4.38 (95% CI: 1.13, 16.9, $p = .032$). Implementation of peer support should include a focus on relationship building in the first session.	**Limitations:** Missing data in some baseline variables. Low numbers of participants in some groups. Incomplete contact logs by PSWs at one site. Qualitative research would help interpret these findings.

Appendix 6: Community Models - Detailed Descriptive Table

Table 1: **Peer Work Models**

Author(s), Year, Country	Design, Setting and Sample	Aims	Key Findings/Conclusion	Strengths & Limitations
Acri et al. (2013) Examining the Feasibility and Acceptability of a Screening and Outreach Model Developed for a Peer Workforce. USA	Mixed methods of 24 (family peer advocates, their direct supervisors, and mothers seeking services) at family non-clinical settings. Maternal depression.	Examined the feasibility and acceptability of a screening and outreach intervention delivered by peers in non-clinical settings	Results offer preliminary support that peers can administer outreach and educational interventions with appropriate training and supervision; that mothers with depression can be detected in non-clinical settings, and that participants viewed the intervention as concordant with the services provided by peers and relevant to caregivers' emotional health.	**Limitations:** Small sample.
Ashford et al. (2018) Peer-delivered harm reduction and recovery support services: initial evaluation from a hybrid recovery community drop-in center and syringe exchange program. USA	Mixed methods. Statistical and descriptive evaluation of 417 substance use participants.	To gain a better of the understanding of the characteristics of an RCO providing peer-based SEP services.	Recovery community organizations are well situated and staffed to provide harm reduction services, such as syringe exchange programs. Given the relationship between engagement and participant housing, criminal justice status, and previous health diagnosis, recommendations for service delivery include additional education and outreach for homeless, justice-involved, LatinX, and LGBTQ+ identifying individuals.	**Strengths:** Large sample. **Limitations:** Minimal discussion of peer role.
Atif et al. (2022) Technology-assisted peer therapy: a new way of delivering evidence-based psychological interventions.	Mixed methods involving 6 women service recipients and 3 peers. Describes the process of co-development with end-users and key features of the App.	To develop a Technology-assisted, peer delivered Thinking Healthy Programme for perinatal depression focusing on the needs of women	Cognitive-therapy based intervention are delivered by a virtual 'avatar' therapist incorporated into the App which is operated by a 'peer' (a trained woman from the neighbourhood with no prior experience of healthcare delivery). Using automated cues from the App, the peer reinforces key	**Strengths:** Novel concept of 'Task Shifting' to meet gross unmet need in Pakistan. Avatar using CBT assisted by a local peer.

Pakistan		living in resource-poor rural communities.	therapeutic messages, helps with problem-solving and provides essential therapeutic elements of empathy and support. The peer and App therefore act as co-therapists in delivery of the intervention.	Limitations: Specific to a community within Pakistan.
Belden et al. (2022) Appropriateness of psychiatric advance directives (PAD) facilitated by peer support specialists and clinic. USA	RCT PAD facilitation by peers and clinicians on Assertive Community Treatment (ACT) teams. Total 72 consisting of certified peer-support specialist (30 PADs) and clinicians (42 PADs).	Examination of PAD documents for variations between peer and clinician facilitated.	Found nearly 9 out of 10 (86.7%) of peer-facilitated psychiatric advance directives (PADs) were rated "very feasible and consistent," and contrary to the expectation that peer specialists may promote proscriptive preferences in PADs.	**Strengths:** Nuanced, under researched area of advanced care directives. **Limitations:** Small sample.
Bellingham et al. (2018) Peer work in Open Dialogue: A discussion paper. Australia	A discussion paper that comes out of an iterative process involving a review of the available literature on peer work in Open Dialogue, as well as dialogue with experts in the field.	Examples and models of peer work in Open Dialogue are examined, and the potential benefits and challenges of adopting this approach in health services are discussed.	Peer work in could potentially disrupt clinical hierarchies, but could also move peer work from reciprocal to a less symmetrical relationship of 'giver' and 'receiver' of care. It remains uncertain whether the hierarchical structures in healthcare and current models of funding would support such models.	**Strengths:** Multi-tiered garnering and appreciation of the policy strengths and limitations. **Limitations:** As a discussion paper - low research rigor.
Byrne et al. (2017) Acknowledging Rural Disadvantage in Mental Health: Views of Peer Workers. Australia	13 peer workers interviewed (qualitative, semi-structured).	To present views and opinions of (peer workers with specific focus was on their capacity to contribute meaningfully to mental health service provision and in rural areas and associated barriers.	Significant barriers to the provision of quality mental health services in rural and regional locations. The two main areas identified were the following: transport and distance, and lack of mental health staff and services. Given appropriate and resources and support peer workers could contribute significantly to improved mental health services in rural and remote areas.	**Strengths:** Contributes to under researched area – rural. **Limitations:** Small sample.

Cheesmond & Davies (2020) The role of the peer support worker in increasing rural mental health help-seeking. Australia	Rural survey of 765 residents in selecting MH seeking facilitators	to explore the perceived value of rural peer support workers as facilitators to rural mental health help-seeking	a help provider with lived experience of mental illness or distress would make mental health help-seeking easier. Similarly, rural life experience in a help provider was thought to facilitate help-seeking. Participants also believed that flexible and informal meeting settings would make it easier to seek help for mental distress. Engaging rural mental health peer support workers in a flexible/informal setting, as a complement to conventional health service provision, may increase rural help-seeking for mental distress.	**Strengths:** Large sample. Strong evidence of pw potential for rural mental health.
Chisolm & Petrakis (2020) Peer Worker Perspectives on Their Potential Role in the Success of Implementing Recovery-Oriented Practice in a Clinical Mental Health Setting. Australia	Qualitative. Focus Group of 8 peer workers. ROP focus.	To examine the views of peer workers, in one Australian clinical mental health service, about ROP pre-implementation, and to evaluate these against the current ROP literature.	Peer workers considered their roles as educating clinicians, representing service users, aiding in cultural/systemic shifts in services, and as leaders. Peer workers add lived experience and can contribute to clinician uptake and fidelity of practice in ROP. The study contributes to the growing evidence that the inclusion of peer workers in mental health services is advantageous in the implementation of ROP to ensure a lived experience grounded perspective underpins practice and policy change.	**Limitations:** Small sample. Like their 2023 study (of a participant pool of 30) Limited new information.
Coates et al. (2018) The development and implementation of a peer support model for a specialist mental health service for older people: lessons learned.	Sub-study – survey – focus groups of key stakeholders (older Australian care recipients and peer workers).	To identify stakeholder preferences in the design of the model; implementation challenges and barriers as they occurred; ways in which to overcome or manage these barriers; and the effectiveness or	Findings contribute to the limited evidence base specific to the development and implementation of peer work models for older people. The most powerful change agent for clinicians in terms of embracing peer work was their experience of working with peer workers and directly observing their unique skillset and insight when working with consumers and carers.	**Strengths:** New evidence of the value of peer work in older people. Identification of unique barriers and enablers.

Australia		acceptability of the model from the perspective of stakeholders.		**Limitations:** Sub-study. Small sample. Does not explore or discuss the role of volunteer peer supports.
Dickerson et al. (2016) The use of peer mentors to enhance a smoking cessation intervention for persons with serious mental illnesses. USA	Mixed methods of 30 program participants (with substance abuse and mental health concerns) and 8 peer mentors. Multi-measures – CO breathalyzer, Smoking Decisional Balance Scale	To evaluate a peer mentor program that enhanced a professionally led smoking cessation group for persons with serious mental illnesses.	Program participants had a decline in carbon monoxide levels and number of cigarettes smoked per day. High feasibility and acceptability of the intervention.	**Strengths:** Novel study.
Evans et al. (2020) Standardization and adaptability for dissemination of telephone peer support for high-risk groups: general evaluation and lessons learned. USA	Qualitative mixed methods evaluation. The review of telephone peer support services contact data for years 2015–2016 and structured interviews with peer supporters and clients; and audit of case notes.	To evaluate telephone peer support provided by trained peer staff for high-risk groups, implemented according to key tasks or functions of the Reciprocal Peer Support model (RPS)	With the balance of standardization and adaptability provided by the RPS, telephone peer support can address diverse needs and provide diverse contact patterns, assistance, support, and benefits	**Strengths:** Evaluative data pointing to the benefits of peer phone support. **Limitations:** Evaluation, low rigor research.
Flegg et al. (2015) Peer-to-peer mental health: a community evaluation case study.	Qualitative. Survey and focus group evaluation of services of 131 peers.	To report the findings of a third-sector community review into peer-to-peer best practices in mental health service provision in Sussex.	Suggests peer-to-peer support services as an innovative approach to reducing suicide, self-harm, reliance on public health services (GPs, hospital stays, etc.) and engaging with drugs, alcohol and criminal activity. Conducted by and for people with personal or family experiences with mental health	**Strengths:** Community led project. Good sample size. **Limitations:**

UK			challenges, this review captures the often, inaccessible ideas of a highly marginalised group. It communicates how they would prefer to work in partnership with academic institutions, public and statutory service to improve individual and community health outcomes.	Community specific but may translate to similar projects.
Fortuna et al. (2022) Assessing a digital peer support self-management intervention for adults with serious mental illness: feasibility, acceptability, and preliminary effectiveness. USA	21 adults with serious mental illness received PeerTECH intervention in the community. Nine peer support specialists were trained to deliver PeerTECH. Data were collected at baseline and 12-weeks. Self-reported/index tools.	To assess the feasibility, acceptability, and preliminary effectiveness of digital peer support integrated medical and psychiatric self-management intervention ("PeerTECH") for adults with a serious mental illness.	Demonstrated that a 12-week, digital peer support integrated medical and psychiatric self-management intervention for adults with serious mental illness was feasible and acceptable among peer support specialists. It was associated with statistically significant improvements in self-efficacy to manage chronic disease and personal empowerment. In addition, pre/post non-statistically significant improvements were observed in psychiatric self-management, medical self-management skills, and feelings of loneliness.	**Strengths:** Potential translation to multiple population groups.
Fortuna et al. (2019) Smartphone Ownership, Use, and Willingness to Use Smartphones to Provide Peer-Delivered Services: Results from a National Online Survey. USA	267 national, statistical survey participants	To assess certified peer specialists' smartphone ownership, use, and willingness to use smartphones to provide peer-delivered services	Peer support could act as a mechanism to promote consumer engagement in a smartphone-based intervention. Certified peer specialist (own and utilize) smartphones, and the majority are willing to deliver technology-based and technology-enhanced interventions using these devices to address medical and psychiatric self-management.	**Strengths**: Good sample size. National study.

Fortuna et al. (2018) Certified Peer Specialists and Older Adults with Serious Mental Illness' Perspectives of the Impact of a Peer-Delivered and Technology-Supported Self-Management Intervention. USA	Qualitative interviews with 8 older adults with serious mental illness and 3 peer specialists.	To obtain the perspectives of certified peer specialists and older adults with serious mental illness on the impact of a peer-delivered medical and psychiatric self-management intervention.	Found that support from peers can potentially influence health behavioural change in a combined peer and technology-based medical and psychiatric illness self-management intervention.	**Strengths:** Novel. **Limitations:** Small scale, more procedural description needed – perhaps also threading back to the PeerTech training.
Gidugu et al. (2015) Individual peer support: a qualitative study of mechanisms of its effectiveness. USA	Qualitative sub-study, convenience sample. Interviews, thematic – from 26 to 15 participants.	The intent of clarifying ambiguities in the role of the peer support specialist, to further elucidate the nature and processes of individual peer support, and to clarify what makes peer support effective from the point of view of the recipient.	Analyses suggest that individual peer support provided various practical, emotional, and social supports which were perceived as beneficial.	Limitations: Small convenience sample.
Gillard et al. (2016) Evaluating the Prosper peer-led peer support network: a participatory, coproduced evaluation.	Mixed method service evaluation. Online survey of 32 people peer participants and one-to-one interviews with 8 and group discussions with 5.	To report on a service evaluation of a social movement, network-type approach to peer support directly commissioned by a UK National Health Service (NHS) mental health trust	Description of an evolving network with strong shared values, and consensus that Prosper could strengthen social networks, improve individual well-being and impact on the way people used mental health services. Challenges were identified around feelings of uncertainty and vulnerability in relation to involvement in the network	**Strengths:** Multiple methods, participatory approach.

UK		(governmental provider organisation)		
Gillard et al. (2015) Developing a change model for peer worker interventions in mental health services: a qualitative research study. UK	Comparative case study of 10 peer worker initiatives across statutory and voluntary sectors. With interviews of 71 peer work stakeholders.	Aims to model the change mechanisms underlying peer worker interventions.	Suggests building trusting relationships based on shared lived experience was the primary mechanism underpinning peer worker interventions. Modelling helps address limitations by indicating a measurable set of outcomes that can be expected to change in response to processes of peer support. Findings help suggest down-stream impacts. An empirically and theoretically grounded change model that can usefully informs the development, evaluation and planning of peer worker interventions.	**Strengths:** Offers a model – for outcomes across different settings. Good no of participants investigated.
Haertl (2007) Outlining the major principles of the model, recent research, fidelity standards, and outcomes supporting the model. USA	Description of studies centred on the Fairweather model.	Outlines the major principles of the model, recent research, fidelity standards, and outcomes supporting the model	Data from the case site and percepts outlined in the fidelity standards emphasize the importance of long-term comprehensive consumer driven care.	
Hoy, (2014)	Sub-study qualitative analysis of 24 consumers of	To describe how individuals who are part	Participants held explanatory models inclusive of both developmental stressors	**Strengths:**

Consumer-operated service program members' explanatory models of mental illness and recovery. USA	a larger project at one peer center, referred to as a consumer-operated service center (COSP).	of one COSP understand and explain their respective mental illness and recovery experiences, and to identify any overarching explanatory models of mental illness and recovery that might emerge.	and biomedical causes, consistent with a stress–diathesis model. Particular activities participants linked with developing a positive self-concept included giving and receiving peer support, participation in psychosocial groups such as wellness management and recovery, and other COSP recreational and social activities.	Evidence of peer-immersed explanatory model value. **Limitation:** Limitations not reported. Sub study. Small sample.
Hurley et al. (2018) Qualitative study of peer workers within the 'Partners in Recovery' programme in regional Australia. Australia	Qualitative interviews as part of a larger mixed methods evaluation.	To improve the understanding of the PW roles within one regional setting in Australian, the study sought to respond to the following research questions: 1. What are the experiences of Peer Workers of their roles within PIR? 2. What were other PIR staffs' experience of the Peer Worker role?	Identified themes were: (i) role variance, (ii) the challenges and opportunities for Peer Worker, (iii) the processes Peer Workers employed as they attempted to shape an identify and language, (iv) the inconsistencies and challenges of employing lived experience as a defining feature of the peer worker role, and (v) the nature of trust arising from lived experience relationships. From this study, it is evident that the Peer Worker role remains underdeveloped.	**Strengths:** challenges and opportunities are described. **Limitations:** Small sample.
Kerner et al. (2021) Trends in the utilization of a peer-supported youth hotline. USA	Study of 65,782 adolescent telephone contacts between 2010-2016. Analysis of trends in user demographics, contact method, and the reason for contact were analyzed.	To examine the utilization of a metropolitan peer-supported youth hotline between 2010 and 2016.	Data indicate that adolescents increasingly utilize a peer-supported youth hotline to get help for mental health concerns (including suicide). Therefore, it should be explored whether this hotline model could also be used for prevention and early intervention. Time trend analyses demonstrated a slow but steady increase in adolescents who	Strengths: Extensive time span and trends reported. Limitations:

			contacted the hot-line, from 7222 individuals in 2010 to 12,326 individuals in 2016.	No mention of young person's without access to phone.
Klodnick et al. (2015) Perspectives of Young Emerging Adults with Serious Mental Health Conditions on Vocational Peer Mentors. USA	Survey of 21 young adults with serious mental health conditions. Reports on one facet (peer mentorship) of a 3-year feasibility study of adaptations to IPS.	To explore the feasibility of vocational peer mentors.	Mentees with positive peer mentoring experiences reported stronger working alliances. Sixteen of 21 (76%) participants reported valuing or benefiting from peer mentoring. This study sheds light onto near-age mentoring relational processes for this population, which can inform future research of mentoring processes and intervention design.	Strengths: Youth with severe/complex backgrounds) describing a model type 'mentoring'.
Kowalski (2020) Mental Health Recovery: The Effectiveness of Peer Services in the Community. USA	Repeat surveys of 42 adults service users and semi-structured interviews with peer mentors.	Assesses the impact of peer services on peer mentees' and mentors' recovery capital, quality of life, and general wellness.	Preliminary evidence that subjects' recovery improved over time. The findings also reflect some of the difficulties peer mentors face but also the benefits they derive from their work. The findings provide insight for policymakers, who may make funding decisions for recovery centers.	**Limitations:** Drop out rate across subsequent surveys.
Lewis et al. (2012) Partners in recovery: social support and accountability in a consumer-run mental health center.	10 months of participant observation, coupled with semi structured interviews of 25 and a focus group of 22, and dramatic skits of 17 to identify and define the distinctive features of the	To learn about consumer-run services—for example, how they might strengthen personal capacity for social integration—and to explore how the	Participants in this consumer-run mental health program experienced themselves as accountable for and to their peers in what amounts to a shared project of recovery.	**Strengths:** Use of Zens capability theory (translates to workforce).

USA	program, both structurally and from the point of view of participants. Inquiry framed theoretically by the capabilities approach.	development of these capacities might promote recovery.		**Limitations:** Scant detail in analysis, difficult to see how data was brought together. Convenience sample/bias? Limited thread back to the capabilities approach.
Mak et al. (2021) Nine-Month Longitudinal Impact of Peer Support Workers' Recovery Attributes on Service Users' Recovery in Hong Kong. Hong Kong	Part of a larger, longitudinal study. Periodic scales/inventories of 181 participants.	Investigate the longitudinal effect of the recovery attributes of peer support workers (PSWs) on users of mental health services in Hong Kong over a 9-month period	Results showed that levels of hope and self-esteem among PSWs were statistically significantly associated with improvements in hope and empowerment among service users over time. PSWs' recovery attributes may benefit service users' personal recovery.	**Strengths:** Good sample size investigation of attributes of peer workers and their impact on recovery.
Nelson et al. (2007) A Longitudinal study of mental health consumer/survivor initiatives (CSI's): Part 4—Benefits beyond the self? A quantitative and qualitative study of system-level activities and impacts.	Qualitative mixed method, longitudinal	To show participants in consumer run organizations will show improved outcomes at a 3-year follow-up relative to those in a comparison group who are not active in such organizations, but who are equivalent in terms of other personal characteristics.	Findings of positive outcomes for members of CSIs at 3-year follow-up suggest the promise of these types of settings in promoting recovery, there is a need for further controlled, longitudinal research to determine the replicability of the findings.	**Limitations:** As noted by the study - the use of the non-equivalent comparison group design does not rule out the possibility that a selection factor accounted for the improved outcomes. Also – the possibility that those who are motivated to join and

Canada				participate in a CSI are more likely to improve than those who are not. Peer work assumed but not explicitly described. In this paper.
Pfeiffer et al. (2019) Development and Pilot Study of a Suicide Prevention Intervention Delivered by Peer Support Specialists. USA	RCT pilot study of 'Prevail' a model developed by the team. Total 70 – intervention – 34.	Conducted to assess the acceptability, feasibility, and fidelity of the intervention.	Fidelity was rated for 20 peer support sessions, and 85% of the peer specialist sessions demonstrated adequate fidelity to administering a conversation tool regarding hope, belongingness, or safety, and 72.5% of general support skills (e.g., validation) were performed with adequate fidelity. 23 participant qualitative responses were highly positive regarding peer specialists' ability to relate, listen, and advise and to provide support specifically during discussion.	**Strengths:** Rigorous, well described **Limitations:** Small-ish sample but reasonable given the detail.
Price et al. (2009) Dedicated personality disorder services: A qualitative analysis of service structure and treatment process. UK	UK. Qualitative interviews with service users, carers, providers and commissioners of services at each of the 11 sites.	To identify factors that contribute to high quality care for people with personality disorder from the perspective of different stakeholders. personality disturbance and low levels of motivation to change.	The need to combine psychological treatments with social interventions and opportunities for peer support, and the importance of clear boundaries which are shared by service users. Services need to actively	**Strengths:** Multiple sites. **Limitations:** To mental health type.

Radigan et al. (2014) Youth and caregiver access to peer advocates and satisfaction with mental health services. USA	768 youth and caregivers of youth care satisfaction survey (YACS).	The survey includes items on access to youth or family advocates and degree of satisfaction with mental health services.	A greater proportion of youth or caregivers with access to peer advocates compared to those without access responded positively on the satisfaction domains of access to services, appropriateness of services, participation in services and overall/global satisfaction. Access to peer advocates was also positively associated with agreement on the psychotropic medication comprehension domain for youth and on perceptions of child functioning and social connectedness for caregivers compared to those without access.	**Strengths:** Good size sample. **Limitations:** Evaluation survey without the rigor, controls
Radovic, (2022) A Social Media Website (Supporting Our Valued Adolescents) to Support Treatment Uptake for Adolescents with Depression or Anxiety: Pilot Randomized Controlled Trial. USA	A 2-group, single-blind, pilot RCT in a single adolescent medicine clinic. 38 completed the baseline survey, and 25 completed the 6-week measures.	To examine the feasibility of and refine recruitment and retention strategies and to document outcomes and implementation fidelity. Pilot trial of a peer support website intervention for adolescents with depression or anxiety.	The pilot trial of a peer support website intervention for adolescents with depression or anxiety found lower-than-expected study enrollment after recruitment. The main findings of this pilot trial highlight the difficulties in conducting research with adolescents for technology-based mental health studies in the primary care setting. referrals to this pilot study were adequate, retention and engagement were lacking.	**Limitations**: As identified by the study itself e.g., challenges in engagement of participants etc.
Robinson et al. (2015) Peer support as a resilience building practice with men.	MINDS project. A mixed methodology design involving before and after survey data and qualitative interviews (n19) to report results concerning effectiveness in changing	To present findings from an evaluation of a community mental health resilience intervention for unemployed men aged 45-60.	Significantly raised the perceived resilience of participants. Project activities promoted trusting informal social connections, gains in social capital arose through trusting relations and skill-sharing, and peer-peer action-focused talk and planning enhanced men's resilience.	**Limitations:** Brief discussion with limitations not clearly described.

UK	men's perceived resilience, to consider project processes concerning peer support, and to situate these within wider community environments.			
Rogers et al. (2016) A Randomized Trial of Individual Peer Support for Adults with Psychiatric Disabilities Undergoing Civil Commitment. USA	Statistical RCT n113 over a period of 3½ years (2007–2010) – from 2 psych patient units.	To test hypothesis - individuals receiving intensive, 1:1 peer support from a trained peer support specialist (PSS) would experience increases in perceived social support, improved functioning, improved quality of life, increased perceptions of recovery, and decreased self-reported symptoms when compared to individuals not receiving such support.	Intent-to-treat analyses revealed no significant differences in outcomes by study condition. As-treated analyses comparing high- and low-use peer support groups with control group participants found significant differences favoring peer support recipients in quality of life and functioning but no differences in other study outcome. Provides only modest evidence of the effectiveness of individual peer support.	**Limitations:** Fidelity concerns - but not acknowledged is the fidelity of the control intervention. Is the study testing against 'real-life' or the control intervention? Nuanced group – court ordered.
Simmons et al. (2022) Implementing a combined individual placement and support and vocational peer work program in integrated youth mental health settings.	(Uncontrolled pilot study of 326 of combined IPS (individual placement support) and VPW (vocational peer worker) VPW) intervention that took place between 14th October 2016 and 13th May2020	To describe the implementation and outcomes of a combined individual placement and support (IPS) and vocational peer work program for young people with mental ill-health	The program achieved positive vocational outcomes and good fidelity to the IPS model. Approximately half of young people had employment placements, with a relatively high proportion maintained over time. he addition of VPWs to implementing the IPS model is worth exploring further, since VPWs are uniquely positioned to support young people experiencing mental ill-health	**Strengths:** Good sample size. Nuanced insight into emerging role ('vocational peer worker') specializing in the inter-section between peer support and career support.

Australia			and assist them to develop employability skills, informed by similar lived experiences.	**Limitations:** Missing an RCT which would make this much more compelling. Is difficult to claim outcomes to the intervention. Discrepancy btw study & publication date.
Stefancic et al. (2019) Participant Experiences with a Peer-Led Healthy Lifestyle Intervention for People with Serious Mental Illness. USA	Qualitative Study Focus groups and interviews with 63 people with SMI living in supportive housing and participated in a peer-led healthy lifestyle intervention. Adults (83% racial/ethnic minorities, mostly non-Hispanic Black and Hispanic)	To understand whether and how Peer-Led Group Lifestyle Balance (PGLB) participants engaged in the process of healthy lifestyle change, the challenges they encountered, and how they utilized PGLB strategies.	Qualitative component of a larger trial that found the proportion of study participants achieved clinically significant weight loss at 12-months (29%) comparable to 12-month outcomes of other trials reporting non-peer-led healthy lifestyle interventions. Though there were several challenges, and change was often small, participant general reported that the peer-led program shifted their mindset about healthy living. Support to sustain self-monitoring, meal planning, tailored physical activity, and advocacy was noted as needed.	**Limitations:** More feedback from low-attenders and the usual care group was needed for comparison. Behavior changes were self-reported, and subject to recall bias and social desirability.
Styron et al. (2018) Home Groups: Integrating Peer Support and Clinical Care in a Community Mental Health Center.	Vignettes-based study description of a hybrid peer and-clinician co-led support group model called “Home Groups”	To introduce and describe ‘Home Groups’	That intervention provides unique learning opportunities for peers and trainees and many potential benefits to group members	**Limitations:** Low research rigor.

USA				
Swarbrick et al. (2016) Promoting health and wellness through peer-delivered services: Three innovative state examples. USA	Data compiled from the authors' experiences as champions (university and community leader stakeholders) in three USA states and the National Association of State Mental Health Program Directors, as well as documents from and discussions with local state and national sources.	To provide examples of the development, implementation, and funding of peer- delivered health and wellness services in three states.	Key issues for the implementation and expansion of peer delivered services are identified as defining the model to be disseminated, providing training to prepare the peer workforce, accessing funding for implementation, and establishing clear expectations (to sustain services and quality). Suggests savings might be generated by the implementation and use of peer- delivered health and wellness services.	**Strengths:** Collaborative, multi-state, translatable descriptions of service impact. **Limitations:** Self-described 'champions of peer work' points to possible bias.
Thomas & Salzer, (2017) Associations between the peer support relationship, service satisfaction and recovery-oriented outcomes: a correlational study. USA	Statistical measures study 46 (sub study of RCT) adults with serious mental illnesses	Evaluates correlates of the peer-to-peer relationship and its unique association with service satisfaction and recovery-oriented outcomes.	Evidence for the unique association between the peer relationship and the outcomes of those who participated in a peer-delivered intervention. Similarly to non-peer-delivered interventions this has important implications for program administrators and policymakers seeking to integrate peer specialists into mental health service systems.	**Limitations:** Small sample, mostly well educated/female. The cross-sectional design and use of correlational analysis preclude the drawing of causal inference(s.
Watkins et al. (2020) Keeping the body in mind: A qualitative analysis of the	Qualitative Study	To explore the personal experiences of KBIM participants, in particular the aspects of the	A NSW multi-disciplinary model (nurses, dietitians, exercise physiologists and peers) focusing on the physical health of younger people commencing anti-psychotic	**Limitations:** Positive bias potential with a member of KBIM team present during the

experiences of people experiencing first-episode psychosis participating in a lifestyle intervention programme. Australia	Interviews with 11 young people aged 18-25.	programme that they perceived to be helpful in achieving physical health and other improvements.	medications (Keeping the Body in Mind (KBIM) involves a 12-week lifestyle programme involving health coaching, dietetic advice, and exercise support, with peers working alongside clinical staff. The value of peer interaction was reported as giving people a sense of belonging, created empathy and respect between participants, increased confidence, empowerment, social inclusion, coping skills, teamwork and shared learning, reduced social isolation and stigma.	interviews. Small sample. Experiences of families and carers of participants and KBIM non-peer staff members was not captured.
Yamaguchi et al. (2017) Efficacy of a Peer-Led, Recovery-Oriented Shared Decision-Making System: A Pilot Randomized Controlled Trial. Japan	RCT of 26 intervention patients and 27 control patients of adults across 2 settings in Japan.	To examine the impact of a comprehensive shared decision-making system.	The core components and processes of shared decision making were observed in the intervention group more frequently than in the control group. The intervention group also reported a significantly more positive participants' view of the relationship with their doctor than the control group. The intervention did not have a significant effect on most clinical and recovery-related outcomes.	**Limitations:** Localised to Japan, small scale, declared non-blind to assessors.

Appendix 7: Family/Carer Peer Work Models – Detailed Descriptive Table

Tables 1: Family, Carers, Volunteers

Author(s), Year, Country	Design, Setting and Sample	Aims	Key Findings/Conclusion	Strengths & Limitations
Chapin et al. (2012) Reclaiming Joy: Pilot Evaluation of a Mental Health Peer Support Program for Older Adults Who Receive Medicaid. USA	Quantitative using measuring tools e.g., Geriatric Depression Scale (GDS-15) to test invention of pairing an older adult "participant" experiencing mental health symptoms with an older adult peer "volunteer". With 32 participants of 3 ageing service agencies.	Evaluation of the peer support intervention for older adults.	The pilot study demonstrated promising clinical outcomes and improvements in older adults' quality of life. Participants showed statistically significant improvement in symptoms of depression after completing the intervention.	**Limitations:** No control group. Volunteer resource not discussed.
Rebeiro Gruhl et al. (2015) Authentic peer support work: challenges and opportunities for an evolving occupation. Canada	52 peer workers answering a survey & 33 in a focus group.	To examine the role of the PSW, along with the challenges and benefits, and to understand why the PSW is not more integrated within mainstream services.	Peer support work was described by participants as being *authentic* when PSWs can draw upon lived experience, engage in mutually beneficial discussions, and be a role model. Authentic peer support was noted to be important to the recovery of mental health service users; yet, participants revealed that many positions continue to reflect more generic duties. Challenges to further integration include acceptance, training and credentialing, self-care, and voluntarism.	**Limitations:** Small cities/Canadian towns Strengths: Tackles the issues of voluntarism. Voluntarism was raised as a way to provide PSW in communities that did not have paid positions, as well as a meaningful occupation for many of the participants. Voluntarism was also perceived to reflect a

				lack of acceptance and valuing of PSWs and serve as a barrier to mainstream integration. Good participant response rate as of total of 65 identified in area.
Markoulakis et al. (2018) Exploring Peer Support Needs of Caregivers for Youth with Mental Illness or Addictions Concerns in Family Navigation Services. Canada	Descriptive, qualitative of 10 family carers supporting family members in a Family Navigation Service for youth attempting to access mental health services.	To understand the potential role and value of a caregiver peer support worker in a Family Navigation service (a caregiver peer support role - identifying families' perceptions of and need for a PAL within the "Parent Advocate with Lived Experience (PAL)" as adjunct support for caregivers in addition to the support they receive from their Navigators.	Study findings indicate that a caregiver peer support worker can provide support for engaging in the caregiving role, utilize lived experience as a skill, and complement navigation support through lived experience. PAL role was effective as a complement to navigator role, not a replacement for it.	**Limitations:** Small convenience sample. PALs participants were also clients of the FNP. Focused on clients' expectations of the PAL prior to implementation of this role, findings reveal what clients anticipate will be helpful but it is not yet known whether the role will unfold this way in practice.
Nayak et al. (2022) Engaging and Supporting Young Children and their Families in Early Childhood Mental Health Services: The Role of the Family Partner.	Qualitative interviews & focus groups of 38 participants consisting of staff, leadership, and caregiver participants.	Reports on a qualitative study that examined the organisational enablers and barriers to implementing peer support work in an Australian, rural, community-based mental health service.	Family partners with lived experience play a key role in engaging families in mental health services by using their lived experience to build rapport and help families navigate services and build skills. Early engagement and effective services that family partners deliver are a promising strategy deserving of more policy attention, including developing payment mechanisms for teaming of integrated family partners	**Strengths:** Recent. Novel. Under researched. Nuanced group – young children

USA			and ECMH clinicians in primary and community-based settings.	
Visa and Harvey (2019) Mental health carers' experiences of an Australian Carer Peer Support program: Tailoring supports to carers' needs. Australia	Semi-structured phone interviews were conducted with 20 carer participants in 2015, 5–10 months following their last contact with the service.	To explore carers' experiences within a community based CPSW pilot program in an Australian mental health service.	Provides additional evidence that carer peer support can offer beneficial emotional and practical assistance to carers. Demonstrates the importance of tailoring the service to the carer and service user's needs. May encourage organisations to consider employing carer peer support workers and provides a framework for how best to utilise their services.	**Limitations:** Small sample and program specific.
Wisdom et al. (2014) What family support specialists do: examining service delivery. USA	Mixed methods interviews, quantitative survey data and observation.	To understand what FSS do with families and to contrast with what staff think they do.	Is an important step toward understanding both how teams that provide services to children conceptualize FSS' roles and going beyond current literature to describe what FSS actually do in a walkthrough exercise with families.	**Strengths**: Rigorous investigation into an emerging arm of peer work.
Wisdom et al. (2011) Family Peer Advocates: A Pilot Study of the Content and Process of Service Provision. USA	Simulation pilot of Four family peer advocates providing 25 services during each 2-session simulation.	To understand the process, content, and context of family peer advocate services.	Revealed variability in the range of services provided and identified challenges in aspects of service provision, such as boundaries of advocate roles, availability of confidential service environments, and addressing crises and parent concerns about child safety.	**Limitations:** Simulation. Low research rigor. Small sample.

Appendix 8: Peer Workforce Issues - Detailed Descriptive Table

Table 1 Peer Workforce

Author(s), Year, Country	Design, Setting and Sample	Aims	Key Findings/Conclusion	Strengths & Limitations
Adams, (2020) Unintended consequences of institutionalizing peer support work in mental healthcare. USA	49 semi-structured interviews with 35 adult, forensic PSWs and 14 stakeholders and an online survey.	To explore the inherent tension between Institutionalization of peer support, and the resulting consequences for workers, organizations, clients, and the recovery movement.	Found progress into scope and nature of peer work, the peer workforce, peer client relationships, and workplace stigma but peer workers frequently remain underpaid and unable to advance professionally. The institutionalization of peer support serves as a barrier to worker entry and retention and highlights tensions between the consumer-driven origin of the recovery field and the current mental healthcare system.	**Limitations:** Limitations not stated.
Asad & Chreim (2016) Peer Support Providers' Role Experiences on Interprofessional Mental Health Care Teams: A Qualitative Study. USA	US. Interview with peer support workers across two service models: 8 from Assertive Community Treatment Team (ACTT) and 4 interviewed from non-standardized team (non-ST) models (e.g. in-patient programs at hospitals)	To explore the following questions: How are peer support providers' roles defined and integrated in inter-professional mental health care teams? How do these providers relate to other practitioners and clients?	Peer support workers experience ambiguity which may offer benefits. Peer support workers enhance team acceptance of their role through several means and strategies (e.g. challenging others' perceptions of their role and value). Setting boundaries with clients – an ongoing challenge in the role.	**Limitations:** Small sample precluded ability to make meaningful comparisons between the 2 model types.
Blixen et al. (2015) Training peer educators to promote self-management skills in people with serious	Qualitative RCT of 8 adults.	To describe the training and participant experience of patients with both severe mental illness (SMI) and diabetes (DM) who were enrolled in a Peer	Structured training for PEs with SMI and DM may be a way to leverage the strengths and talents of SMI patients to self-manage complex comorbidity. Use of trained PEs in primary care might be a way to change the otherwise poor	**Limitations:** Setting dependent. Small sample.

mental illness (SMI) and diabetes (DM) in a primary health care setting USA		Educator Training Program.	health prognoses for persons with SMI and DM.	
Burke et al. (2018) Providing mental health peer support 1: A Delphi study to develop consensus on the essential components, costs, benefits, barriers and facilitators. UK	Delphi - 147 UK peer supporters rated statements online or via post.	To develop consensus on the essential components, personal costs, personal benefits, barriers and facilitators involved in providing mental health peer support.	Consensus was reached on statements pertaining to essential components (*n* = 67), personal benefits (*n* = 21), barriers (*n* = 1) and facilitators (*n* = 35). Formal peer support involves many skills and competencies. Most participants agreed that a wide range of personal benefits come with the role. Organisations may facilitate peer support through their values, actions and oversight. Approximately half of the sample worked in public services and were more likely to have concerns regarding pay and career progression.	**Strengths:** Good size, rigor. **Limitations:** Brief in description in parts.
Burr et al. (2020) Peer support in Switzerland - Results from the first national survey. Switzerland	Self-developed, mixed method questionnaire/survey of 55 peer workers.	To describe peer support specialists' (PSSs') work conditions and job satisfaction & challenges of integration into the workforce in Switzerland. To identify possible development topics (interventions, training).	Show very high job satisfaction amongst PSSs. Positive results of employer treatment of the PSS respectfully and is concerned about PSS's. Job descriptions with high proportion corresponding to the actual work which leads to increased role clarity & satisfaction. Note: salaries appear higher in Switzerland than in the US.	**Strengths:** Detailed questionnaire, covering multiple relevant fields & variables.
Byrne et al. (2016)	Qualitative interviews with 13 adult peer workers.	To enhance understanding of perspectives of individuals working in lived experience roles to more closely understand their	Medical model as major model. development of Recovery oriented services requires a strong lived experience practitioner workforce, with appropriate resourcing and support	**Strengths:** In-depth exploration of barriers and enablers

Lived experience practitioners and the medical model: world's colliding? Australia		experiences and opinions about these roles.	available. The current medical model approach requires critique to facilitate reform and avoid tokenism.	**Limitations:** Small sample.
Byrne et al. (2016) The stigma of identifying as having a lived experience runs before me: challenges for lived experience roles. Australia	Qualitative, in-depth interviews were conducted with 13 adult lived experience practitioners.	To understand the impact of stigma and discrimination on the effectiveness of lived experience roles from the perspective of lived experience practitioners.	Lived experience practitioners can potentially play a vital role in lessening stigma and discrimination but they must be supported to do so and not face the additional burden of discrimination within the workplace.	**Strengths:** Strong focus on major thematic peer work issue – stigma and evidence of pw helping to reduce stigma.
Byrne et al. (2019) 'You don't know what you don't know': The essential role of management exposure, understanding and commitment in peer workforce development. Australia	Qualitative interviews of 29 senior managers of services.	Explores the role of executive and senior management understanding in the employment of peer roles.	Importance of Management exposure to peer work and peer principles was identified as critical in developing understanding and commitment to peer roles.	**Strengths:** Nuanced evidence into the role of managers in enabling peer work. **Limitations:** Limitations not described.
Byrne et al. (2022) Effective Peer Employment Within Multidisciplinary	Qualitative focus groups & interviews of 132 participants.	A clearer understanding of organizational mechanisms reinforcing effective peer employment and	Suggest whole-of-organization commitment, culture and practice are essential for the organizational transformation needed to support	**Strengths:** Builds on solutions.

Organizations: Model for Best Practice. USA		organizational change from the perspectives of peer workers, non-peer staff and management in multidisciplinary mental health and substance use recovery services.	effective employment of peers in multidisciplinary environments.	**Limitations:** Reiterative of already well documented stigma barrier.
Chisolm & Petrakis (2023) Peer Worker Perspectives on Barriers and Facilitators: Implementation of Recovery-Oriented Practice in a Public Mental Health Service. Australia	Focus group of 6 consumer peer workers and 2 carer peer workers. Adults.	Explore the attitudes of peer workers about ROP (recovery-oriented practice).	Identified several barriers to implementing recovery-oriented practice.	**Limitations:** Small sample size without explanation. Data collected in 2016.
Chisolm & Petrakis (2020) Peer Worker Perspectives on Their Potential Role in the Success of Implementing Recovery-Oriented Practice in a Clinical Mental Health Setting. Australia	Qualitative. Focus Group of 8 peer workers. ROP focus.	To examine the views of peer workers, in one Australian clinical mental health service, about ROP pre-implementation, and to evaluate these against the current ROP literature.	Peer workers considered their roles as educating clinicians, representing service users, aiding in cultural/systemic shifts in services, and as leaders. Peer workers add lived experience and can contribute to clinician uptake and fidelity of practice in ROP. The study contributes to the growing evidence that the inclusion of peer workers in mental health services is advantageous in the implementation of ROP to ensure a lived experience grounded perspective underpins practice and policy change.	**Limitations:** Small sample. Similar to their 2023 study (of a participant pool of 30).

Coniglio et al. (2012) Peer support within Clubhouse: a grounded theory study. Australia	Semi-structured interviews conducted with 10 Clubhouse members.	To develop a theoretical understanding of peer support within the Clubhouse context, using a grounded theory approach.	A conceptual model of peer support was derived from Clubhouse members' experience. Four levels of peer support emerged: Social inclusion and belonging; shared achievement through doing; interdependency; and intimacy.	**Strengths:** In-depth interviews. **Limitations:** Small scale. Limited to one Clubhouse.
Crane et al. (2016) Unique and common elements of the role of peer support in the context of traditional mental health services. USA	Discovering a Curriculum Methodology (DACUM) model (focus groups) to compare tasks/duties of 11 peer workers and 12 case managers.	To clarify the unique role of peer support providers (PSPs) and define peer support as a distinct occupation in the context of traditional mental health services.	A variety of duties/tasks specific to PW. Reveals overlap btw CM's & PW's. Addresses challenges to the emerging role of PW.	**Strengths:** Good contextual understanding of the unique role. Aligns with barriers and opportunities. **Limitations:** Small sample – setting specific and model (DACUM) specific to the host university.
Curtin & Hitch (2016) Experiences and perceptions of facilitators of *The WORKS*. Australia	Theory, Evidence and Action (ITEA) method used in this study, Facilitators of The WORKS at a metropolitan Australian mental health service were purposively sampled.	To explore the lived experiences and perceptions of facilitators of *The WORKS*.	Five themes emerged Consumer Growth, Facilitator's Occupational Identity, Role of Facilitators, Workload of Facilitators (performance capacity), and Adaptation of The WORKS Resources [performance capacity]. All participants perceived benefits related to The WORKS however raised co-facilitation power imbalance between facilitators. More development is needed around the co-facilitation relationship between Occupational Therapists and Peer-Support Workers.	**Limitations:** Project specific.

Ehrlich et al. (2019) What happens when peer support workers are introduced as members of community-based clinical mental health service delivery teams: a qualitative study. Australia	Cross-sectional qualitative study design of 24 participants was used and included semi-structured interview techniques.	answer the following research questions: (1) "How is peer support work constructed in an interprofessional clinical care team?" and (2) "How do interprofessional mental health clinical care teams respond to the inclusion of PSWs as team members?"	Offers practical considerations to the employment of PSW's within tertiary mental health-care contexts. Themes identified: peer support worker' ability to navigate a legitimate place within care teams, their value to the team once they established legitimacy and their ability to traverse the care landscape. Ultimately, successful integration in interprofessional teams was dependent upon the ability of clinical staff to focus on unique strengths that peer support workers bring, in addition to lived experience with mental illness as a carer or consumer.	**Limitations:** Similar findings to earlier (mostly international) studies – no specifically new workforce knowledge provided.
Fletcher et al. (2020) A Case Study of a Peer Respite's Integration into a Public Mental Health System. USA	Secondary analysis of a data set (25 interviews & focus group) of (Second Story) collected between the opening of the Second Story peer respite in May 2011 through to June 2015.	We aim to analyze peer staff's beliefs about the transformative capacity of a peer respite within a public mental health system.	Emerging themes (1) systemic constraints that limited the program's autonomy to uphold peer values, (2) challenges associated with peer leadership, which contributed to organizational restructuring, and (3) peer staff perception of ideological differences in recovery-oriented practices between the County and the individual peer worker.	**Limitations:** Secondary analysis. Low rigor.
Forbes et al. (2022) Experiences of peer support specialists supervised by nonpeer supervisors.	94 participant, survey and qualitative semi-structured interviews	To understand the experiences of peer support specialists (PSS) supervised by nonpeer supervisors (NPS) in adult community mental health settings.	Thematic analysis revealed eight major themes including supervisor attitudes, role integration, trauma-informed supervisory techniques, facilitative/supportive environment, perspective-taking, mutual learning, opportunities for peer networking, and	**Strengths:** Helps clarify mismatches between the traditional way supervision is conducted in the professional practice domains and the relatively

USA			the desire for a supervisor who was a more experienced peer support worker.	new supervision of the nonclinical PSS role. **Limitations:** Limitations not stated. Methods lacking procedural detail.
Franke et al. (2010) Implementing mental health peer support: a South Australian experience. Australia	Surveys completed by participants of the IPW course, 24 telephone interviews participants and a focus group with peer workers undertaking the Certificate III course and telephone interviews with members of the Stakeholder Reference Group.	To report on the evaluation of the IPW course.	Evaluation of the three-step model for employers (prepare, train and support) has provided organisations with the tools to successfully introduce peer workers.	**Strengths:** Cross service collective of local NGO's peer work data and evaluation. **Limitations**: Limitations not stated. Low rigor research - evaluation.
Gates et al. (2010) Building capacity in social service agencies to employ peer providers. USA	Mixed methods interviews, log-book recordings, mixed groups, reporting on goal attainment. 71 peers from 6 agencies.	To report findings of a pilot test of a workplace strategy that promoted inclusion of peer providers at social service agencies by building organizational capacity to support people with mental health conditions in peer provider roles.	Applied an iterative 3-step learning/ implementation process: 1. Training: A three-hour training presenting connections between peer job expectations and Human Resource (HR) policies and practices. 2. Implementation Teams to help them identify the challenges their units experienced related to peer and non-peer staff working together effectively and set goals for tackling the challenges.	**Strengths:** Evidence supportive of the PIP Peer integration project across multiple fields – e.g., job description, recruitment and leadership etc.

			3. Consultation by the researchers was provided to each Team to support them as they applied the strategies learned. Findings demonstrate that a strategy of training, goal setting and consultation can positively affect perceptions of inclusion and promote implementation of practices associated with inclusive workplaces.	
Gillard et al. (2022) The impact of working as a peer worker in mental health services: a longitudinal mixed methods study. UK	32 peer workers interviewed across 7 services. mixed method, longitudinal, using standardised measures of outcome, structured questionnaires, and semi-structured qualitative interviews. Discharge to community PW focus.	To measure the impact of working as a mental health peer worker on wellbeing and employment-related outcomes, and to explore the experience of impact through in-depth interviews with peer workers.	Peer workers largely stay well and experience a positive sense of self and growth in their work. Peer workers seem no more likely to experience negative impacts of working than other healthcare professionals but should be well supported as they settle into post, provided with in-work training and support around job insecurity. Research is needed to optimise working arrangements for peer workers alongside clinical teams.	**Strengths:** Reinforces the value of PW and allays fears that PW will be significantly impacted by the work.
Gillard et al. (2021) Developing and testing a principle-based fidelity index for peer support in mental health services. UK	57 (service user researchers and peer supports) of 17 services, testing of a draft principle-based fidelity index for peer support in mental health services.	Reports the development and testing of a fidelity index for one-to-one peer support in mental health services, designed to assess fidelity to principles that characterise the distinctiveness of peer support.	A fidelity index for 1:1 peer support in mental health services was produced with good psychometric properties. The index offers potential to improve the evidence base for peer support in mental health services, enabling future trials to assess fidelity of interventions to peer support principles, and service providers a means of ensuring that peer support retains its distinctive qualities as it is introduced into mental health services.	**Strengths:** Rigor with reasonable size and across multiple services.

Gillard et al. (2013) Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the organisational benefits and challenge. UK	Qualitative secondary analysis of 41 service users, Peer Workers, non-peer staff and managers.	To describe the emergence of UK Peer Worker roles in mental health services from the perspectives of mental health service users, peer workers, and mental health service staff & managers and to describe the organisational benefits and challenges of introducing Peer Worker roles into existing mental health service teams.	Peer Workers were highly valued by mental health teams and service users. Indicative of potential benefits for mental health service teams of introducing Peer Worker roles.	**Limitations**: Small sample. Secondary analysis.
Gray et al. (2017) Finding the right connections: Peer support within a community-based mental health service. Australia	Qualitative Exploratory. 19 semi-structured interviews with peer and non-peer ROP staff.	Reports on a qualitative study that examined the organisational enablers and barriers to implementing peer support work in an Australian, rural, community-based mental health service.	Peer workers valued for their ability to build trusting connections with clients and to accept client choice in a non-judgemental way. However, peer support workers tended to 'fill service gaps' within services.	**Strengths:** Good description of AU policy background & ROP. **Limitations:** Reiteration of well evidenced enablers and barriers.
Hagaman et al. (2023) An examination of peer recovery support specialist work roles and activities within the recovery ecosystems of central Appalacia.	Quantitative survey and semi-structured focus groups. multi-settings	The primary goal of the sequential exploratory mixed methods study was to address the call in the literature to provide clarity regarding PRSS work roles and scope of practice.	Respondents indicate that they frequently provide emotional support in a broad array of regional service settings but have few professional advancement opportunities. PRSS also report that their role is frequently misunderstood. Study provides information about training, remuneration, job satisfaction,	**Strengths:** Broad area of USA.

USA			work roles and activities within the context of existing recovery ecosystems.	
Hamilton et al. (2015) Implementation of consumer providers into mental health intensive case management teams. USA	Mixed methods/RCT Of 285 eligible clients of the service (149 were at intervention sites and 133 were at control sites) 8 interviews at each implementation site with providers (n=8) and CPs (n=5), and two focus groups with clients (n=8).	To evaluate facilitators and challenges to implementation of Consumer Providers on mental health intensive case management teams.	Commonly described implementation facilitators included site preparation, external facilitation, and positive, reinforcing experiences with the CPs (e.g. the issue of boundaries was thoroughly discussed during pre-implementation planning and subsequent supervision in order to help the CPs negotiate the balance between professionalism and empathy. Implementation challenges included role definitions (e.g. determining which clients would be seen by the CP) and deficiencies in CPs' technical knowledge (e.g. sufficient knowledge of standard workplace behavior; "basic work professionalism").	**Limitations**: Limitations not stated.
Holley et al. (2015) Peer worker roles and risk in mental health services: a qualitative comparative case study UK	Qualitative case studies, interviews/questionnaire of 91 peer workers.	Empirical evidence exploring potential risks to peer workers and the people they support, or the challenges posed to peer working by existing risk management practice in mental health services.	New understandings of risk management related to the role.	**Strengths:** New information on an under researched topic – risk. Good size cohort.
Jacobsen et al. (2012)	Data were gathered through interviews, focus groups, and activity logs.	To specify the work that peers do.	Proposes a general peer job description that may be useful to organizations	**Strengths:** Influential/foundational 114 citations.

What do peer support workers do? A job description. Canada			seeking to develop peer support programming.	**Limitations:** Dated.
Kern et al. (2013) A demonstration project involving peers as providers of evidence-based, supported employment services. USA	Supported peer-supported employment fidelity scales.	Development and fidelity testing of a training program for peer advocates to provide evidence-based supported employment services to consumers with severe mental illness.	Fidelity review revealed that peers met IPS (individual placement and support) standards of implementation on 7 of 14 items assessing service delivery.	Limitations: Very small scale - only 3 participants. No control group.
Meurk et al. (2019) Staff Expectations of an Australian Integrated Model of Residential Rehabilitation for People with Severe and Persisting Mental Illness: A Pragmatic Grounded Theory Analysis. Australia	Qualitative arm of a mixed methods longitudinal study. Interviews of 15 peer support workers.	Analyze qualitative interviews undertaken with staff at two new agencies trialing a staffing model incorporating peer support about their understandings and expectations of working in recovery-oriented rehabilitation services in an Australian setting.	Good will/enthusiasm tempered by realism regarding the potential challenges of recovery-oriented rehabilitation and of integrating peer roles with clinical care.	**Strengths:** Highlights challenges/barriers. **Limitations:** Small sample. Sub-study.
Moore et al. (2020) More 'milk' than 'psychology or tablets': Mental health	Qualitative interviews (2x) of 5 mental health professionals each from a different discipline and health setting.	To explore what National Health Service mental health professionals value about the peer support worker role.	Mental health professionals valued peers for the deeply empathic, relational approach they brought, based in their subjective experience.	**Limitations:** Too small a sample.

professionals' perspectives on the value of peer support workers. UK				
Moran et al. (2012) Challenges Experienced by Paid Peer Providers in Mental Health Recovery: A Qualitative Study. USA	Qualitative arm of findings from a larger exploratory mixed-methods study of 31 peer support workers.	Explore challenges faced by peer work in diverse settings.	Long list of challenges presented. (a) direct and indirect expressions of prejudice; (b) relationship problems with co-workers; (c) lack of recovery environment; and (d) being the only peer provider in the agency.	**Strengths**: Triangulated data collection via 2 interviews (a recovery interview and a life story interview) and self report questionnaires. **Limitations:** Appears unbalanced when comparing to projects at similar time e.g., Salzer 2013 (below) and vice versa.
Mourra et al. (2014) Pushing, Patience, and Persistence: Peer Providers' Perspectives on Supportive Relationships. USA	Qualitative interviews. Sub-study of a broader project.	To understand the nature of the work involved in providing peer support from the perspective of the peer provider.	Detail of what works in the relationship btw. Peer workers & 'consumers'. Suggest the need for ways to train peer staff in managing safely the vicarious trauma, frustrations, and inevitable setbacks involved in this work.	**Limitations:** Insufficient description of a secondary study procedure.
Myrick & Vecchio (2016)	Environmental scan and analysis of peer support services within the behavioral health care field in the United	Examine how the history and philosophy of peer support services has shaped current mental	Peer support services have the potential to increase access to recovery-oriented services for people with mental and substance use disorders served by the	**Limitations:** Low rigor research.

Peer Support Services in the Behavioural Healthcare Workforce. USA	States, with particular attention to initiatives of the Substance Abuse and Mental Health Services Administration.	health and substance use service delivery systems.	public behavioral health care system. Numerous initiatives in various states are being undertaken to build this workforce.	
Ojeda et al. (2020) Roles of peer specialist and use of mental health services among youth with serious mental illness USA	Descriptive records 6329 transition age youth aged 16-24 with SMI who received services from 76 outpatient public mental health programs with peer specialists on staff.	To examine whether roles of peer specialists affect service use among Black, Latinx and White youth ages 16-24.	In Los Angeles having three or more peer specialist trainings (vs fewer trainings) was associated with lower use of inpatient services. In San Diego County, having a transition age youth peer specialist and peer specialists that provide four or more services was associated with lower use of inpatient services.	**Limitations:** Region specific.
Otte et al. (2020) Challenges faced by peer support workers during the integration into hospital-based mental health-care teams. Germany	Open-ended, semi-structured interviews with 8 peer support workers from 5 psychiatric hospitals.	The purpose of this study is to explore the challenges faced by PSWs during their integration into hospital-based mental health-care teams.	Highlight several challenges that can arise during the integration of PSWs into hospital-based multidisciplinary mental health-care teams. 3 themes 'Pioneers and the pressure to succeed'; 'a colleague, a rival or yet another patient?' and 'sharing of information, boundaries and professionalism'.	**Limitations:** Small, widely stretched sample and less likely to be translatable to AU.
Otto et al. (2022)	Co-designed, mixed method study, convenience sample of 33 consumers and 35 carers.	To establish a consensus on the underpinning, context-specific, peer support principles for both	High rates of agreement on scale items measuring five co-designed peer support principles indicated strong service quality	**Limitations:** Insufficient detail in some parts of procedure and analysis.

Co-designing consumer and carer peer support principles to assess quality. Australia		consumer and carer peer support and to pilot test a scale.		
Parker et al. (2022) Staff Experiences of Integrating Peer Support Workers and Clinical Staff in Community-Based Residential Mental Health Rehabilitation: A Pragmatic Grounded Theory Analysis. Australia	Qualitative component of a mixed-methods longitudinal evaluation of 15 participants.	Test the integrated staffing model.	Exploratory findings support the assertion that the integrated staffing model shows promise in supporting clinical services to achieve recovery-oriented practice.	**Strengths:** Structured tested model with positive outcomes. Context reliant – as the majority of staff in these 2 settings are peers. **Limitations:** Small sample.
Reeves et al. (2023) Organisational Actions for Improving Recognition, Integration and Acceptance of Peer Support as Identified by a Current Peer Workforce. Australia	18 qualitative interviews.	To investigate peer workers experiences being integrated into mental health organisations and their perspectives on how organisations can improve recognition, integration, and acceptance of peer support.	That barriers remain in the integration of peer support roles in mental health service organisations. Builds on earlier work re recommendations e.g., pathways for professional development.	**Strengths:** Advancing recommendations. Evidence of persistent barriers in current time. **Limitations:** Small sample.
Salzer et al. 2013	271 peer support workers surveyed with 230 interviews	Examined possible benefits of working as a certified peer specialist.	CP initiatives appear to benefit the individual worker and may result in societal cost savings.	**Strengths:** Large samples.

Benefits of working as a certified peer specialist: results from a statewide survey. USA				
Scanlan et al. (2020) Workplace experiences of mental health consumer peer workers in New South Wales, Australia: a survey study exploring job satisfaction, burnout and turnover intention. Australia	NSW statewide Job satisfaction survey of 67 peer workers using REDCap electronic data capture.	To explore workplace experiences of peer workers.	Peer workers are not less satisfied, nor more burnt out than mental health professionals from other disciplines. More needed to support the full integration and acceptance of the peer workforce. Key areas for improvement include the expansion of the peer workforce – peer seniors/leaders and continuing education of the non-peer mental health workforce to understand the unique skills and contribution of peer workers and to promote more inclusive attitudes.	**Strengths:** Reveals many types of barriers/challenges and opportunities of PW.
Siantz et al. (2019) Where do Peer Providers Fit into Newly Integrated Mental Health and Primary Care Teams? A Mixed Method Study. USA	Exploratory qualitative/mixed methods study of 32 in social network analysis and interviews.	To understand variation in network positions of peer providers in newly integrated care coordination networks using social network analysis coupled with qualitative interviews with peer providers.	In this study, peer providers occupied a wide range of network positions, job responsibilities, and experiences related to their involvement in these pilot programs. Social network analyses revealed that peer providers had varying levels of involvement within LA Innovations integrated health care teams. This positional variation differed according to their roles, backgrounds, service populations, and perceived levels of team involvement.	**Limitations:** Specific to services in LA. Reiterates known (albeit highlights their persistency) challenges of including peer specialists in medical and integrated settings (challenges of role clarity, supervision, and training).

Siantz et al. (2017) Peer Support in Full-Service Partnerships: A Multiple Case Study Analysis. USA	Case study analysis arm of a large mixed methods project.	The goal of the study was to understand the role of peer providers in promoting client autonomy in recovery-oriented programs.	In these cases, peer providers were champions for recovery, and used practice-based strategies to promote client autonomy despite working in settings with lower recovery orientation. Peer providers could be uniquely positioned to promote client autonomy in settings where organizational factors limit consumer choice.	**Limitations:** Overall study findings appear to offer little new knowledge. Appears to reiterate what is known. US project specific which may not translate.
Simmons et al. (2020) The Experiences of Youth Mental Health Peer Workers over Time: A Qualitative Study with Longitudinal Analysis. Australia	Focus groups involving 8 peer support workers.	The benefits and barriers to peer work has been with youth peers.	Youth peer workers are likely to experience similar benefits and barriers to those of adult peer workers, and that some of these barriers are likely to improve over time. Providing appropriate support to Youth peer workers, who are in an early career phase, will likely reduce some of these barriers.	**Strengths:** Youth nuance. **Limitations:** Lacks a clear thread from aims to results. Small scale.
Simpson et al. (2014) Evaluating the selection, training, and support of peer support workers in the United Kingdom. UK	Mixed methods. Nottingham Peer Support Training Evaluation Tool (NPSTET) used with 16 pw trainees and focus group interviews.	To describe the preparation, selection, training, and support of a group of peer support workers (PSWs) and report the findings of an evaluation of the training and support provided. Results of the trial are reported elsewhere.	Training being valuable, challenging, yet positive experience that provided PW with a good preparation for the role. A key area for improvement concerned the strength of emotional involvement and feelings PSWs had for their peers, especially in regard to ending the support relationship. Skilled, sensitive supervision and support is essential for the success of such roles.	Limitations: Project specific. Small sample. Confusing – 13 or 16 trainees? Drop out and recruit midway.

Simmons et al. (2020) The Experiences of Youth Mental Health Peer Workers over Time: A Qualitative Study with Longitudinal Analysis. Australia	8 youth peer support workers in focus groups.	The benefits and barriers to peer work has been with youth peers.	YPW are likely to experience similar benefits and barriers to those of adult peer workers, and that some of these barriers are likely to improve over time. Providing appropriate support to YPW, who are in an early career phase, will likely reduce some of these barriers.	**Strengths:** Youth nuance. **Limitations:** Lacks a clear thread from aims to results. Small sample.
Stefancic et al. (2019) "What We Have in Common": A Qualitative Analysis of Shared Experience in Peer-Delivered Services. USA	In-depth qualitative interviews were 8 peer specialists and 2 supervisors working in a Peer Wellness Program.	To examine what constitutes shared experience and how peer specialists integrate it into their practice, particularly from the perspective of the peer specialists themselves.	Peer specialists and supervisors indicated that "peer" status contributed to greater levels of trust, empathy, and open communication in relationships with clients.	**Limitations:** Small sample.
Wu et al. (2022) Positive Organizational Psychology Factors as Serial Multiple Mediators of the Relationship between Organization Support and Job Satisfaction Among Peer Support Specialists. USA	Statistical survey of 121 peer support specialists including self-reported measures.	To formulate and test a positive organizational psychology model of job satisfaction for peer support specialists.	Perceived organizational support increased autonomous motivation to work, work engagement, organizational commitment, and job satisfaction.	**Strengths:** Good sample size. Research rigor.

Appendix 9: Literature Reviews – Quality Ratings

Table 1: Peer-reviewed literature - CASP quality ratings of systematic reviews (CASP, 2018)

Author (year)	Model Context/Setting or Population	Clearly focused question	Right type of papers	All the important, relevant studies	Quality of included studies assessed	Reasonable to combine the results	Overall results	Preciseness of results	Applicability of results to local	All important outcomes are	Benefits worth harms & costs
Akerblom & Ness (2023)	Various	✓	✓	?	✓	✓	✓	✓	✓	✓	✓
Barker et al. (2020)	IUPS/ Mentoring	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Bowersox et al. (2021)	Suicide Prevention	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Charles et al. (2021)	Peer training formats	✓	✓	?	X	✓	✓	✓	✓	✓	✓
Chinman et al. (2020)	Various	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Corrigan et al. (2022)	Various	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
De Beers et al. (2022)	Youth Peer Workers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Doughty & Tse (2011)	Various	✓	✓	X	✓	✓	✓	?	✓	✓	✓
Gillard et al. (2014)	Clinical MHS	✓	✓	?	X	✓	?	?	✓	✓	✓
Harvey et al. (2023)	Community models	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
King et al. (2018)	Various	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Luke et al. (2024)	Various/Rural Community	✓	✓	?	✓	?	✓	?	✓	✓	✓
Miler et al. (2020)	Homelessness Drug/Alcohol	✓	✓	?	X	✓	✓	✓	✓	X	✓
Murphy et al. (2023)	Youth / Primary care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mutschler et al. (2022)	Various	✓	✓	X	?	✓	✓	✓	✓	✓	✓
Pitt et al. (2013)	Various	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Reif et al. (2014)	Mental Health Drug/Alcohol	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Repper & Carter (2011)	Various	✓	✓	✓	X	✓	✓	X	✓	✓	✓
Schlichthorst et al. (2020)	Various	✓	✓	X	X	✓	✓	?	✓	✓	✓
Shalaby et al. (2020)	Various	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Walker & Bryant (2013)	Mental health clinical services	✓	✓	?	X	X	✓	?	✓	?	✓
Watson (2019)	Various	✓	✓	?	✓	✓	✓	?	✓	✓	✓
Yin et al. (2023)	Various	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Zeng & McNamara (2021)	Various	✓	✓	✓	X	✓	✓	?	✓	✓	✓

✓ = Yes, X = No, ? = Can't Tell

Appendix 10: Hospital Inpatient/Avoidance/Discharge/Transition Programs – Quality Ratings

Table 1: MMAT Quality Rating for Qualitative Studies

Author/Date	Model Context/Setting or Population	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Overall Quality *
Böhm et al. (2014)	Inpatient / Forensic	Y	Y	Y	N	Y	****
Klim et al. (2022)	Inpatient / suicide	Y	C	Y	C	Y	***
Otte et al. (2020)	Inpatient	Y	N	C	N	C	*
Poremski et al. (2022)	Inpatient	Y	Y	Y	C	Y	****
Rooney et al. (2016)	Inpatient	Y	C	Y	C	C	**
Reinhardt-Wood et al. (2018)	Inpatient/Wellness Centre	Y	C	C	C	Y	**
Smith et al. (2017)	Inpatient	Y	Y	Y	Y	Y	*****
Wolfendale & Musaabi (2017)	Inpatient Forensic Rehab Uni	Y	N	N	N	N	*
Forchuk et al. (2020)	Hospital Transition Discharge	Y	N	Y	Y	Y	****
Hancock et al. (2022)	Hospital Transition Discharge	Y	Y	Y	Y	Y	*****
Ostrow & Croft (2015)	Hospital avoidance	Y	Y	C	C	C	**
Shattell et al. (2011)	Hospital avoidance	Y	C	Y	C	Y	***
Van Zanden & Bliokas (2022)	Suicide Postvention from Emergency Department	Y	Y	Y	Y	Y	****

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 2: MMAT Quality Rating for Quantitative Randomized Controlled Trials

Author/Date	Model Context/Setting or Population	2.1. Is randomization appropriately performed?	2.2. Are the groups comparable at baseline?	2.3. Are there complete outcome data?	2.4. Are outcome assessors blinded to the intervention provided?	2.5 Did the participants adhere to the assigned intervention?	Overall Quality *
Pfeiffer et al. (2019)	Hospital inpatient	Y	C	Y	N	Y	***
Griswold et al. (2010)	Transition	Y	Y	C	C	Y	***
Gillard et al. (2022)	Post-Hospital Discharge	Y	Y	Y	Y	Y	*****
Le Novere et al. (2023)	Hospital avoidance / early discharge	Y	Y	N	Y	Y	*****
Mahlke et al. (2017)	Transition-Hospital Discharge	Y	Y	N	C	Y	***
O'Connell et al. (2016)	Hospital avoidance	Y	Y	N	C	Y	***
Reynolds et al. (2004)	Transition-Hospital Discharge	C	C	C	C	Y	*
Sledge et al. (2011)	Hospital avoidance	Y	Y	N	N	Y	***

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 3: MMAT Quality Rating for Quantitative Non-randomized Trials

Author/Date	Model Context/Setting or Population	3.1. Are the participants representative of the target population?	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	3.3. Are there complete outcome data?	3.4. Are the confounders accounted for in the design and analysis?	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	Overall Quality *
Croft & Isvan (2015)	Hospital avoidance / Respite services	Y	Y	N	Y	Y	****
Dermatis et al. (2006)	Post-Discharge / MH and Drug Use	Y	Y	No	No	Y	***
Min et al. (2007)	Hospital avoidance / Community Centre	Y	Y	N	C	Y	***

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 4: MMAT Quality Rating for Quantitative Descriptive Studies

Author/Date	Model Context/Setting or Population	4.1. Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?	Overall Quality *
Ashford et al. (2019)	Emergency Department	Y	Y	C	N	Y	***
Lam et al. (2020)	Hospital Discharge	Y	Y	Y	Y	Y	*****
Short et al. (2012)	Hospital Discharge/ transition/Forensic	Y	Y	C	C	C	**
White et al. (2023)	Hospital Discharge	Y	Y	C	C	Y	***

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 5: MMAT Quality Rating for Mixed Methods Studies

Author/Date	Model Context/Setting or Population	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Overall Quality *
Lawn et al. (2008)	Hospital avoidance / early discharge	Y	Y	Y	N	N	***
O'Neill et al. (2024)	Emergency Department	Y	Y	Y	Y	Y	*****

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Appendix 11: Community Peer Work Models

Table 1: MMAT Quality Rating for Qualitative Studies

Author/Date	Model Context/Setting or Population	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Overall Quality *
Bellingham et al. (2018)	Open Dialogue	Y	N	Y	Y	C	***/*
Byrne et al. (2017)	Rural	Y	Y	Y	Y	Y	***
Chisolm & Petrakis (2020)	Recovery clinical	Y	N	Y	Y	Y	**
Coates et al. (2018)	Aged peer support	Y	Y	Y	Y	Y	***
Flegg et al. (2015)	COP	Y	Y	Y	Y	Y	****
Fortuna et al. (2018b)	Aged peer support	Y	N	C	Y	Y	**
Gidugu et al. (2015)	General evaluation	Y	N	Y	Y	Y	**
Gillard et al. (2015)	General evaluation	Y	Y	Y	Y	Y	****
Haertl (2007)	COP	N	N	Y	Y	Y	*
Hoy (2014)	COP	Y	Y	Y	Y	Y	***
Hurley et al. (2018)	Recovery clinical	Y	Y	Y	Y	Y	***
Kowalski (2020)	Recovery clinical	Y	N	Y	Y	Y	**
Lewis et al. (2012)	Recovery	Y	Y	Y	Y	Y	***
Price et al. (2009)	Diagnosis specific	Y	Y	Y	Y	Y	***
Stefancic et al. (2019)	Recovery physical health	Y	C	Y	Y	Y	****
Styron et al. (2018)	Groups	Y	N	C	N	N	*
Swarbrick et al. (2016)	General evaluation	Y	N	Y	Y	N	*
Watkins et al. (2019)	Groups physical health	Y	Y	Y	Y	Y	****

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 2: MMAT Quality Rating for Quantitative Randomized Controlled Trials

Author/Date	Model Context/Setting or Population	2.1. Is randomization appropriately performed?	2.2. Are the groups comparable at baseline?	2.3. Are there complete outcome data?	2.4. Are outcome assessors blinded to the intervention provided?	2.5 Did the participants adhere to the assigned intervention?	Overall Quality *
Belden et al. (2022)	Advanced care directives	y	y	y	y	y	***
Easter et al. (2021)	Advanced care directives	Y	Y	Y	Y	Y	****
Fortuna et al. (2022)	Digital	Y	Y	Y	Y	Y	***
Pfeiffer et al. (2019)	Suicide prevention	Y	Y	Y	Y	Y	****
Radovic (2022)	Digital	Y	C	Y	Y	N	**
Rogers et al. (2016)	Statutory	C	C	C	C	C	*
Thomas & Salzer (2017)	General evaluation	C	C	C	C	C	*
Yamaguchi et al. (2017)	Shared decision-making	Y	Y	Y	Y	Y	****

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 3: MMAT Quality Rating for Quantitative Non-randomized Trials

Author/Date	Model Context/Setting or Population	3.1. Are the participants representative of the target population?	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	3.3. Are there complete outcome data?	3.4. Are the confounders accounted for in the design and analysis?	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	Overall Quality *
Dickerson et al. (2016)	D&A.	Y	C	C	C	Y	**
Fortuna et al. (2018a)	Digital	Y	Y	Y	Y	Y	****
Kerner et al. (2021)	Digital	Y	Y	Y	Y	Y	***
Radigan et al. (2014)	Youth and caregivers	Y	Y	Y	Y	Y	***
Simmons et al. (2022)	Employment	y	N	y	C	y	***

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 4: MMAT Quality Rating for Quantitative Descriptive Studies

Author/Date	Model Context/Setting or Population	4.1. Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?	Overall Quality *
Mak et al. (2021)	Scales/inventories	Y	Y	C	C	Y	***

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 5: MMAT Quality Rating for Mixed Methods Studies

Author/Date	Model Context/Setting or Population	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Overall Quality *
Acri et al. (2013)	Rural maternal depression	Y	Y	Y	Y	Y	***
Ashford et al. (2018)	AOD	Y	Y	Y	Y	Y	***
Atif et al. (2022)	Digital	Y	Y	Y	Y	N	**
Cheesmond & Davies (2020)	Rural	y	y	y	y	y	***
Evans et al. (2020)	Digital	Y	Y	Y	Y	Y	***
Klodnick et al. (2015)	Employment	y	y	y	y	y	***
Nelson et al. (2007)	COP	Y	Y	Y	Y	Y	***
Robinson et al. (2015)	Resilience men	Y	C	C	C	C	*

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Appendix 12: Carer Peer Worker Models – Quality Ratings

Table 1: MMAT Quality Rating for Qualitative Studies

Author/Date	Model Context/Setting or Population	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Overall Quality *
Markoulakis et al. (2018)	Family carers supporting family members in a Canadian Family Navigation Service for youth attempting to access mental health services.	Y	Y	Y	C	Y	***
Nayak et al. (2022)	Young Children and their Families in Early Childhood Mental Health Service.	Y	Y	Y	Y	Y	***
Rebeiro Gruhl et al. (2015)	52 adult peer workers answering a survey & 33 in a focus group. Canada.	Y	Y	Y	Y	Y	***
Visa & Harvey (2019)	Carer peer support workers in an Australian mental health service.	Y	Y	Y	Y	Y	***
Wisdom et al. (2011)	Family Peer Advocates: A simulated Pilot Study of the Content and Process of Service Provision.	Y/N	N	C	C	N	**

Y = Yes, N = No, C = Can't Tell
*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 2: MMAT Quality Rating for Quantitative Non-randomized Trials

Author/Date	Model Context/Setting or Population	3.1. Are the participants representative of the target population?	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?	3.3. Are there complete outcome data?	3.4. Are the confounders accounted for in the design and analysis?	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?	Overall Quality *
Chapin et al. (2012)	Quantitative measuring tools e.g., Geriatric Depression Scale (GDS-15). Older adults. US	Y	Y	Y	Y	Y	***

Y = Yes, N = No, C = Can't Tell
*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 3: MMAT Quality Rating for Mixed Methods Studies

Author/Date	Model Context/Setting or Population	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Overall Quality *
Wisdom et al. (2014)	What family support specialists do? Mixed methods interviews, quantitative survey data and observation.	Y	Y	Y	Y	Y	***

Y = Yes, N = No, C = Can't Tell
*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Appendix 13: Peer Workforce Issues – Quality Ratings

Table 1: MMAT Quality Rating for Qualitative Studies

Author/Date	Model Context/Setting or Population	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?	Overall Quality *
Adams, (2020)	Interviews with forensic PW's and others. US	y	y	y	y	y	***
Asad & Chreim, (2016)	Interview with PWs across 2 service models.	Y	C	C	C	C	**
Blixen et al. (2015)	8 with severe mental illness and diabetes.	Y	N	Y	Y	C	**
Byrne et al. (2022)	Focus groups/interviews of PWs & multi-D mental health/substance use recovery services. US	Y	Y	Y	Y	Y	***
Byrne et al. (2019)	Interviews - managers of PWs. Australia	Y	Y	Y	Y	Y	***
Byrne et al. (2016)	PW vs medical model. Australia.	Y	N	Y	Y	Y	***
Byrne et al. (2016)	PW stigma experiences.	Y	Y	Y	Y	Y	****
Burke et al. (2018)	Delphi-benefits, costs, barriers, facilitators. UK	Y	Y	Y	Y	Y	****
Chisolm & Petrakis (2023)	Barriers and facilitators. ROP.	Y	Y	Y	Y	Y	***
Chisolm & Petrakis (2023)	Views of PW's. ROP.	Y	Y	Y	Y	Y	***
Coniglio et al. (2012)	Peer experiences of Clubhouse. – Australia.	N	Y	Y	Y	Y	**
Crane et al. (2016)	Curriculum Methodology model (focus groups)	Y	Y	Y	Y	Y	****
Ehrlich (2019)	Cross-sectional qualitative study design.	Y	Y	Y	Y	Y	***
Fletcher et al. (2020)	2ndy analysis of Second Story peer respite.	Y	Y/N	Y	Y	Y	***
Forbes et al. (2022)	PW survey and qualitative semi-structured interviews	Y	Y	Y	Y	Y	***
Franke et al. (2010)	Surveys, telephone interviews, focus group	Y	Y	Y	Y	Y	***

	with PWs undertaking the Certificate III course.						
Gillard et al. (2020)	57 PWs of 17 services, testing a draft principle-based fidelity index for peer support in mental health services	Y	Y	Y	Y	Y	****
Gillard et al. (2013)	Secondary analysis of (n41) service users, Peer Workers, non-peer staff and managers.	Y	N	Y	Y	Y	**
Gray et al. 2017	PW in Australian community health.	Y	Y	Y	Y	Y	***
Holley et al. (2015)	Risks to PWs. Qualitative case studies, interviews/ questionnaire. 91 UK.	Y	Y	Y	Y	Y	***
Jacobsen et al. (2012)	Interviews, focus groups, and activity logs.	Y	Y	Y	Y	Y	***
Meurk et al. (2019)	Qualitative arm of a mixed methods longitudinal PW study.	Y	Y	Y	Y	Y	***
Moore et al. (2020)	Interviews of 5 MH professionals	Y	N	Y	Y	Y	**
Mourra et al. (2014)	Sub-study of a broader project. US PWs.	Y	N	C	C	C	*
Moran et al. (2012)	Qualitative arm of a larger exploratory mixed-methods study.	Y	Y/N	Y	Y	Y	***
Myrick & Vecchio (2016)	Environmental scan of peer support services.US	Y	Y	Y	Y	C	**
Ojeda et al. (2020)	Descriptive records (past). US	Y	N	N	C	C	*
Otte et al. (2020)	Interviews with PWs in 5 psychiatric hospitals in Germany.	N	N	Y	Y	Y	*
Parker et al. (2022)	Qualitative component of a mixed-methods study of Australian staff experiences of PW.	Y	Y	Y	Y	Y	***
Reeves et al. (2023)	18 qualitative interviews Australia	Y	Y	Y	Y	Y	***
Sianz et al. (2017)	Case study arm of mixed methods ROP study. US	Y	Y	Y	Y	Y	***
Simmons et al. (2020)	8 Focus groups. Australia	Y	Y/N	Y	Y	Y	**
Stefancic et al. (2019)	8 PW's and 2 supervisors in a wellness program.	Y	Y/N	Y	Y	Y	**

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 2: MMAT Quality Rating for Quantitative Descriptive Studies

Author/Date	Model Context/Setting or Population	4.1. Is the sampling strategy relevant to address the research question?	4.2. Is the sample representative of the target population?	4.3. Are the measurements appropriate?	4.4. Is the risk of nonresponse bias low?	4.5. Is the statistical analysis appropriate to answer the research question?	Overall Quality *
Kern et al. (2013)	Supported Employment Fidelity Scales.	Y	N	N	C	C	*.
Wu et al. (2022)	Statistical survey – self-reported measures	Y	Y	Y	Y	Y	****

Y = Yes, N = No, C = Can't Tell
*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *

Table 3: MMAT Quality Rating for Mixed Methods Studies

Author/Date	Model Context/Setting or Population	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?	5.2. Are the different components of the study effectively integrated to answer the research question?	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	Overall Quality *
Burr et al. (2020)	National mixed method survey 55 PW in Switzerland	Y	Y	Y	Y	Y	****
Curtin & Hitch (2016)	Interviews about 'The Works' project.	Y	C	C	C	Y	**
Gates et al. (2010)	Log-book recordings, mixed groups, reporting on goal attainment.	Y	Y	Y	Y	Y	****
Gillard et al. (2020)	Interviews across 7 mental health services- longitudinal	Y	Y	Y	Y	Y	****
Hagaman et al. (2023)	Quantitative survey and focus groups, multi-settings.	Y	Y	Y	Y	Y	***

Hamilton et al. (2015)	Implementation PWs MH intensive case management teams.	Y	Y	Y	Y	Y	***
Otto et al. (2022)	Co-designed, mixed method study, 33 consumers and 35 carers. Australia.	Y	Y	Y	C	C	***
Parker et al. (2022)	Longitudinal evaluation.	Y	Y	Y	Y	Y	***
Salzer et al. 2013	Benefits of working as a PW. USA.	Y	Y	Y	Y	Y	***
Scanlan et al. (2020)	NSW statewide Job satisfaction survey of 67 participants.	Y	Y	Y	Y	Y	***
Siantz et al. (2019)	Qualitative/mixed methods 32 network analysis. USA.	Y	C	Y	Y	C	**
Simpson et al. (2014)	Nottingham Peer Support Training Evaluation Tool (NPSTET) plus focus groups with 16 PW trainees.	Y	Y	Y	Y	N	**

Y = Yes, N = No, C = Can't Tell

*MMAT v.18 quality rating: low = 1 to 2 stars; moderate = 3 stars; moderately high = 4 stars; high = 5 stars (Hong et al. 2018). *