Multi-Agency Peer Support

A model based on best practice

21 February 2022

Phoenix AUSTRALIA

Acknowledgement of Country

Phoenix Australia acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of Country throughout Australia and pays respect to all Elders, past and present. We acknowledge continuing connection of Aboriginal and Torres Strait Islander peoples to land, water and communities—places of age-old ceremonies, of celebration and renewal—and their unique contribution in the life of these lands.

We are committed to fostering an environment in which the relationship between Aboriginal and Torres Strait Islander peoples and their fellow Australians is characterised by a deep mutual respect, leading to positive change in our nation's culture and capacity.

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This project was led by the Department of Environment, Land, Water and Planning (DELWP) with support from VicForests, Department of Jobs Precincts and Regions (Agriculture Victoria), Environment Protection Authority (EPA) Victoria, Parks Victoria, and Melbourne Water (herein "the agencies").

This material/publication was produced with funding provided by the jointly funded Commonwealth-State Disaster Recovery Funding Arrangements through the Support for Emergency Services Initiative.

Suggested citation

Lawrence-Wood, Dell, L., E., Freijah, I., Madden, K., Sbisa, A., & Sadler, N. (2021) Multi-Agency Peer Support Outcomes of the literature and sector review. Report prepared for DELWP. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.

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Executive summary

During the bushfire response in 2019/2020, the Department of Environment, Land, Water and Planning (DELWP) and other partnering agencies identified the need for a wellbeing role based in the state control centre to facilitate collaboration between representatives from all agencies involved in the response. Whilst identifying what resources and supports were available, it became apparent that agencies varied significantly in regards to their peer support models, approaches and resources. DELWP recognised that a comprehensive review of best practice guidelines and current peer support models and programs within the sector was required in order to identify current gaps and future needs.

Emergency Management Victoria (EMV) is responsible for the management of emergency responses across Victoria, and oversees the deployment of various government and other agencies and departments to emergency situations. DELWP were successful in receiving a grant under the Wellbeing Grants Program managed though EMV, with Phoenix Australia engaged as subject matter experts. This project aimed to inform the development of a sustainable peer support program model for DELWP and the partnering agencies.

The first phase of this project (*this report*) involved identification and development of evidence and practice-based recommendations and principles to:

- Inform best-practice peer support programs
- Guide the use of peer support in multi-agency contexts
- Develop a self-evaluation tool that allows agencies to assess themselves against best practice.

A sector review and a concurrent systematic review of peer reviewed literature were undertaken and the results synthesised to inform the outcomes of this phase.

Key findings of the sector and systematic reviews

- The consensus guidelines for best practice peer support programs released in 2012 (hereafter referred to as “consensus guidelines (Creamer et al., 2012)”) still stand as the gold standard international guidelines, however, based on the reviews a number of refinements have been made to the guidelines to reflect actual practice in peer support, and to provide further clarification regarding their application.
- The agencies are applying most of the consensus guidelines (Creamer et al., 2012), however, there is variation in the extent to which they are applied and adhered to. This was due to differences in the core functions of the agencies, their size and capacity (including financial and staffing constraints), and more practical issues regarding being unclear about how to apply the recommendations in practice.
- Key areas where there is a need for guidance and support include: program documentation, policies and procedures regarding selection, intake and ongoing supervision and support for peer supporters; peer support program coordination; linkage of training to role and responsibility statements; and opportunities for skill practice and development.
- Many of the agencies are co-located in regional areas and are involved in cross-sector work and multi-agency responses (both day-to-day and in emergency situations), however there is a lack of

consistency in and visibility of peer support programs and approaches across the sector. Nor is there a model to guide multi-agency approaches to peer support.

Outcomes

Three clear outcomes emerged from the sector and systematic reviews:

1. Refined best practice guidelines for peer support programs in agencies in the emergency management and response sector

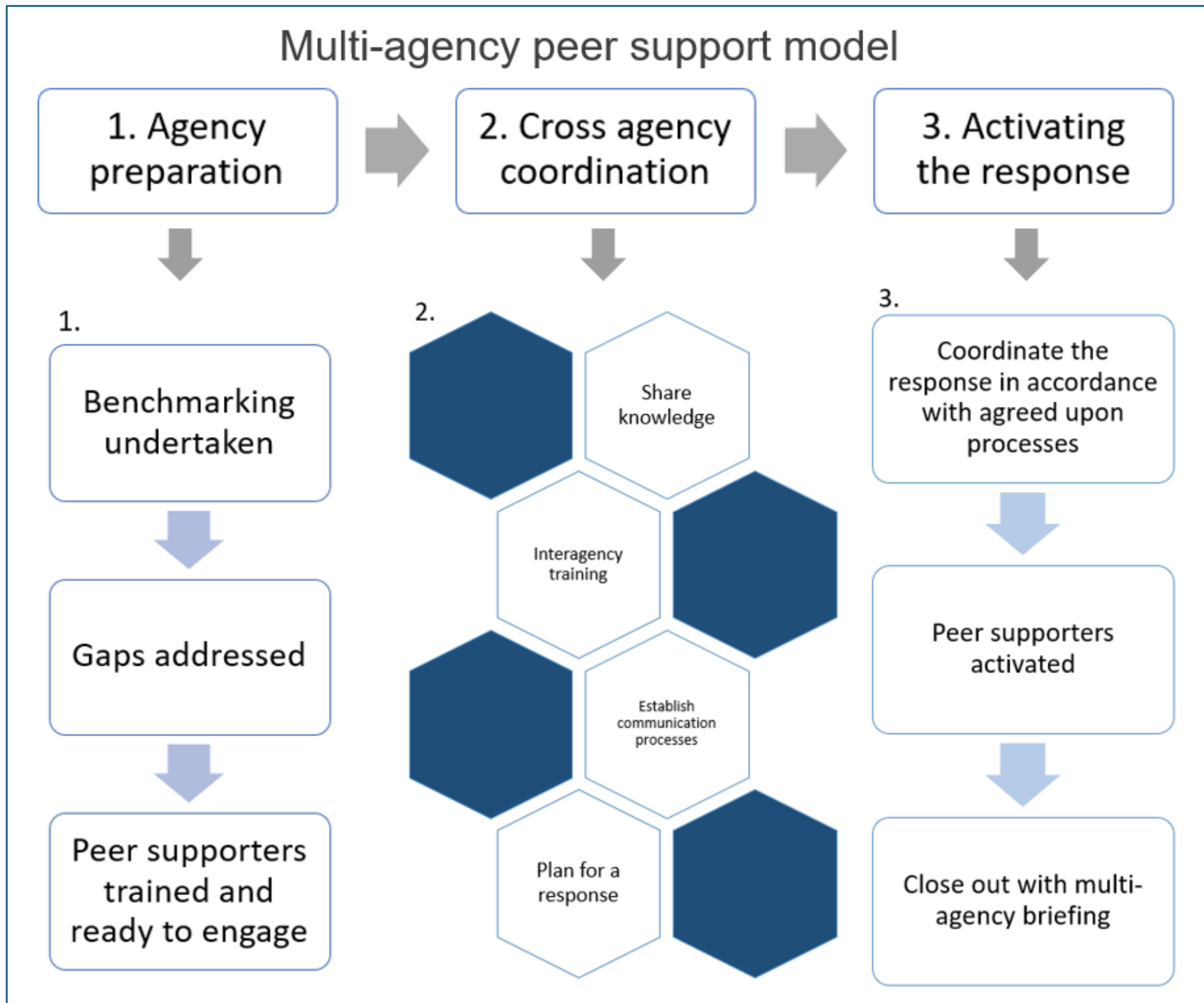
Recommendation		Items	Updates and additions
1	The goals of peer support	Peer supporters should: (1a) provide an empathetic, listening ear; (1b) provide low level psychological intervention; (1c) identify colleagues who may be at risk to themselves or others; and (1d) facilitate pathways to professional help	• Restructure to combine recommendations 1 and 5 (goals of peer support and role of peer supporters) into a single domain where the role of peers directly relates to the goals and activities they will perform.
2	Selection of peer supporters	In order to become a peer supporter, the individual should: (2a) be a member of the target population, (2b) be someone with considerable experience within the field of work of the target population, (2c) be respected by his/her peers (colleagues), and (2d) undergo an application and selection process prior to appointment that should include interview by a suitably constituted panel	• Recruitment and selection process should be linked to key selection criteria, be merit-based (meaning some individuals may not be deemed suitable), responsive to organisational need and demand, and be transparent and formally documented. • The different roles that peer supporters can undertake should be considered in the selection of peers. • There should be explicit linkage of training and accreditation to the selection process
3	Training and accreditation	Peer supporters should (3a) be trained in basic skills to fulfil their role (such as listening skills, psychological first aid, information about referral options); (3b) meet specific standards in that training before commencing their role; and (3c) participate in on-going training, supervision, review, and accreditation	• Training and development should be explicitly linked to the core competencies required by peers to perform their role, and should be linked to the peer selection process. • Training should incorporate agency specific content, and have experiential, skills-based learning

4	The role of mental health professionals	Mental health professionals should: (4a) occupy the position of clinical director, and (4b) be involved in supervision and training	• There should be internal or external program oversight/involvement by mental health professionals, and access to clinical supervision and/or support for all peers • Where possible, peer support programs should be embedded within a mental health and wellbeing team.
5	The role of peer supporters	Peer supporters should (5a) not limit their activities to high-risk incidents but, rather, should also be part of routine employee health and wellbeing; (5b) not generally see "clients" on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases; and (5c) maintain confidentiality (except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others)	• (To be captured under the new combined recommendation) The role of peer supporters should be clearly defined and consideration should be given to the different functions that peer supporters can have (including peer roles such as: peer coordinator, peer mentor) along with the skill level each peer is expected to perform within (from empathetic listener to low level intervention delivery)
6	Access to peer supporters	Peer supporters should normally be offered as the initial point of contact after exposure to a high-risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters	• Information about peers should be provided in multiple formats and on multiple platforms, to ensure it is readily accessible by all members of the workforce. • Identifiable clothing, badges or other items can be a useful tool in emergency contexts and for those staff who may be newer to an organisation. • Inclusion of information about peer support programs, and peers themselves, in regular workplace communications and training and wellbeing activities to increase visibility and credibility
7	Looking after peer supporters	In recognition of the potential demands of the work, peer supporters should (7a) not be available on call 24 hours per	• Participation in supervision should be a requirement of the role, and should include formal and informal

		day, (7b) be easily able to access care for themselves from a mental health practitioner if required, (7c) be easily able to access expert advice from a clinician, and (7d) engage in regular peer supervision within the program	opportunities to connect with coordinators and other peers. • There should be a regular review process allowing mental health and wellbeing, workload, and any current issues to be addressed. • Supervision and support should be proactive on the part of the agency, and should include facilities to allow peers to initiate support where required
8	Program evaluation	Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation	
	NEW: Collection of routine data (program monitoring)		• Inclusion of an additional recommendation separate to, but linked to evaluation: collection of routine data and monitoring that incorporates: o Ongoing collection of routine data from peers that measures: engagement, utilisation, capability, needs and demands o Data collection and management rationale and plan covering confidentiality protocols, data access and storage o A data collection platform that is easily accessible by

			peers and where possible linked with other organizational tools and platforms
	NEW: Barriers and enablers		• consideration should be given to including stigma reduction as an additional explicit goal of peer support programs • Programs should be tailored and responsive to the needs and culture of the agency • Peer supporters should be engaged in program design and continuous improvement, have autonomy in their role, and opportunities for formal and informal reward and recognition • Peer support programs should where possible be embedded within existing organisational structures, policies and processes
	NEW: Recommendations for multi-agency approaches to peer support		• Core documentation of peer support capability for each agency including (a) number of peers, (b) roles and core activities, (c) training, accreditation and experience to facilitate mapping of resources across the sector in the event of an emergency situation. • Consistency of core competencies, underlying training and access to resources for peers, directly related to their specific peer role. • A central coordination role allowing for resources to be deployed across the sector according to need, operational requirements and availability. • Where applicable, opportunities for cross agency training and supervision should be undertaken to ensure consistency in peer skills and response.

2. The model for a multi-agency approach to peer support



3. The peer support program self-evaluation tool (test version)

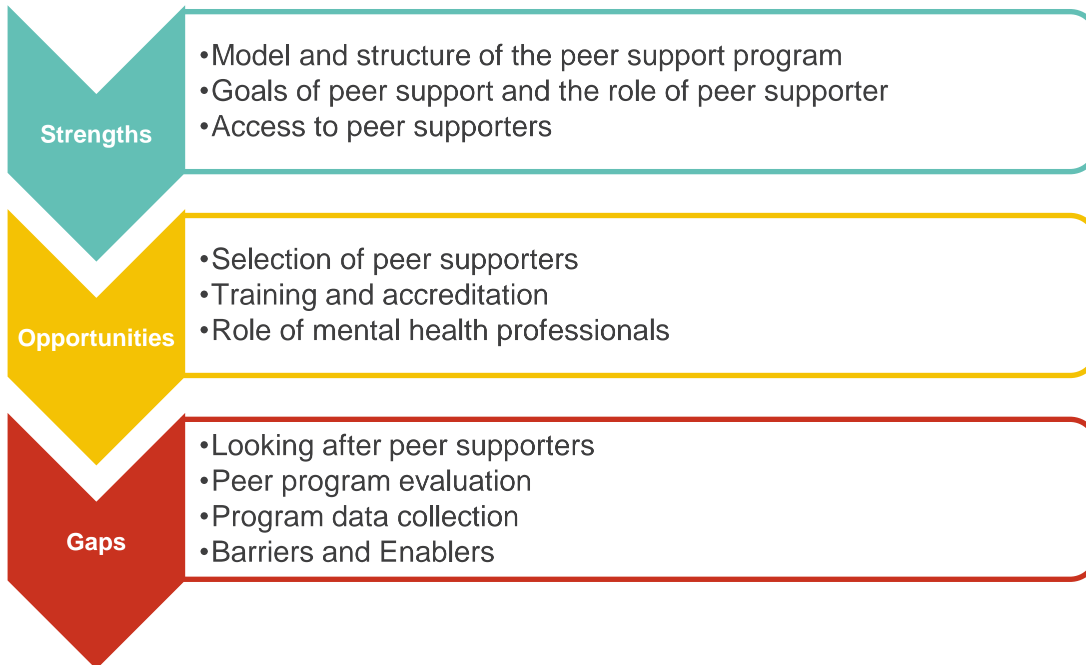
A self-evaluation tool was developed to provide structure for agencies in assessing their peer support program against best practice guidelines. The tool (found in Appendix F) was tested through the agencies and further refined. The final version of the self-evaluation tool is available from Phoenix Australia or DELWP.

Benchmarking using the self-evaluation tool

Following development of the self-evaluation tool, a benchmarking activity was undertaken with the agencies (with the exception of Melbourne Water). Each agency engaged in a self-evaluation of their peer support program (where they currently had one) and an interview with Phoenix Australia.

There was wide variability in the extent to and way in which each agency's peer support program met each best practice requirements. Differences generally reflected program maturity and, in some cases, resourcing constraints.

When considered collectively, the benchmarking findings showed there are a number of areas of strength across agencies, some areas of opportunity, and some gaps.



Importantly, for most elements, at least one agency was partially or fully meeting some or all of the requirements, which provides an opportunity for the agencies involved to collectively share existing information and materials, and leverage off each other's strengths in the ongoing development of their programs. This will also contribute to consistency in the basic foundations of programs across the working group agencies.

For those elements in which most or all agencies were not meeting or only partially meeting some or all of the requirements, these represent important gaps for consideration in the development of new material in next phase of this project.

Next steps

Given the diversity in agency peer support needs, capacity and resourcing, the extent to which agencies peer support programs currently align to best practice requirements differs substantially. In order to address this, and provide a model that supports alignment with best practice across the sector, and facilitates the application of the multi-agency response framework, there are two possible approaches to consider.

1. **Bespoke peer support programs for each agency**.

   This approach allows for the specific peer support needs of each agency to dictate the goals and capacity of their programs. Each agency would be supported by a set of guidelines, templates and training options which they could then tailor to their individual needs and resources, but, similar to the current status, there would likely be significant variability across agencies to engage in a consistent, coordinated peer response. Additionally, for agencies with resourcing challenges, or those with smaller

workforces, there may be some disadvantage with this approach, and greater difficulty meeting best practice requirements.

2. **A centrally coordinated multi-agency peer support program**.

   This approach prioritises consistency and collaboration between agencies, addressing resourcing and demand challenges. The core component of this approach is a central peer support program hub which serves to facilitate networking across agencies and peers, as well as ensures consistency in supervision, training and documentation across agencies regardless of their level of need or maturity. The central hub would help to facilitate development of a common data collection system which will allow for collective and agency level evaluation and quality assurance. Agencies of all sizes would benefit from a centralised hub of coordination as this would ensure equal and consistent access to best-practice supervision, support and training. Importantly this approach recognises that the day to day needs of each agency are different and not all agencies are required to respond to all events. It allows each agency to meet their own peer support needs, but in a way that is consistent so that they can work in a cross-agency fashion when and where required.

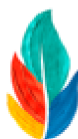
Recommendations

Key recommendation

Given the results of the sector review, the benchmarking process and the driver for this project, **option 2 presented above is the recommended model for consideration**. Having a centralised point of oversight and coordination of peer support programs across agencies, with agency level implementation and day-to-day management would allow for greater efficiencies in resourcing, and ensure consistency in coordination, supervision and training. Those agencies with fewer resources or less need would then also still be able to meet basic requirements where they have a peer support program.

Additional recommendations

- **Development of core peer support program documentation templates** for use by working group agencies. This will include use of findings from benchmarking activity to leverage off existing agency documentation where appropriate.
- **Upskilling peers from each agency with consistent core basic training** to equip for day-to-day and emergency response, to ensure consistent capability and knowledge is held within each agency and across agencies.
- **Establishment of a multi-agency peer supporter network**, including peer supporters from each agency. This network should engage in annual training as well as skill development and networking activities on a regular (at least quarterly) basis.
- **Commitment from agencies to share information and resources** and engage in multi-agency preparatory activities.



Context and background

The bushfires in the summer of 2019/2020 burnt an estimated 35.8 million hectares of land and caused significant damage to communities, lands, wildlife and livelihoods (Department of the Prime Minister and Cabinet, 2020). Through informal multi-sector consultations during and following this period, the Department of Environment, Land, Water and Planning (DELWP) and other partnering agencies developed a state wellbeing role based in the state control centre to facilitate collaboration with representatives from each agency. As part of this process, the agencies conducted a mapping exercise to identify what supports were available, where that support was available, and aligned the deployment of support across agencies, with respect given to proper agency processes.

This significant incident highlighted the differences between agencies in regards to their peer support models, and highlighted the need for the development of a sustainable peer support program that incorporates best-practice for both the day-to-day peer support response and includes consideration for best-practice multi-agency wellbeing response using peer support.

DELWP recognised the need to review and refine their day-to-day Peer Support Program to meet best practice standards, as well as the value of upskilling peer supporters to ensure they are equipped with the required skills and capabilities to support their workforce while ensuring their own wellbeing. DELWP also sought to identify gaps in current peer support programs more broadly to ultimately contribute to the development of revised guidelines. Together with their partnering agencies, DELWP recognise the importance of coordinating wellbeing support provided during emergencies where multiple agencies are responding, to enhance efficiency and effectiveness of the support provided to the collective workforces.

Peer support

Peer support has a history steeped in formal and informal community support groups, within both emergency services organisations and the military.

> Peer support programs are coordinated programs where members of an organisation volunteer their time to provide mental health and wellbeing support to their colleagues.

In a formalised peer support program, the peers providing the support receive some level of training. The peer support model encourages individuals within an organisation to talk with trained peer supporters who are empathic and supportive members of the organisation. The trained peers act as a contact point for individuals in need – engaging and supporting them, assessing their needs, and referring them on to relevant support services where appropriate. Peer support is not intended to be ongoing or a therapeutic relationship.

> Peer support is a support and triage service with an emphasis on brief, practical interventions.

Peer support programs have become an important 'prevention/early intervention' pillar in strategic wellbeing programs. Through destigmatising the notion of seeking help, peer support programs aim to offer an alternative to traditional support services. The rationale for the provision of peer support programs often includes the goals of meeting the legal and moral duty to care for members of an organisation, as well as addressing multiple barriers to standard care (including stigma, lack of time, poor access to providers, lack of trust, and fear of job repercussions). Peers are not expected to be or act as psychologists or therapists, but are support persons primarily there as someone to talk to.

It has been suggested that the provision of peer support may have direct beneficial effects for those who use the service, and indirect effects on the organisation, due to the fact that members feel supported by the organisation. Peer support programs are also among the most common mental health programs that occur in emergency services in Victoria, according to a review of wellness programs (Baurn & Lanier, 2011).

Nowadays, peer support programs are considered standard practice within organisations whose staff are at high-risk of exposure to traumatic events, such as emergency services (Creamer et al., 2012). Historically, despite the popularity of peer support programs, there was a lack of consensus around the basic parameters of peer support, such as how it is defined, its goals, how peer support programs should be implemented, and how effective peer programs are on a range of outcomes. Using a Delphi methodology, an international consensus of expert opinions on best practice peer support models was developed and a set of eight domains were recommended as the foundations for effective peer support programs, see Figure 1 below (Creamer et al., 2012). These domains remain the gold standard of best-practice peer support programs, commonly referred to as the 'consensus guidelines', and were recommended to be implemented where appropriate and within the context of each organisation. At the time of publication of the guidelines there was a significant lack of objective empirical evidence for the effectiveness of peer support programs to improve psychological outcomes, and as such the guidelines were not intended to be interpreted rigidly, but as appropriate to the context of the organisation.

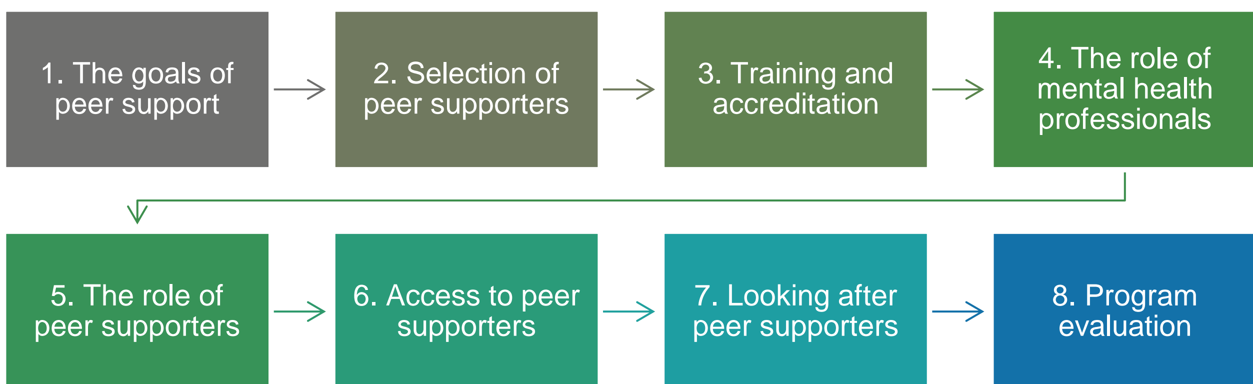


Figure 1. Eight domains for the foundation for effective peer support programs.

A decade has passed since the publication of the consensus guidelines (Creamer et al., 2012) and almost all first responder agencies now have peer support programs firmly embedded within their psychological support offerings. With a growing awareness of the advantages of a coordinated approach to peer support in an emergency context when multiple agencies are involved, it is timely to review the model of peer support and confirm the applicability of the recommended guidelines particularly for a multi-agency response.

Aim of the project

This project aims to inform the development of a sustainable peer support program model for the DELWP and partnering agencies (Vic Forests, Parks Victoria, Melbourne Water, Department of Jobs, Precincts, and Regions (Agriculture Victoria), and Environment Protection Authority and their families); with evidence and practice-based recommendations and principles to guide the use of peer support in multi-agency contexts.

Project objectives

The objectives for this project are:

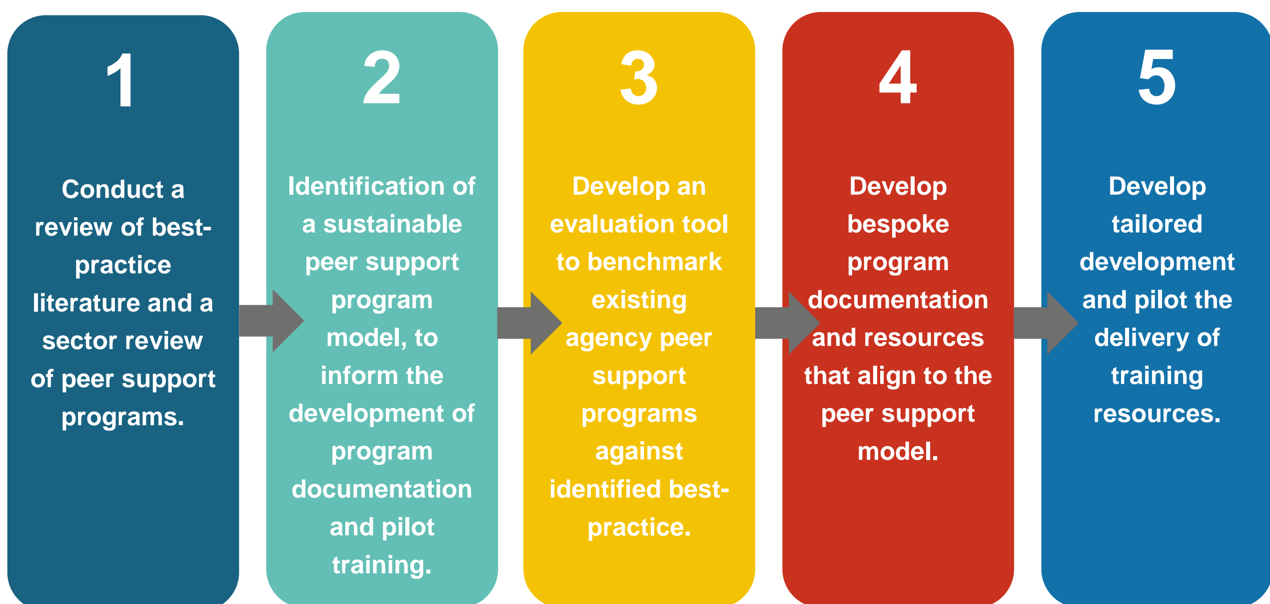


Figure 2. Project objectives.

This summary report addresses objectives 1-3.

A guide to this report

This report is broken up into five sections:

- Section 1 provides the outcome of the synthesis of the sector and literature reviews, identifying the key components of a peer support model for agencies that respond to emergency.
- Section 2 presents the multi-agency peer response model.
- Section 3 presents the agency benchmarking tool.
- Section 4 provides the synthesis of the sector and literature reviews in detail.
- Section 5 provides the detail on the methodology and the results of the sector and literature reviews.

Section 1

Emergency management and response agencies: Best practice peer support model components

Best practice recommendations

The following best practice recommendations were developed on the basis of the findings from an in-depth review of agencies involved in emergency management and response within Australia (broader than the agencies in the project working group), and a systematic review of peer reviewed literature (described in detail later in this report). To review the evidence underpinning these recommendations, please refer to Section 4 of this report.

Model and structure of programs

- The day-to-day and emergency response functions of an agency should both inform the development and structure of their peer support program.
- The model and structure of a peer support program should reflect the role and function of peers within an agency. This should be aligned against a framework for best practice that includes both core and optional components, and allows flexibility for agencies to tailor their program to suit their needs.
- Agencies identified a clear need for a consolidated map of the components of peer support programs aligned with best practice guidelines, and applied examples for use across the sector.

The goals of peer support and the role of peer supporters

- Where an agency uses peer support solely for emergency response functions, consideration should be given to formalising the role of peers in a day-to-day capacity also.
- There are additional benefits to including day-to-day functions for peers as this increases their visibility, formalises activities already occurring, and provides opportunity for skill practice and development.
- The role of peer supporters should be clearly defined and consideration should be given to the different functions that peer supporters can have (including peer roles such as: peer coordinator, peer mentor) along with the skill level each peer is expected to perform within (from empathetic listener to low level intervention delivery).

Selection of peer supporters

- Agencies should have a recruitment and selection process that is linked to key selection criteria, is merit-based (meaning some individuals may not be deemed suitable), responsive to organisational need and demand, and is transparent and formally documented.
- The different roles that peer supporters can undertake should be considered in the selection of peers.
- Core considerations for selection should include strong communication and listening skills, willingness to assist colleagues in difficult/confronting circumstances (and remain calm in these situations), having demonstrated time management skills and ability to maintain confidentiality. The psychological safety and wellbeing of peers should be considered in assessing their suitability for the role. This includes if the individual has experienced or is experiencing mental health issues, they

have demonstrated they are in recovery, or that their symptoms are stable, and where necessary they are receiving appropriate treatment and support. In the event that an individual is deemed unsuitable for reasons of psychological safety and/or wellbeing, appropriate referral and support pathways should be provided, and this should not preclude the individual for applying to become a peer supporter in the future.

Training and accreditation

- Training and development should be explicitly linked to the core competencies required by peers to perform their role, and should be linked to the peer selection process. Peers should be able to demonstrate competency following the completion of training.
- Training should incorporate agency specific content, and have experiential, skills-based learning.
- Where applicable, opportunities for cross agency training and supervision should be undertaken to ensure consistency in peer skills and response.

Role of mental health professionals

- There should be internal or external program oversight/involvement by mental health professionals, and access to clinical supervision and/or support for all peers.
- There should be clear processes for peers to triage employees in the event of risk identification (e.g. low level versus significant distress) and pathways for referral.
- Where possible, peer support programs should be embedded within a mental health and wellbeing team.

Looking after peer supporters

- Participation in supervision should be a requirement of the role, and should include formal and informal opportunities to connect with coordinators and other peers.
- There should be a regular review process allowing mental health and wellbeing, workload, and any current issues to be addressed.
- Supervision and support should be proactive on the part of the agency, and should include facilities to allow peers to initiate support where required.

Access to peer supporters

- It is important for information about peers to be provided in multiple formats and on multiple platforms, to ensure it is readily accessible by all members of the workforce.
- While many peers are well-known among their colleagues, identifiable clothing, badges or other items can be a useful tool in emergency contexts and for those staff who may be newer to an organisation.
- Inclusion of information about peer support programs, and peers themselves, in regular workplace communications and training and wellbeing activities increases visibility and credibility.

Program evaluation

- Program evaluation should be tied to clearly defined best practice goals and standards, and performed by a body independent to the agency (ideally every 4 years from commencement of the program).

Collection of routine data (program monitoring)

- The ongoing collection of routine data from peers is a valuable way of identifying resource demands and needs, and additional training and development needs.
- If collecting routine data from peers, there needs to be a clear rationale for and understanding of its value, use, application and management (including confidentiality protocols, data access and storage).
- The data collection platform should be easily accessible from various locations (e.g., app based), simple and quick to complete (e.g., 5 minutes), and where possible be linked with other organisational tools and platforms.
- Development of a measurement platform should consider routine data that can practically be used to capture resource demands and needs, and ongoing training and development needs.

Barriers and enablers

- Mental health help-seeking stigma may be a barrier to effectiveness and use of peer support programs. However, a number of agencies discussed how their programs helped to reduce stigma and facilitate help seeking. Therefore, consideration should be given to including stigma reduction as an additional explicit goal of peer support programs.
- Embedding peer support programs within existing organisational structures, policies and processes enabled greater oversight and accountability of programs and functions, and sent a clear message of commitment to and value of programs. This also facilitated greater role clarity for peers, more rigorous recruitment and selection processes, and training and development requirements.
- Program maturity was an important factor related to the level of structure and rigor around peer support within agencies. Those agencies with a longer history of peer support tended to have more rigorous recruitment and selection processes, training and development and supervision models, and measurement and evaluation goals. Therefore, it is important that program maturity is considered in the application of benchmarking.
- Those programs that were more well-established and positively received tended to be more tailored and responsive to the needs and culture of the agency.
- Engagement of peers in program design and continuous improvement, autonomy for peers in their role, and opportunities for formal and informal reward and recognition of peers, (e.g., awards for commendable work, annual celebration activities to convey thanks, regular peer support awareness days) were all core components for more well-established programs.

Multi-agency approaches

- Core documentation of peer support capability for each agency including (a) number of peers, (b) roles and core activities, (c) training, accreditation and experience to facilitate mapping of resources across the sector in the event of an emergency situation.
- Consistency of core competencies, underlying training and access to resources for peers, directly related to their specific peer role.
- A central coordination role allowing for resources to be deployed across the sector according to need, operational requirements and availability.
- Where applicable, opportunities for cross agency training and supervision should be undertaken to ensure consistency in peer skills and response.

The way forward

Drawing together the findings from the sector and literature reviews it is clear that for the most part current peer support programs are aligned with the consensus guidelines (Creamer et al., 2012). These guidelines were not intended to be applied rigidly, but should be applied as appropriate to the specific context of the peer support program. The synthesis of information from the sector (i.e. agencies, departments and organisations who are involved in emergency management and response)) and literature reviews provides the foundation for a benchmarking tool that emergency response agencies can evaluate their peer support programs against. The tool will support agencies in setting up and evaluating peer support programs against best practice.

It is important to recognise that not all agencies will be at the same maturity with their peer support program, and indeed many agencies have made and will continue to make substantial advances with their peer support programs. The benchmarking tool is not intended to re-design or re-establish these programs, rather it provides an opportunity for agencies to review their program and assist with aligning them to best practice.

Section 2

Multi-agency peer response model

Multi-agency peer response

A model for multi-agency peer support has been developed as a result of the synthesis of the sector and literature reviews. This model has application in both day-to-day operations and, importantly, speaks to the multi-agency response that could be enacted in particular emergency situations.

The model has three core components, within each there are specific activities, and is intended to be activated as required. Ideally, all agencies would undertake components 1 and 2 on an annual basis in advance of the primary emergency season in Australia. Component 3 is intended to be applied when a multi-agency peer support response is required.

The model is described here, and is presented pictorially below.

Component 1: Agency preparation	
Benchmarking undertaken	Agencies should conduct an annual self-assessment of their peer support program utilising the peer support program benchmarking tool.
Gaps addressed	Based on the outcomes of the annual benchmarking process, gaps identified should be addressed.
Peer supporters trained and ready to engage	An annual review of peer skills and training needs, alongside readiness and capacity to support the associated workforce should be undertaken. At this stage, peer supporters are ready to undertake day-to-day peer support work.

Component 2: Cross agency coordination	
Share knowledge	Agencies should connect bi-annually to share knowledge around the number and experience of peers available. Sharing policies, processes and handbooks is also encouraged to ensure as much alignment as possible in regards to peer support response.
Interagency training	Efficiencies in training peers should be considered, with agencies encouraged to share the investment in training peer support workers. This also ensures consistency in skills, and therefore the response, of peer workers. At this stage, peer supporters are ready to undertake cross agency peer support work.
Establish communication processes	Agencies should establish key points of contact and the means of contact to be enacted during events requiring a multi-agency response.

Plan for a response	A clear plan should be documented regarding the role and responsibility of each agency during a multi-agency peer response to an emergency (for example, data capture, reporting, close out).

Component 3: Activating the response	
Coordinate the response in accordance with agreed upon processes	When the multi-agency response is activated, all agencies should coordinate in accordance with the agreed upon plan and processes.
Peer supporters activated	Based on the established communication processes, the peer supporters should be activated to respond.
Close out with multi-agency briefing	After an incident in which a multi-agency response is required, agencies should come together to review the effectiveness and success of the coordinated response, and should update any training, processes or plans as deemed necessary. Engagement, utilisation, capability and satisfaction with the program should be considered.

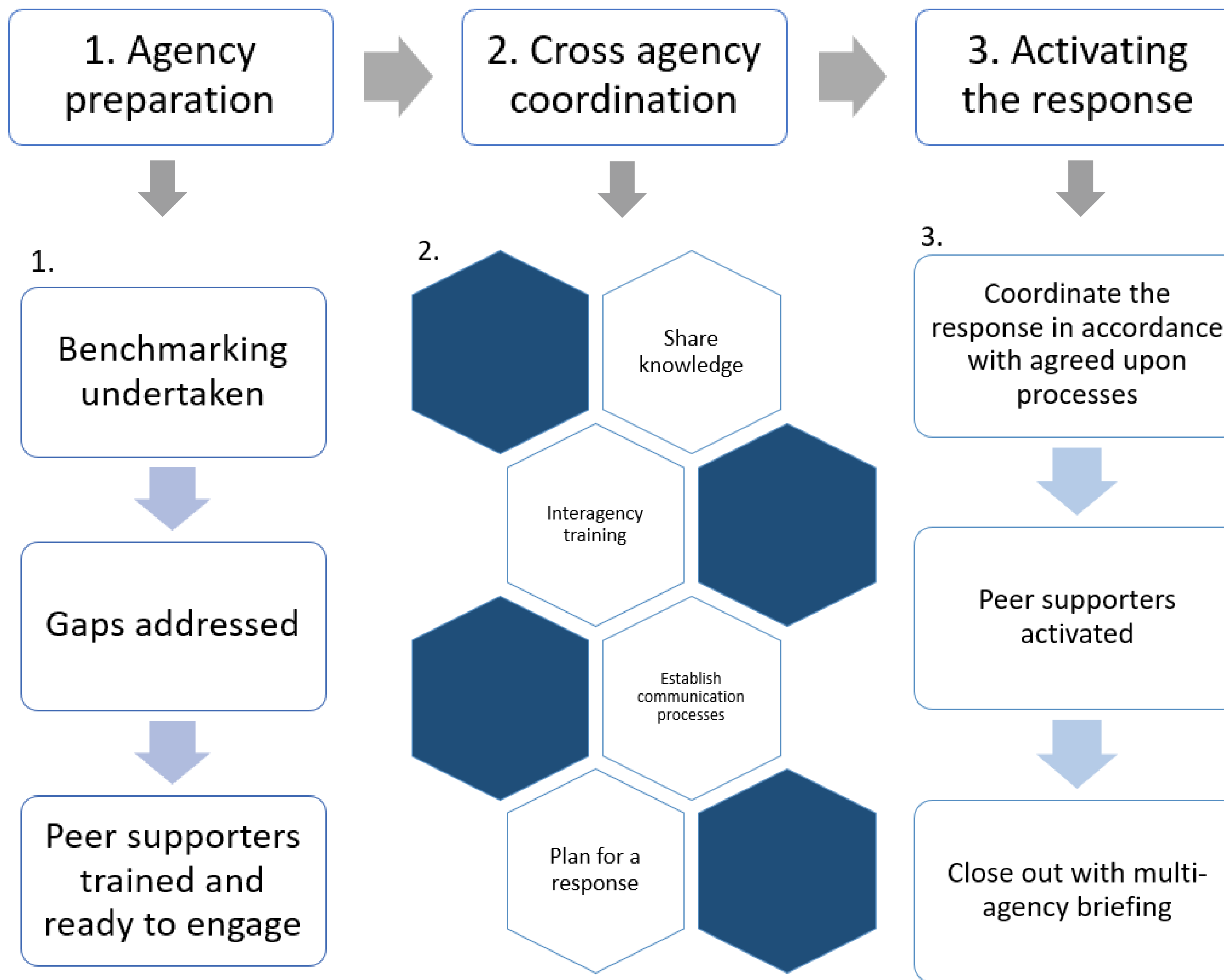


Figure 3. Multi-agency peer support model.

Section 3

Agency benchmarking tool

Benchmarking

Grounded in the consensus guidelines (Creamer et al., 2012) and enhanced by the sector and literature reviews, a proposed self-evaluation tool for agencies has been developed to allow for self-evaluation of peer support programs against best practice. The tool operationalises the updated best practice recommendations presented in Section 1. This tool is intended to be used as a resource for agencies to routinely assess their peer support program – with annual application recommended.

The purpose of undertaking benchmarking will demonstrate to agencies the alignment, and any deviation, of their peer support program with best practice. Not all items will be relevant to all agencies and multi-agency collaboration is encouraged to ensure there is cross-agency competency in all areas that can be drawn upon in the event of a multi-agency emergency response.

Benchmarking should be conducted by the manager or employee responsible for the peer support program in consultation with the peers of that agency. Transparency between agencies in sharing the results of the benchmarking is advised, so that a collaborative response to upskilling and maturing the peer support models can be undertaken.

The application of the self-evaluation tool was tested with the agencies as part of this project, and a summary of the methodology and findings are included in Annex 1. A summary of the tool elements is presented below, with the test version of the tool itself included in Appendix F.

Phoenix AUSTRALIA

Peer support program self-evaluation tool for agencies and organisations involved in emergency management and response

The purpose of this self-evaluation tool is to aid agencies in assessing existing or planned peer support programs against the best practice guidelines presented in this report. It presents the core requirements needed to meet best practice, across 10 core program elements, and 1 element specifically focussed on multi-agency approaches.

Not all agencies will be at the same maturity with their peer support program and nor do all peer support programs need to look exactly alike – the function and needs of each agency must be front of mind when using this tool. The tool will allow agencies to identify areas of strength and areas for improvement to align their program to best practice. It can also be used as a guide to support agencies in the development of a new peer support program or in the redesign or re-establishment of a peer support program.

Element	Requirement
Model and structure of the peer support program	1. The structure of the peer support program is suitable for the day-to-day needs of the organisation 2. The structure of the peer support program is suitable during an emergency response event 3. The peer support program has been tailored to reflect the role and function of peers within the organisation 4. The peer support program is still relevant for the organisation 5. The program has a designated peer support coordinator
Goals of peer support and the role of peer supporters	6. The goals of the peer support program are clearly articulated and documented 7. The role of the peer supporters is clearly defined and linked to the goals of the peer support program
Selection of peer supporters	8. Intake of peers occurs at regularly determined intervals and there is a policy for additional intake when needed 9. Nomination, application, assessment and selection policy and process is clearly documented 10. Peers are representative of our workforce
Training and accreditation	11. Training is explicitly linked to core competencies that reflect the peer role description and includes basic skills training for these roles 12. Training is based on current best practice evidence-informed education and training tools, programs and practices 13. There are clearly defined processes for demonstrating competency with a requirement to meet documented standards prior to commencing role 14. The program includes routine skills practice and development opportunities, including refresher training
	15. The program includes a formal annual review process for all peers

Looking after peer supporters	16. The program includes policies that cover on-call schedules and requirements, information about and how to access care for themselves, where to access expert advice from a mental health clinician, when and how to engage in regular supervision 17. Peers are required to participate in regular formal supervision 18. The program documentation includes information and processes for ad-hoc and informal supervision 19. We provide reward and recognition to peers on a regular basis
Access to peer supporters	20. Up-to-date information about the peer support program is provided in multiple formats on multiple platforms 21. The organisation provides regular updates and reporting on our peer support program
Role of mental health professional	22. The program has internal or external oversight and involvement by mental health professionals 23. Access to clinical supervision and/or support is provided for all peers 24. Documented processes that guide peers to triage employees are available in the event of risk identification and include pathways for referral
Peer program evaluation	25. The program has an evaluation framework with a plan for when formal evaluations should be conducted 26. The organisation has a process for reviewing the utilisation of the peer support program on a regular basis
Program data collection	27. The program has a mechanism for the routine collection of data on peer activities and utilization 28. The data collection mechanism is easily accessible by peers 29. The data collected on the peer program are regularly reported and linked to ongoing quality assurance activities
Barriers and enablers	30. Barriers and enablers are routinely considered and addressed
Recommendations for enabling a multi-agency peer support response	31. Shared documentation of peer support capability for agreed multi-agency partners 32. Documented agreement of core competencies underlying training, and processes for cross-agency access to resources for peers 33. Clearly documented coordination and engagement process and bi-annual cross-agency connection meetings 34. Regular opportunities for peer supporters to connect across the sector

Section 4

Sector and literature review synthesis

Synthesis of the reviews

Collectively the literature and sector review findings showed that peer support programs in the sector endorse and apply most of the consensus guidelines (Creamer et al., 2012). However, there is variation in the extent to which recommendations are applied and adhered to, and this depends on the core functions of organisations, their size and capacity (including financial and staffing constraints), and more practical issues regarding clear guidance for application of the guidelines in practice.

The goals of peer support and the role of peer supporters

Findings from the sector review illustrated that the goals of peer support and the role of peers were closely related concepts, and in practice were applied as a single domain (role and function of peers), with the role of peers directly aligned to the proposed goals of the peer support program. The subcomponents of not limiting activities to high-risk incidents and being part of routine employee health and wellbeing, not generally seeing "clients" on an ongoing basis but offering referral pathways, and maintaining confidentiality, were all captured as part of the role and function descriptions provided. The literature review found that while the goals of peer support were well endorsed and described, the role of peers was less often included, and generally poorly described.

In considering this evidence we recommend the restructuring of the consensus guidelines (Creamer et al., 2012) to combine these elements into a single recommendation regarding the goals of peer support where the role of peers directly relates to the activities they will perform.

Selection of peers

Selection of peers was strongly endorsed as an important component of peer support programs. Self-nomination and a formal application process were generally consistent components, as were formal and informal assessments of key peer attributes. Similarly, the requirement for peers to be a member of the target population and have experience in the field of work was either explicitly addressed or could be inferred.

In both the sector and literature reviews there was significant variability in selection criteria. This is likely to reflect the variability in the role and function of peers within different organisations. Most organisations had some component of selection that reflected the regional spread and needs of the workforce, though this was often ad hoc. There was mixed endorsement of assessing whether peers were respected by their colleagues, with both formal and informal approaches to this, or it was not addressed at all.

Selection processes themselves were extremely varied. Very few agencies or studies explicitly reported a formal selection process where peers may *not* be selected for the role on the basis of not meeting core criteria, however use of a panel in the selection process, and formal or informal mechanisms for judging the suitability of an applicant for the role were often present.

The linkage of training and accreditation to the selection process was less common, however was present in more mature peer support programs, and particularly in larger workforces. Findings from the sector review highlighted the evolution of programs and processes over time as a feature of more mature peer support programs, with changes typically addressing identified gaps or needs. Linking training and accreditation to selection allowed organisations to ensure their peers had the appropriate skills and training to perform their

role, and where there was a larger pool of applicants than peer roles, provided a mechanism for ranking and selecting the most appropriate applicants.

Training and accreditation

Evidence indicated that training and accreditation is a key component of successful peer support programs however the type and extent of training was highly variable. All programs have foundation training, which is focussed on general skills and organisation specific material. Additional specialised training was not a consistent feature of all programs, instead reflecting specific roles of peers in relation to goals of the program. For example, where suicide risk assessment or provision of individual and group psychological first aid was a core activity for peers, appropriate accredited training was required as a part of that role.

Role of mental health professionals

Findings from the review indicated that in almost all cases mental health professionals play some role in peer support programs, and in supporting and training peers. However, there was substantial variation in what this looked like in practice. Mental health professionals were commonly involved in both training and supervision of peers, and as a source of support and guidance. In many cases mental health professionals were engaged through linkage of the peer support program with the organisation's Employee Assistance Program. Some programs sat within a mental health and wellbeing team, with mental health professionals involved in the oversight, training and support for peers. Some programs had assigned internal or external mental health professionals such as a psychologist as a point of contact for peers for the purpose of supervision and/or clinical support.

Looking after peer supporters

Not all programs have formal mechanisms for checking in on the mental health and wellbeing of peers. While all programs had some form of regular review for peers, this was rarely explicit in the intent of ensuring peers were seeking support themselves where needed. A number of more mature peer support programs had evolved to address this through training in the importance of self-care, formal and informal processes for checking in on the mental health and wellbeing of peers, and policies and procedures for 'resting' peers from their duties where required.

Very few programs had any formal policies regarding the extent to which peers would be on call. The exception to this were agencies with a subset of paid peer roles. Part of this role was to be the nominated 'on call' peer, and triage to other peers and services. While there was a lack of formal policies, the sector review indicated that agencies informally address this through regular supervision mechanisms, or through the peer network identifying where there may be an issue.

The ability for peers to access regular support was discussed by most agencies in the sector review, but few studies in the literature. Support for peers from a variety of sources, including their coordinator, mental health professionals and other peers was a common component of more mature programs. Most programs had some form of formal or informal support for peers through regular supervision sessions with the peer coordinator or a mental health professional, and through peer networks, where peers could provide support to each other through regular meetings and dedicated communication channels. Regular formal supervision and review sessions were part of almost all programs, although the regularity with which these occurred was variable and sometimes dependent on the staffing constraints of the organisation. Peer networks were a formal component of a number of programs, however the engagement of peers with these was variable, with

some programs arranging but not enforcing attendance at regular meetings, while others mandated a minimum attendance requirement to continue in the peer role. Importantly, where they weren't formalised, peer networks also emerged organically, suggesting their value to peers in supporting their role.

Access to peer supporters

While the literature review revealed little evidence regarding access to and availability of peer supporters, the sector review highlighted the importance of multiple means of advertising peer support contact information. All agencies had details of their peers available to all members of the workforce, however there was variability in how accessible this was. More mature programs used multiple platforms to share peer details, including through regular organisational communications, inclusion of peers in workforce training and wellbeing activities, and induction processes. A number of more mature peer programs also discussed the value of matching peers to need. Sometimes this was managed through formal channels (i.e., a central peer leader or program coordinator) or more informally through peer networks and word of mouth. The extent to which peers were known by or visible to the workforce was also related to the extent to which they were accessed.

Program evaluation

Measurement of the use and effectiveness of peer support programs emerged as a challenging issue. While most programs included in the literature review reported some form of evaluation, the majority of agencies in the sector review did not have past or present formal evaluation frameworks or mechanisms for measurement of their programs. Key reasons for this included a lack of guidance and understanding of what type of information should be collected and why, the challenge of burdening peers with collecting routine data, and the difficulty in formally measuring aspects of peer support which account for a substantial component of the peer support role, such as informal conversations. The small number of agencies that did have formal mechanisms for measurement and evaluation had developed these alongside the evolution of their programs. Ongoing measurement typically used bespoke tools developed by agencies in response to need, and formal program evaluations were conducted by external agencies.

In more mature programs, where ongoing measurement and evaluation was embedded within programs, there was a clear rationale for how this information was used, and related to all elements of the program including resource demands and needs, and ongoing training and development needs. Having a clear process that takes minimal time and does not include sensitive or identifiable information was important, as was the provision of the underlying rationale to peers. Collectively these all facilitated improved data collection.

Section 5

Methodology and results

Methodology

This project has been supported by a working group comprised of representatives from DELWP, Vic Forests, Parks Victoria, Melbourne Water, the Department of Jobs, Precincts, and Regions (Agriculture Victoria), and the Environment Protection Authority.

Sector review

A broad cross-section of agencies were included in the review, both from within Victoria and nationally. Stakeholders represented those involved in emergency services, emergency response and management, and government, were of varying sizes, included both paid and volunteer workforces, and all but one had established peer support programs with varying levels of program maturity.

Agencies who participated in the sector review included:

- Department of Environment, Land, Water and Planning
- Department of Jobs, Precincts and Regions (Agriculture Victoria)
- Parks Victoria
- Melbourne Water
- Vic Forests
- Environment Protection Authority
- Country Fire Authority
- Victoria Police
- Fire Rescue Victoria
- Victorian State Emergency Services
- QLD Fire and Emergency Services
- NSW Fire and Rescue

The sector review included the following components:

1. Evidence gathered from current documentation and past reviews of peer support programs
2. Semi-structured interviews with participating agencies
3. Written responses to a key set of questions from 14 peers working within the sector.

The semi-structured interviews and questions for peers targeted:

- Current sector practices relating to peer support programs
- The role and function of peer support day-to-day and in relation to significant incidents/emergency response
- Approaches to peer support in the context of multi-agency emergency response
- Measurement and evaluation of peer support programs
- Barriers and facilitators for development, implementation and evaluation of best practice peer support.

Data from all sources was de-identified and aggregated for the purpose of analysis and synthesis. Data from components 1 and 2 were collated under the key questions/areas outlined in Appendix A, with recurrent

themes documented and quantified where appropriate. Data from component 3 were grouped according to question, then thematically coded to identify recurrent themes in relation to each question, with endorsement of these themes quantified according to frequency (Appendix B).

Data from all sources were further synthesised and summarised under the following domains and sub-components:

- Programs - model and structure; role and function; access, visibility and use; barriers and enablers
- Peers - recruitment and selection; training and development; tenure and review; supervision and support
- Measurement and evaluation
- Multi-agency approaches.

Literature review

A scoping review was conducted involving a systematic search of studies examining current best-practice approaches to the development, implementation, and evaluation of peer support programs in high-risk organisations to promote the wellbeing and support the mental health of staff members (Arksey & O'Malley, 2005). A scoping methodology was chosen over a systematic review as scoping reviews typically address broader topics examined in various study designs, while systematic reviews typically comprise of well-defined research questions answered by a narrow range of study designs (Arksey & O'Malley, 2005). The scoping methodology is also the most appropriate technique to 'map' the state of the relevant literature, summarize bodies of knowledge from heterogenous study designs, and identify gaps in the literature (Tricco et al., 2018).

Detailed information on the identification of relevant studies, study selection, data charting and quality assessment processes are provided in Appendix C. Importantly, most studies contributing to this synthesis were judged to be of high quality.

The findings from the review have been summarized using a narrative descriptive synthesis approach in accordance with the evidence-informed consensus guidelines for peer support in high-risk organisations developed by Creamer et al. (2012) (see Table 1). These eight recommendations and their subcomponents were derived from a 3-round, web-based Delphi review of key statements by 90 experts, including clinicians, researchers, and peer-support workers across 17-countries.

Table 1. Consensus guideline recommendations for peer support in high-risk organisations adapted from Creamer et al. (2012)

	Recommendation	Items
1	The goals of peer support	Peer supporters should: (1a) provide an empathetic, listening ear; (1b) provide low level psychological intervention; (1c) identify colleagues who may be at risk to themselves or others; and (1d) facilitate pathways to professional help
2	Selection of peer supporters	In order to become a peer supporter, the individual should: (2a) be a member of the target population, (2b) be someone with considerable experience within the field of work of the target population, (2c) be respected by his/her peers

Recommendation		Items
		(colleagues), and (2d) undergo an application and selection process prior to appointment that should include interview by a suitably constituted panel
3	Training and accreditation	Peer supporters should (3a) be trained in basic skills to fulfil their role (such as listening skills, psychological first aid, information about referral options); (3b) meet specific standards in that training before commencing their role; and (3c) participate in on-going training, supervision, review, and accreditation
4	The role of mental health professionals	Mental health professionals should: (4a) occupy the position of clinical director, and (4b) be involved in supervision and training
5	The role of peer supporters	Peer supporters should (5a) not limit their activities to high-risk incidents but, rather, should also be part of routine employee health and wellbeing; (5b) not generally see “clients” on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases; and (5c) maintain confidentiality (except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others)
6	Access to peer supporters	Peer supporters should normally be offered as the initial point of contact after exposure to a high-risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters
7	Looking after peer supporters	In recognition of the potential demands of the work, peer supporters should (7a) not be available on call 24 hours per day, (7b) be easily able to access care for themselves from a mental health practitioner if required, (7c) be easily able to access expert advice from a clinician, and (7d) engage in regular peer supervision within the program
8	Program evaluation	Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation

How to read this report

There are a number of graphics to aid in the readability of this report. The following information has been provided to assist with orienting the reader to the style of this report.

Tree plots are used throughout the report to visualise endorsement of themes that emerged from the interviews. The size of the boxes within the tree plots are meaningful and corresponds to the proportion of participants who endorsed each theme e.g. the number of participants who mentioned a specific function of

peers in their agency. As interviewees were able to mention more than one theme in response to a question, the data in these plots does not always total 100%. These plots are descriptive only and do not represent a statistical test of differences between responses.

Results of the sector review

The following section summarises the core components of current practice in peer support programs across the emergency management and response sector, which were identified in documentation, interviews and written responses. Agencies included and relative workforce size of each are presented in the figure below.

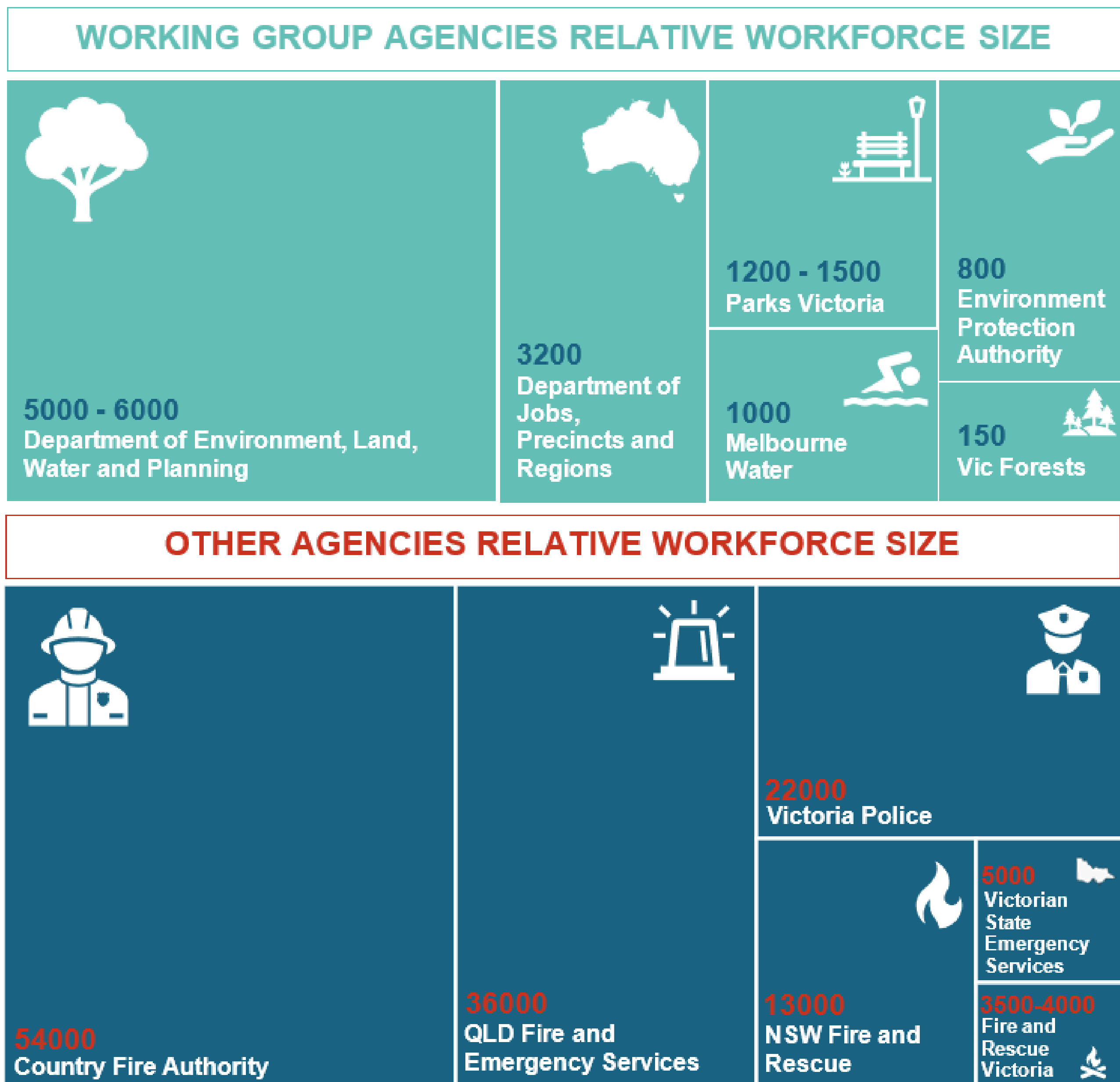


Figure 4. Relative workforce size per agency group.

Programs

Model and structure of peer support programs

Agencies differed in the models and functions of their peer support programs, and the organisational structure within which they sit. Typically, agencies did not refer to a specific model of peer support underpinning their programs. This was mainly due to many programs developing organically, a lack of best practice 'models' for peer support programs, and the need for agencies to tailor their peer support programs around the function and role of peers. Where agencies referred to existing 'models' this was generally the Mitchell Model and Critical Incident Stress Management (which in all cases was either phased out of practice, or was in the process of being phased out), or an application of the consensus guidelines (Creamer et al., 2012). There is however a lack of clarity around how to put into practice existing recommendations for peer support programs, with agencies using various strategies to address this including:

- Looking to other agencies to see what they're doing, and picking and choosing those components which fit with the needs and requirements of their agencies.
- Only adopting those recommendations that had clear and measurable application.

Within the organisational structure, peer support programs typically sat within wellbeing, people and culture, or occupational health and safety functions, with broad program oversight by the manager of the respective work function. Within all agencies there was an explicit link between the peer support program and other mental health and wellbeing services and supports, including the workplace employee assistance program.

For all agencies there was some form of coordinator role overseeing their peer support program, however the extent of this was influenced by funding and resource constraints, particularly within smaller agencies, or those agencies where peer support was not embedded in day-to-day emergency support functions. As the peer coordinator role tended to be a paid position within agencies, there were ongoing requirements to request and justify support for the role, meaning that in some cases the role was not ongoing, and there may be periods during which the role was not occupied. For example, some agencies noted the current absence of an individual in their coordinator role due to the process of requesting management support for its continuance being underway. All agencies highlighted the importance of this coordinator role as integral to the success of their programs.

Typically, peer support roles were voluntary, and *in addition to* their normal duties, with no financial re-imbursement. The exception to this was in some agencies where the peer support program had a specified role and function within the organisational response to incidents or emergencies. Two examples of this included:

1. A subset of 'peer leaders' or 'peer duty officers' who were seconded from regular duties for a specified period of time, during which they perform a leadership role in management and delegation of peer support agency wide
2. In some cases peers may be considered 'on duty' while performing their role where they are directed to respond to specific workplace incidents.

For all agencies, day-to-day functions of peers that did not relate to workplace emergencies or incidents were considered voluntary in nature.

Role and function of peer support programs

In practice, peers typically fulfil an employee/volunteer wellbeing and support function. This may be in relation to critical incidents and emergencies or to day-to-day workplace or personal wellbeing and support. The role and function of peers largely reflected the primary day to day activities of the agency:

- Agencies typically involved in emergency and incident management on a day-to-day basis were more likely to have multi-modal peer support programs that had both emergency/incident response and general day-to-day functions.
- Other agencies were more likely to have peer support programs focussed on day-to-day employee and volunteer support and wellbeing, with no emergency response function.

A number of agencies noted the evolution of peer support needs over time, particularly within those agencies involved in emergency response, where initially peer support programs evolved from needs during emergency and disaster response. Where the role of peers was initially restricted to emergency response, with time peers began to find themselves taking on more of a navigator/guidance capacity, in pointing the workforce in the direction of services and supports.

Across agencies the common core function of their peer support programs were to provide a confidential source of wellbeing support to the workforce, including listening, referral and guidance, and in some cases informal coaching and advice. For those agencies with a specified emergency/incident response role for peers, their function often also included provision of psychological first aid, risk assessment and triage to further services and support during and following critical incidents. A summary of the core activities of peers is presented below (figure 5):

Figure 5. Core functions of peer support programs.

Access to, visibility of and use of peer support programs

All agencies provide an accessible list of peers on their intranet, although there was variation in how easy the information was to find, and how often it was updated. Most agencies noted that peers were often ‘known’ through word of mouth, and existing connections with colleagues. Beyond this, there were various ways agencies promoted their programs: these included through specific identifiable clothing and badges, or transport for their peers, which was viewed as particularly useful during disaster and emergency response, and in the context of induction of new staff.

Inclusion of program information in regular organisational communications, emails and physical posters and flyers was another important means of increasing accessibility. In those agencies with a strong contingent of operational or field staff, access to other means such as intranet, was not always possible.

Those agencies with more well-established programs tended to use a multitude of methods to get peer information out to the workforce. For a number of these agencies, their peers were also involved in workforce induction, training and wellbeing programs. This served to not only increase the visibility of peers, but also boosted their credibility and provided ongoing opportunities for upskilling.

Barriers and enablers to effective peer support programs

A number of different barriers and enablers to the effectiveness of peer support programs were discussed by agencies. Key barriers included stigma around help-seeking, issues of discretion and confidentiality, challenges of the virtual environment, and the voluntary nature of the role. Enablers included well-embedded programs, programs and peer roles that were tailored to the needs and culture of each agency, and engagement of peers within ongoing program review and development.

The issue of stigma emerged as an ongoing barrier to the use and effectiveness of peer support programs, however overcoming stigma was also discussed as a key goal of peer support within a number of agencies. Further, stigma reduction was discussed as a key outcome of highly visible and mature peer support programs within the sector.

When discussing barriers to the effectiveness of peer support programs, a number of agencies discussed the challenges of provision of support within virtual environments: in particular, the requirement for those in need of support to proactively reach out to peers more formally through phone or digital channels. The virtual environment impeded the provision of informal support and check-ins with colleagues in an ad-hoc manner, and further reduced visibility of peers. Some agencies and peers discussed the adoption of more proactive approaches on the part of peers to address this, however it still represented a significant barrier to the uptake of peer support during the COVID-19 lockdown periods.

The primarily voluntary nature of peer support roles was cited by a number of agencies as a barrier to introducing rigorous requirements of peers such as mandated training or merit-based recruitment and selection. Importantly, among those agencies who did have more stringent requirements of their peers, it did not deter uptake of volunteers, and in fact in some cases was perceived to increase the value and credibility of the role. Peers themselves also discussed the value of supervision and training opportunities, indicating that further formalising training and supervision requirements is unlikely to deter potential volunteers.

In addition to barriers, there were a range of enablers discussed by agencies, including the importance of tailoring programs and the role of peers to the needs and culture of the agency/organisation, autonomy and engagement of peers, demonstration of organisational commitment to and valuing of their programs, and formal avenues for reward and recognition for peers. Another key enabler was autonomy and engagement of peers within their role and program: this was most often done through policies and practices that involved peers in the decision-making processes related to the evolution, format, training and development activities, and running of programs.

Peers

Recruitment and selection

For all agencies, individuals self-nominate to become a peer, and require endorsement from their line manager to apply. While there was a formalised selection process within each agency, the components of this were variable. The majority of agencies required a written application or expression of interest, and an interview, and had a mechanism of independently verifying the suitability of applicants for the position. Not all agencies reported on key selection and exclusion criteria. Other elements included panel involvement, linkage of training and assessment to the selection process, and a small number of agencies had a process of rating applicants (figure 6).

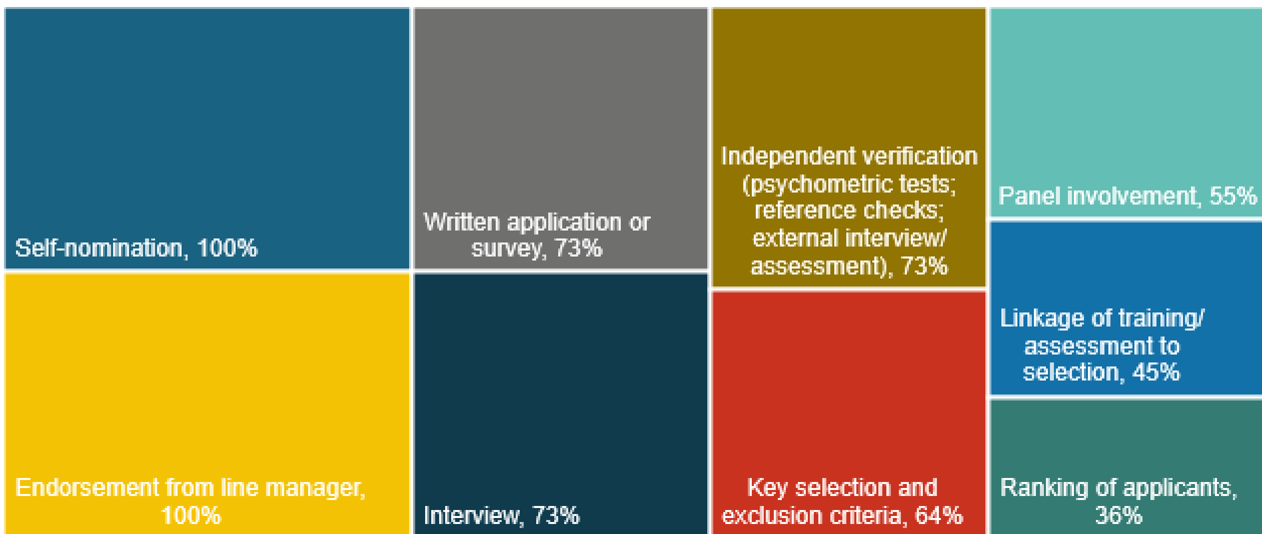


Figure 6. Peer application processes.

Personal characteristics and the needs and distribution of the workforce were also used in the recruitment and selection process. The majority of agencies required peers to have experience in the agency, just under half included some assessment of an individual's motivations for applying to become a peer, and their level of credibility among their colleagues. Personal qualities and attributes of applicants were explicitly used in the selection process for 3 agencies.

All agencies recruited peers to ensure diversity and spread across regions served by their workforce, with around half of the agencies selecting on the basis of level of need, spread across levels of seniority, and representation across all areas of the organisation. Whether or not these factors were used in the recruitment process was determined by the size, structure and functions of agencies, and the level of interest in the role (figure 7).

Figure 7. Selection of peers.

Training and Development

All agencies reported basic foundational training and accreditation requirements, with training either run internally or by external providers, and for most agencies this included experiential skills-based content. Accredited psychological first aid or mental health first aid training was also provided by the majority of agencies as a formal requirement for peers. There was agency specific content incorporated into the training for all agencies, and two thirds of agencies had a mechanism for including input from peers into their training development.

The majority of agencies provided opportunities for ongoing training and development for peers, however these were not always mandated. Ongoing skills practice and development and training opportunities were typically provided at regular peer network meetings, and for a number of agencies compulsory attendance at these was a requirement of continuing in the peer role (figure 8). This also served as a mechanism for ensuring peers maintained their skills, particularly where there were reduced opportunities from practicing peer support due to COVID-19 lockdowns.

Figure 8. Peer training and development.

Tenure and Review

Around 40% of agencies reported formalised policies and procedures regarding the tenure and review of peers. These included mechanisms for ensuring current and ongoing certifications and accreditations,

managing peer wellbeing and workload, and refreshing the peer workforce. Discussion of these processes tended to reflect the maturity of the programs, with agencies having longer standing and more well-established peer support programs more likely to have these sorts of mechanisms in place (figure 9).

Figure 9. Review of peer support programs.

Supervision and Support

All programs included a mechanism for supervision of their peers, though the extent and format of this was variable. Typically, formal supervision was conducted by trained mental health professionals either within the agency or through the agencies Employee Assistance Program. This varied in frequency, with standard yearly supervision and role review sessions required by the majority of agencies, and ad-hoc supervision and debriefing provided as required. Some agencies used formalised peer networks or communities of practice as an additional support mechanism for their peers, with dedicated communication channels and frequent meeting opportunities allowing peers to share experiences, discuss practice, and learn from others.

The peer's perspective

A total of 14 peers across 5 agencies provided written or verbal responses to a series of questions about their experience as a peer, covering the following areas:

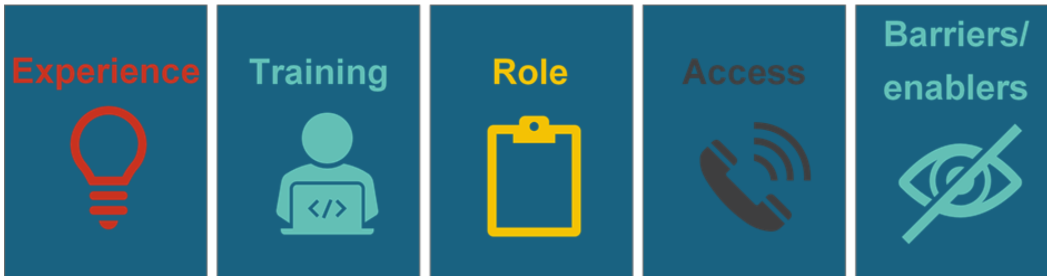


Figure 10. Topics addressed in questions for peers.

There was a broad cross-section of experience ranging from 0-3 years up to 7+ years.

Figure 11. Peers range of experience.

When asked about the functions of their role, the vast majority cited listening and emotional support as their core activity, with referral discussed by more than half, and more active forms of support including formal check-ins and stress management discussed by about a third (figure 12).

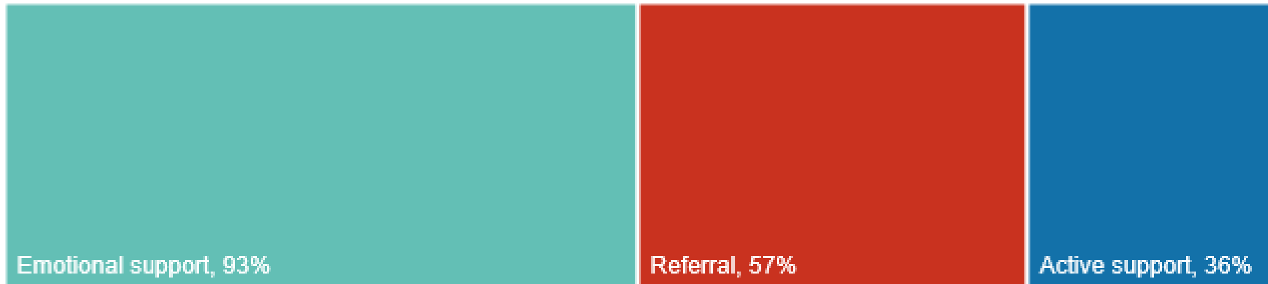


Figure 12. Functions of the peer support role.

A number of key themes emerged in their discussion of barriers and enablers to performing their role as a peer. Importantly, as with the agency interviews, culture and stigma around mental health and sharing feelings was still perceived to be a significant barrier to utilisation of peers. Most peers discussed the importance of support for their role, with the types of support discussed including formal meetings and catch-ups with other peers and coordinators, and opportunities for further training and development, with around a third of peers citing a lack of support as a barrier to them performing their role. Importantly, the only enabler reported was also formal support from their agency, and this was endorsed by the majority of peers (figure 13).

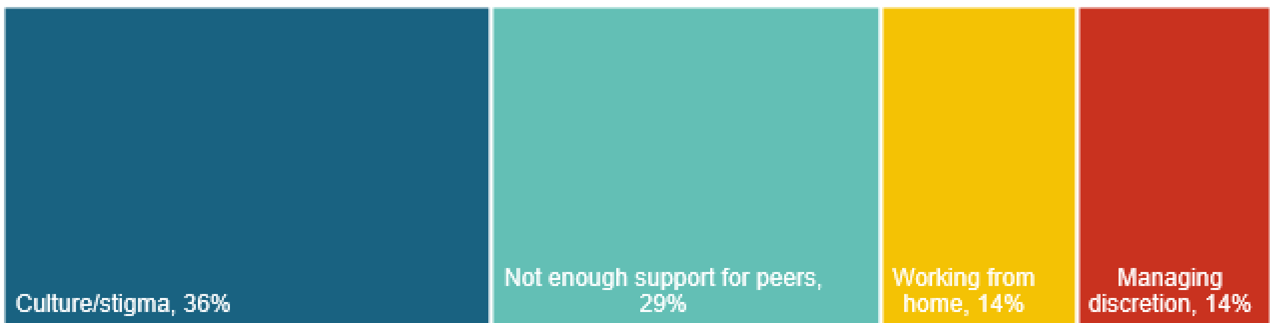


Figure 13. Barriers experienced by peers.

Measurement and evaluation

Measurement of the use and effectiveness of peer support programs was discussed by most agencies as challenging. Reasons included a lack of guidance regarding what type of information should be collected and why, as well as finding methods for collecting routine data that would not burden their peers and would be possible within their occupational roles. For example, operational and field staff may not have ready access to computers to record information. All agencies also acknowledged the difficulty in formally measuring aspects of peer support which account for a substantial component of the peer support role, such as informal conversations.

Where ongoing measurement and evaluation was embedded within programs, there was a clear rationale for how this information was used, and related to all elements of the program including resource demands and

needs, and ongoing training and development needs. Having a clear process that takes minimal time and does not include sensitive or identifiable information was important, as was the provision of the underlying rationale to peers. Collectively these all facilitated improved data collection.

There was strong endorsement of the need for metrics that would allow agencies to measure the cost and applied benefits of their programs. However, there was also a lack of clarity about how best to do this and concerns regarding the burden of enforcing additional reporting requirements on their peers who were primarily engaged in a voluntary capacity. Generally, only the more mature or historically long-standing agencies had developed processes for collection of these types of data – these tended to evolve over time, and continue to be a work in progress.

The majority of agencies did not have past or present formal evaluation frameworks or mechanisms for measurement of their programs, meaning that discussion of program effectiveness was limited to:

- Anecdotal evidence from discussions with peers
- Appetite among the workforce to become a peer
- Lack of attrition of the peer support volunteers.

A commonly cited reason for lack of formal evaluation and measurement was the absence of clear guidance regarding what a best practice peer support program looks like – making it difficult to identify what programs should be evaluated against.

The small number of agencies that did have formal mechanisms for measurement and evaluation had developed these alongside the evolution of their programs. Ongoing measurement typically used bespoke tools developed by agencies in response to need, and formal program evaluations were conducted by external agencies.

Use of peer support in multi-agency disaster response

All agencies discussed involvement in multi-agency responses to disaster or emergencies, however there were variations in the extent to and frequency with which this occurred. For some agencies, they also operated within multi-agency sites in their day-to-day functions, particularly when located in regional areas.

Some agencies heavily emphasised the model of peer support where ‘a peer is a peer’ either formally or anecdotally, which lent itself well to multi-agency response situations. In this case, peers had well-established roles and clear guidelines for practice that were in addition to specific agency activities. This enabled them to easily apply their general peer skills in a flexible manner when needed. Other agencies had more specific guidelines regarding peers being restricted to their own agency and their people. One challenge noted by many agencies related to the role of peers as a point of referral to services and supports: this was more difficult when working with people outside their agencies due to a lack of intimate knowledge of services and supports available to them.

A number of those agencies with well-established or historically long-standing peer support programs discussed the Victorian Emergency Services Peer Alliance (VESPA) as being a previously important mechanism for networking and communication between peer support programs and agencies across the Victorian sector. The formalisation of an alliance such as this was something discussed as being a potentially important facilitator of multi-agency approaches, allowing for knowledge sharing and

communication between coordinators of programs, and a forum for sector-wide quality improvement. On a more practical level, interviews revealed that the existing networks program coordinators had across the sector equipped them with visibility and knowledge of cross sector resources and needs during multi-agency responses.

A number of agencies discussed the value of having a framework or guidelines for multi-agency disaster response that could guide individual agency policies and procedures. This would allow each agency autonomy and flexibility in how they prioritise their own people and needs, and identify areas where they have capacity to assist other agencies. This was highlighted by all agencies as a current gap in the sector.

The concept of a coordinator to oversee multi-agency responses was considered valuable, however a number of barriers and sensitivities to this were also identified, including the issue of which agency would take on that leadership role. Suggestions included this being an externally appointed and funded role, or one that was shared amongst sector agencies on a regular rotation basis.

Results of the literature review

Search results

Electronic searches yielded 709 records, with 547 of these (minus duplicates) screened on the basis of title and abstract. Of these, 83 were subject to full text review, with 10 studies eligible for inclusion. Eighty-four additional records were identified through manual citation searches (n = 18), websites (n = 62) and organizations (n = 4), of which nine were eligible for inclusion. Overall, 19 studies were eligible for inclusion in the review (see Supplementary Figure 1).

Study characteristics

As seen in Table 2, a total of 19 studies describing 13 peer support programs were identified. The most common study design was quantitative (*n* = 7), including surveys (*n* = 3), pre-post studies (*n* = 2), and a single randomised controlled trial (RCT) and historical cohort study, followed by peer support program overviews without evaluative data (*n* = 5), including protocols of an RCT (Baker et al., 2021) and prospective cohort study (Guay et al., 2017) and overviews of a comprehensive staff support service (Queensland Ambulance Service, 2018; Scully, 2011), as well as qualitative studies (*n* = 3), mixed-method studies (*n* = 2), a single review and single best practice guideline. Most studies originated in Australia (*n* = 5) or the United States (*n* = 5), with slightly fewer studies from England (*n* = 4), Canada (*n* = 4) and Germany (*n* = 1). Approximately 40% of studies comprised of first responder populations, including police (*n* = 4), paramedics (*n* = 3) and firefighters (*n* = 1), with an additional 30% of studies in military populations (*n* = 3) or mixed first responder and military populations (*n* = 3). A minority of studies were conducted in mining employees (*n* = 2), with single studies conducted in public transportation operators and youth social services employees. One study failed to report the population. Sample size ranged from 9 to 8200 participants.

Table 2. Key study characteristics.

Author	Country	Design	Population	Program
Agarwal et al. (2020)	UK	Qualitative (interviews)	Not specified (*n* = 9)	StRaW
Baker et al. (2021)	US	Program overview (ongoing RCT)	Military[c]	Airman's Edge PSP
Castellano (2012)	US	Program overview	First responders, military[c]	Reciprocal Peer Support
Clarner et al. (2017)	GER	Quantitative (historical cohort study)	Public transportation operators (*n* = 259)	PFA
Duranceau (2017)[a]	CAN	Quantitative (survey)	Military (*n* = 6,700 Regular members; *n* = 1,500 Reservists)	OSISS
Greenberg et al. (2011)	UK	Qualitative (interviews)	Military (*n* = 330)	TRiM
Guay et al. (2017)	CAN	Program overview (protocol for prospective cohort study)	Youth social services employees[c]	MYSS-UI peer programme
Gulliver et al. (2016)	US	RCT	Firefighters (*n* = 171)	Project Reach out
Hale (2021)[a]	US	Quantitative (survey)	Police (*n* = 99)	Hartford Police PSP
Hohner (2017)[a]	CAN	Mixed-methods	Police (*n* = 87)	Police Department PSP
Milliard et al. (2020)	CAN	Qualitative (interviews)	Police (*n* = 9)	York Regional Police's PSP
Money et al. (2011)[b]	US	Best practice guidelines	Military (active duty and veterans)[c]	NA
QAS (2013)[b]	AUS	Mixed-methods	Paramedics (*n* = 1042)	Priority One
QAS (2018)[b]	AUS	Overview	Paramedics[c]	Priority One
Sayers et al. (2019)	AUS	Quantitative (pre/post)	Mining employees (*n* = 1651)	Mates in Mining
Scully (2011)	AUS	Overview	Paramedics[c]	Priority One
Tynan et al. (2018)	AUS	Quantitative (pre/post)	Mining employees (*n* = 1280)	Mates in Mining
Watson & Andrews (2018)	UK	Quantitative (survey)	Police (*n* = 859)	TRiM
Whybrow et al. (2015)	UK	Review	Military, police[c]	TRiM

Notes. AUS = Australia; CAN = Canada; GER = Germany; MYSS-UI = Montreal Youth Social Services-University Institute; OSISS = Operational Stress Injury Social Support; PFA = Psychological first aid; PSP = peer support program; QAS = Queensland Ambulance Service; StRaW = Sustaining Resilience at Work; TRiM = Trauma Risk Management; UK = United Kingdom; US = United States; *n* = sample size. [a] = Unpublished dissertations identified through the database search or grey literature search. [b] = Grey literature reports. [c] = Study did not collect any evaluative outcome data so does not have a sample.

Narrative descriptive synthesis of the literature

A narrative descriptive synthesis approach was used to map the available evidence from the past decade to the recommendations (and their subcomponents) developed by Creamer et al. (2012) for peer support in high-risk organisations (the consensus guidelines). The distribution of the recommendations and subcomponents across the 19 peer-reviewed studies and grey literature reports can be found in Appendix D with further details from each study and/or report under each recommendation summarised in Appendix E. As some peer support programs were described in multiple papers or reports, information was aggregated when considering results.

A notable caveat of this mapping approach is the reliance on information reported in the studies or reports, with no further program details or evaluative data sought from authors. As such, some studies or reports may not have comprehensively described all aspects of the peer support program due to publication constraints. With regards to peer support program evaluation in particular, it is likely that additional comprehensive evaluation data, if not reported, does not exist.

Goals of peer support programs

- Most peer support programs had clearly defined goals (79%).
- Common goals included identifying colleagues at risk (67%) and, providing low level psychological intervention (67%), followed by facilitating pathways to professional help (60%), and providing an empathetic listening ear (53%).
- With regards to identifying risk, there was variability in what this referred to, including identifying:
  - suicidal behaviours,
  - symptoms of psychological disorders, and
  - everyday stressors on wellbeing.
- Where a goal was to provide low level psychological intervention, there was little consensus about what was being provided with a number of interventions noted:
  - psychological first aid,
  - crisis management,
  - brief CBT techniques,
  - motivational interviewing,
  - suicide prevention training, and
  - a combination of psychoeducation, problem solving, information sharing and mentoring in positive coping.
- Additional goals that extended upon the consensus guidelines emerged. These included:
  - reducing stigma,
  - encouraging help seeking behaviours, and
  - shifting organisational culture.

Selection of peer supporters

- Less than half of the studies described the selection process of peers.
- Of the studies that described this process, undergoing an application/selection process was common (mentioned in 80% of studies) but with significant heterogeneity. Some programs required nomination (by peers, superiors, or self-nomination), some psychological testing, some interview panels, and some referee reports.
- Having the peer supporter as a member of the target population was common (70%), with fewer studies identifying that a peer should be respected by their colleagues (40%).
- Very few studies reported that the peers needed to have direct experience within the field of work of the target population (20%), however it is likely that this subcomponent is inferred in many of the programs (but is not explicitly reported).

- Additional factors around the selection of peers that extended upon the consensus guidelines emerged. Many programs identified important attributes that peers should have, including:
  - having good communication and listening skills,
  - willingness to assist colleagues in difficult/confronting circumstances (and remain calm in these situations),
  - stable or in recovery with their own psychological health issues,
  - having demonstrated time management skills, and
  - having the ability to maintain confidentiality.

Training and accreditation

- The majority of studies (90%) described the training and accreditation process of their peer support programs.
- Most studies reported the time requirement, which ranged from single sessions of 90mins to 6-day trainings. Some programs used a three-tiered process for training.
- All studies noted that their peer supporters were trained in basic skills to fulfil their roles. The most common skills were:
  - psychoeducation around understanding post-traumatic events and stress, common mental health disorders (PTSD, substance use, distress), and the impact of stress on work,
  - crisis response planning and intervention procedures,
  - basic counselling skills (e.g., motivational interviewing, reflecting, questioning),
  - communication/listening skills, and
  - knowledge of referral options.
- Less common was training for peers in:
  - Self-care practices
  - Importance of confidentiality
  - Suicide prevention and crisis training (i.e., Applied Suicide Intervention Skills Training)
  - Other skills (mentioned in single programs)
  - Cultural competence
  - Therapeutic boundaries

Training and accreditation

- Recovery/resilience tools
- A quarter of studies reported that trainees were required to meet specific standards in training before commencing their peer support role.
- On-going supervision and training were reported in almost half of the studies (47%).

Role of mental health professionals (MHPs)

- Where the role of MHPs was noted, it was always in the context of involvement in training or supervision.
- It was unclear what specifically the MHPs undertook during training or supervision, though there was mention of supervision guidelines within one group of studies.

Role of peer supporters

- The role of peer supporters was mentioned in most studies; however, many were lacking in detail.
- Of the studies that did provide information on their role, this included:
  - maintaining confidentiality,
  - not seeing people on an ongoing basis,
  - seeking specialist advice when needed, and
  - offering referral pathways for complex cases.

- An additional consideration around the role of peer supporters that extended upon the consensus guidelines emerged in a number of studies. That is, that peer support workers are volunteers that complete the peer support work alongside their day-to-day responsibilities.

Access to peer supporters

- Around a third of studies mentioned some aspect of access to peer support, however within these some detail was lacking (such as whether employees could self-select their peer supporter).
- A small number reported that the peer support service is offered as the initial point of contact.

- Additional information around access to peer supporters that extended upon the consensus guidelines emerged, notably that:
  - peers and employees should be matched based on shared experience, and
  - access should be easy (in terms of physical location and operation hours)

Looking after peer supporters

- Very few studies provided specific details on how programs look after peer supporters, and of those that did there was no mention of operating hours of the service or access to expert advice from clinicians.
- Of the third who mentioned some aspect of this, engaging in regular supervision and having access to a MHP for their own self-care were strategies undertaken by organisations to look after their peer supporters.

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Program evaluation
➢ Though over two-thirds of studies reported some form of evaluation, only a single program was evaluated by an independent evaluator on a regular basis.

Program outcomes

Clear from the literature is that the measurement of peer support program outcomes is substantially varied – both in the breadth and depth of what is assessed. Appendix D provides a detailed table presenting each of the studies that included an evaluation of outcomes, along with the findings. The main points from that table are summarised here.

- The Queensland Ambulance Service Staff Support Program (Priority One) was formally evaluated twice by an external review committee, 10 and 20 years after program inception. The evaluation showed that Priority One (including the peer support program) was valued and being well utilised. The review committee endorsed that Priority One, including the peer support program, remain in its current form with continued independent evaluation. Of note, no changes were proposed for the recruitment, training (including refresher training) and monthly supervision for the peer supporters.
- Overall, the quantitative and qualitative studies examining the effectiveness of various peer support programs reported positive impacts, including:
    - reductions in sickness related absence following potentially traumatic events (Clarner et al., 2017),
    - following training, feeling more able to support colleagues (and own) mental health as a peer support worker (Agarwal et al., 2020; Tynan et al., 2018),
    - reductions in stigma (Milliard, 2020; Sayers et al., 2019),
    - peer support services being helpful (Duranceau, 2017), and
    - general satisfaction with the program (Hale, 2021)

The best practices identified for peer support programs guideline (Money et al., 2011) noted that metrics of success include:

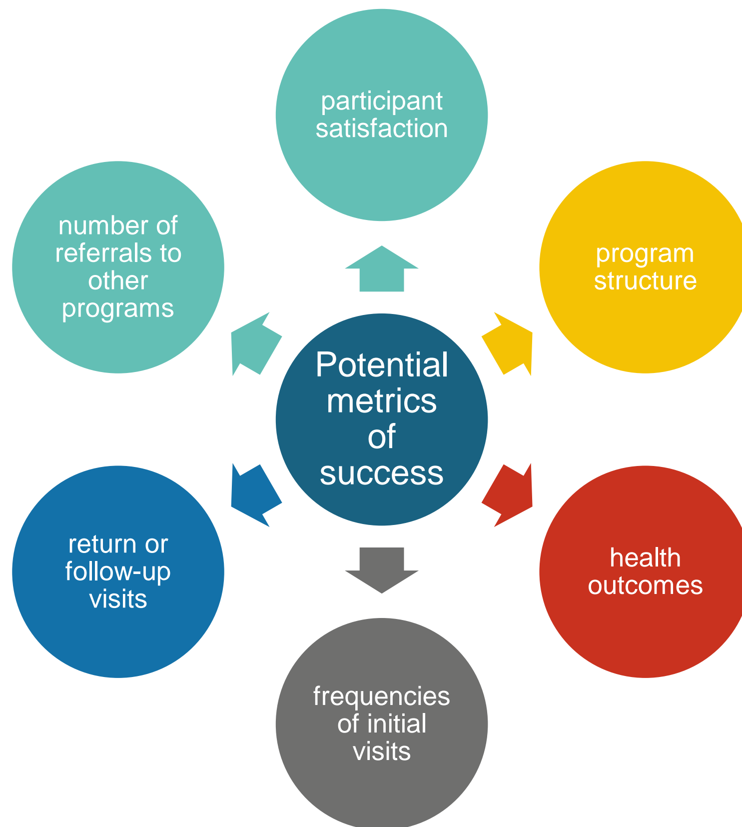

Figure 14. Metrics of success according to Money et al. (2011).

These authors caution that conducting evaluations of programs may raise concerns around confidentiality and reduce trust in the program.

Barriers and enablers to successful peer support programs

Evidence emerged beyond the design and structure of peer support programs that identified a number of key barriers and enablers to such programs. These are important considerations for agencies, both at the outset of implementing a peer support program, and as factors to routinely monitor and assess over time.

Barriers and enablers
➢ The following factors were routinely identified as facilitators seeking peer support: o Availability of services to rural and remote communities o Easy access - physical location (convenient) and hours of operation o Perceived credibility of peer supporters (e.g., shared lived experience) ➢ The following factors were often identified as barriers seeking peer support: o Stigma o Confidentiality o Fears that it will impact their career

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Appendix A

Key questions for agencies

Interview questions

1. **Does your agency have a peer support program?**
2. **How long has the program been in place?**
3. **When thinking about emergency/disaster response/significant incidents, are peer support programs used? If so, how does this work?**
4. **In responses where multiple agencies are involved:**
    a. How does this differ from single agency responses?
    b. How is peer support embedded into the response? (single or cross agency?)
    c. Were there things that worked well?
    d. Were there challenges/barriers?
5. **Are your peers:**
    a. Paid/unpaid
    b. Specified role/additional to usual role
    c. Explore differences
6. **How are peers selected?**
7. **Are there formal training requirements for peers?**
8. **What type of supervision and support models are in place for your peers?**
9. **Do you currently evaluate or measure your peer support program?**
10. **Are there any specific factors or considerations regarding your agency's structure and operations that might impact on:**
    - use of or need for peer support programs
    - how peer support programs might be structured or implemented

Peer questions

1. **How long have you been a peer?**
2. **How were you trained to be a peer?**
3. **What is the role of peers within your agency?**
4. **How often do you provide peer support, and what type of support do you provide?**
5. **How do people within your workplace know about and access/make contact with peers?**
6. **Are there any factors specific to your agency or the sector that are barriers/challenges to, or support/facilitate your role as a peer?**

Appendix B

Data themes

Supplementary table 1. *Interview data themes.*

Question	Themes
Selection and recruitment	**Characteristics of peers** Personal qualities and attributes Motivation Experience in the agency evidence of credibility among colleagues Peers at different levels of seniority Diversity of peers Spread across regions/areas Representing different areas of the organisation Distribution reflects need **Processes** Self-nomination Panel involvement Endorsement from line manager Key selection and exclusion criteria Written application or survey Linkage of training/assessment to selection Interview Ranking of applicants Independent verification (psychometric tests; reference checks; external interview/assessment)
Tenure and review	Mechanism for ensuring current and ongoing certifications/accreditations Mechanism for managing peer wellbeing and load Mechanism for refreshing the peer workforce
Training and development	Basic training and accreditation requirements Linkage of training requirements to selection/recruitment Opportunities for ongoing training and development Input from peers Accredited PFA/Mental health first aid Experiential skills-based training Agency specific content
Supervision and support	Oversight and coordination Mechanism for regular review of peers Supervision model that includes mental health professionals Mechanisms for support by management/other peers Mechanisms for ongoing development and practice improvement

Roles and function of peers	Listening/confidential support Coaching and advice Referral and guidance Identification of risk to the psychological safety of colleagues Support wellbeing of colleagues Psychological first aid Critical incident support
Measurement and evaluation	Evaluation of program Evaluation of peer performance Measurement of need and usage **Challenges relating to reporting and measurement**: confidentiality concerns; resourcing limitations; lack of time; lack of motivation; difficulty in measuring activities
Multi-agency responses	**Multi-agency approaches:** shared peers; central coordination of resources; provision of resources and psychoeducation to workforce and community Barriers to multi-agency approaches: No formal framework or process **Facilitators of multi-agency approaches:** co-location of agencies in regional sectors; existing formal and informal networks among peers and peer coordinators; complementary skills and resources"
How are peers accessed/promoted/identified	**Access**: intranet lists; central phone lines; **Visibility:** Clothing; badges; photos and information **Promotion:** celebration activities; inclusion in organisational communications; word of mouth; peer presence in induction and training; emails/posters **Incorporation of peers into organisation well-being:** peers involved in workforce wellbeing programs; peers sitting within a wellbeing team
Barriers and facilitators for programs	**Barriers:** Virtual environment; lack of visibility of peers; **Facilitators:** Tailoring programs and role to the needs and culture of the agency/organisation; autonomy and engagement of peers within their role and program; demonstration of organisational commitment and value; reward and recognition

Supplementary table 2. *Peer data themes.*

Question	Themes
1	1. 0-3 years 2. 4-6 years 3. 7+ years
2	1. Simon Brown-Greaves training 2. Other initial training with regular ongoing training 3. Other training with fb group 4. AV peer support training
3	Emotional support Referral Active support
4	> Once per year > Once per month Rarely No requests since being in role
5	Physical advertisements Digital advertising Verbal reminders Initiated by others Peer and staff liaise directly
6	Barrier - culture/stigma Barrier - not enough support for peers Barrier - working from home Barrier - managing discretion Facilitate - well supported

Appendix C

Identification of relevant studies for the literature review

Searches were conducted on four electronic databases (Medline, PsycINFO, Embase, Central Register of Controlled Trials) combining terms related to peer support programs in high-risk organisations (see Supplementary Table 1 for search strategy). Manual searches of the reference lists of key studies were conducted to identify any additional relevant publications. To retrieve relevant grey literature, a Google Scholar Advanced Search was conducted, with the first five pages of records included for screening. A manual search of relevant government and institutional reports from 15 organisations was also conducted. Selection of these organisations was guided by the project working group and included: Country Fire Authority; Victoria Police; Fire Rescue Victoria; Queensland Fire & Emergency Services; NSW Fire & Rescue; Victoria State Emergency Service; Parks Victoria; Department of Jobs, Precincts and Regions: Agriculture Victoria; Environment Protection Authority; Melbourne Water; VicForests; Department of Environment, Land, Water and Planning; Queensland Ambulance Service; Bush Search and Rescue; and NSW Parks and Wildlife.

The search strategy included all publication types with the exception of conference abstracts, published from 2011 until September 2021.

Study selection

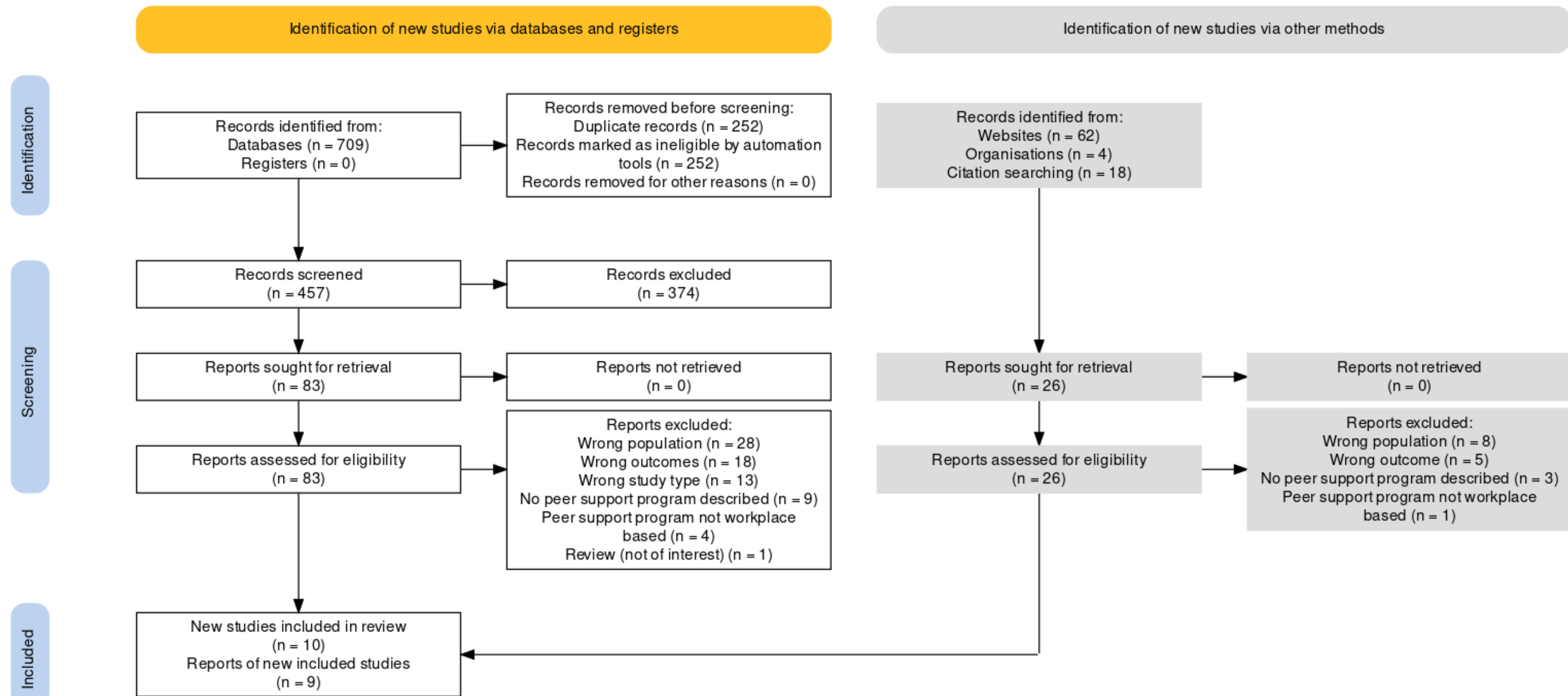
Eligible studies comprised any design that reported on the development, implementation, and evaluation of peer support approaches to support employee's mental health in high-risk organisations. Eligible studies were peer-reviewed studies or grey literature reports (including dissertations) comprising of reviews, trials reporting on program efficacy, qualitative or descriptive quantitative studies, as well as evaluations of programs. The search excluded peer support programs in healthcare populations (with the exception of paramedics) or psychiatric and chronic disease populations (e.g., substance use, critical and acute illness, physical health). Studies assessing external peer support programs outside of an organisational context were also excluded.

Following a pilot test of eligibility criteria, records were initially screened on the basis of title and abstract by one reviewer (I.F.), with 20% of studies screened by a second reviewer (A.S.). All records not excluded on the basis of title and abstract were passed on for full text review. One reviewer (I.F.) reviewed full text records for potentially eligible studies, with 20% of studies screened by a second reviewer (A.S.). Any disagreements at the full-text screening stage were resolved by discussion, or through adjudication with a third reviewer (L.D.). Records deemed ineligible at full-text screening were excluded with the reason recorded. All screening was conducted using the systematic review management tool Covidence (Innovation, 2017).

Supplementary Table 3. Example Search Strategy Conducted in Medline Database on 20th September 2021

1	peer.mp.	97747
2	"peer support".mp.	5405
3	"support program*".mp.	4282
4	"Critical incident stress management".mp.	105
5	CISM.mp.	108
6	"Critical incident stress debriefing".mp.	99
7	"CISD".mp.	190
8	"Crisis management debriefing".mp.	0
9	"psychological first aid".mp.	235
10	"mental health".mp.	220776
11	"mental illness".mp.	32001
12	"mental disorder".mp.	9955
13	wellness.mp.	11828
14	"well*being".mp.	20878
15	depress*.mp.	584163
16	anxi*.mp.	277600
17	PTSD.mp.	28397
18	posttraum*.mp.	41258
19	"post-traum*".mp.	64145
20	"post traum*".mp.	64145
21	"suicid*".mp.	102558
22	1 or 2	97747
23	3 or 4 or 5 or 6 or 7 or 8 or 9	4889
24	10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21	1063391
25	22 and 23 and 24	233
26	limit 25 to (english language and yr="2011 -Current")	183

Supplementary Figure 4. PRISMA flowchart



Data charting

Data were charted using a standardized data collection form by two reviewers, capturing information on key study characteristics. This included author, year, title, study setting, study design, population, peer support program characteristics (e.g., program name, conceptual framework, goals of program) and peer characteristics (e.g., selection, training, and supervision process), as well as information on program implementation (e.g., facilitators and barriers) and evaluation (e.g., utilization, effectiveness, perceptions).

Quality assessment

Peer reviewed studies and grey literature reports providing empirical evaluative data (quantitative, qualitative or mixed-methods) were assessed for quality using the Quality Assessment with Diverse Studies (QuADS; see Supplemental Table 2 for full criteria) (Harrison et al., 2021), a tool developed specifically to appraise the quality of heterogenous study designs. The scoring of each criterion ranged from 0 to 3 (with 0 = no mention at all, 3 = detailed description), with scores of 0 or 1 considered 'low quality' and scores of 2 or 3 considered 'high quality' (Iqbal et al., 2021; Newman et al., 2021) . Two independent reviewers (I.F. and A.S.) completed the quality assessment, with any disagreements resolved by discussion, or through adjudication with a third reviewer (L.D.).

Supplementary Table 5. Quality Assessment with Diverse Studies (QuADS) Criteria

QuADS Criteria	0	1	2	3
1. **Theoretical or conceptual underpinning to the research**	No mention at all.	General reference to broad theories or concepts that frame the study. e.g., key concepts were identified in the introduction section.	Identification of specific theories or concepts that frame the study and how these informed the work undertaken. e.g., key concepts were identified in the introduction section and applied to the study.	Explicit discussion of the theories or concepts that inform the study, with application of the theory or concept evident through the design, materials and outcomes explored. e.g., key concepts were identified in the introduction section and the application apparent in each element of the study design.
2. Statement of research aim/s	No mention at all.	Reference to what they sought to achieve embedded within the report but no explicit aims statement.	Aims statement made but may only appear in the abstract or be lacking detail.	Explicit and detailed statement of aim/s in the main body of report.
3. Clear description of research setting and target population	No mention at all.	General description of research area but not of the specific research	Description of research setting is made but is lacking detail e.g., 'in primary care	Specific description of the research setting and target population of study e.g., 'nurses and

QuADS Criteria	0	1	2	3
		environment e.g., 'in primary care.'	practices in region [x]'.	doctors from GP practices in [x] part of [x] city in [x] country.'
4. The study design is appropriate to address the stated research aim/s	No research aim/s stated or the design is entirely unsuitable e.g. a Y/N item survey for a study seeking to undertake exploratory work of lived experiences.	The study design can only address some aspects of the stated research aim/s e.g., use of focus groups to capture data regarding the frequency and experience of a disease.	The study design can address the stated research aim/s but there is a more suitable alternative that could have been used or used in addition e.g., addition of a qualitative or quantitative component could strengthen the design.	The study design selected appears to be the most suitable approach to attempt to answer the stated research aim/s.
5. Appropriate sampling to address the research aim/s	No mention of the sampling approach.	Evidence of consideration of the sample required e.g., the sample characteristics are described and appear appropriate to address the research aim/s.	Evidence of consideration of sample required to address the aim. e.g., the sample characteristics are described with reference to the aim/s.	Detailed evidence of consideration of the sample required to address the research aim/s. e.g., sample size calculation or discussion of an iterative sampling process with reference to the research aims or the case selected for study.
6. Rationale for choice of data collection tool/s	No mention of rationale for data collection tool used.	Very limited explanation for choice of data collection tool/s. e.g., based on availability of tool.	Basic explanation of rationale for choice of data collection tool/s. e.g., based on use in a prior similar study.	Detailed explanation of rationale for choice of data collection tool/s. e.g., relevance to the study aim/s, co-designed with the target population or assessments of tool quality.
7. The format and content of data collection tool is appropriate to address the stated research aim/s	No research aim/s stated and/or data collection tool not detailed.	Structure and/or content of tool/s suitable to address some aspects of the research aim/s or to address the aim/s superficially e.g., single item response that is very general or an open-response item to capture content which requires probing.	Structure and/or content of tool/s allow for data to be gathered broadly addressing the stated aim/s but could benefit from refinement. e.g., the framing of survey or interview questions are too broad or focused to one element of the research aim/s.	Structure and content of tool/s allow for detailed data to be gathered around all relevant issues required to address the stated research aim/s.
8. Description of data collection procedure	No mention of the data collection procedure.	Basic and brief outline of data collection procedure e.g., 'using a questionnaire distributed to staff'.	States each stage of data collection procedure but with limited detail or states some stages in detail but	Detailed description of each stage of the data collection procedure, including when, where and how data was

QuADS Criteria	0	1	2	3
			omits others e.g., the recruitment process is mentioned but lacks important details.	gathered such that the procedure could be replicated.
9. Recruitment data provided	No mention of recruitment data.	Minimal and basic recruitment data e.g., number of people invited who agreed to take part.	Some recruitment data but not a complete account e.g., number of people who were invited and agreed.	Complete data allowing for full picture of recruitment outcomes e.g., number of people approached, recruited, and who completed with attrition data explained where relevant.
10. Justification for analytic method selected	No mention of the rationale for the analytic method chosen.	Very limited justification for choice of analytic method selected. e.g., previous use by the research team.	Basic justification for choice of analytic method selected e.g., method used in prior similar research.	Detailed justification for choice of analytic method selected e.g., relevance to the study aim/s or comment around of the strengths of the method selected.
11. The method of analysis was appropriate to answer the research aim/s	No mention at all.	Method of analysis can only address the research aim/s basically or broadly.	Method of analysis can address the research aim/s but there is a more suitable alternative that could have been used or used in addition to offer a stronger analysis.	Method of analysis selected is the most suitable approach to attempt answer the research aim/s in detail e.g., for qualitative interpretative phenomenological analysis might be considered preferable for experiences vs. content analysis to elicit frequency of occurrence of events.
12. Evidence that the research stakeholders have been considered in research design or conduct.	No mention at all.	Consideration of some the research stakeholders e.g., use of pilot study with target sample but no stakeholder involvement in planning stages of study design.	Evidence of stakeholder input informing the research. e.g., use of pilot study with feedback influencing the study design/conduct or reference to a project reference group established to guide the research.	Substantial consultation with stakeholders identifiable in planning of study design and in preliminary work e.g., consultation in the conceptualisation of the research, a project advisory group or evidence of stakeholder input informing the work.
13. Strengths and limitations critically discussed	No mention at all.	Very limited mention of strengths and limitations with omissions of many key issues. e.g., one or two	Discussion of some of the key strengths and weaknesses of the study but not complete. e.g., several	Thorough discussion of strengths and limitations of all aspects of study including design, methods, data

QuADS Criteria	0	1	2	3
		strengths/limitations mentioned with limited detail.	strengths/limitations explored but with notable omissions or lack of depth of explanation.	collection tools, sample & analytic approach.

Supplementary Table 6. Quality assessment scores (*n* = 12)

Study	C 1	C 2	C 3	C 4	C 5	C 6	C 7	C 8	C 9	C 10	C 11	C 12	C 13	Total
Agarwal et al. (2020)	2	2	1	3	1	3	3	2	1	3	3	2	1	27
Clarner et al. (2017)	1	3	3	3	2	1	3	3	2	0	3	0	2	26
Duranceau (2017)[a]	2	3	3	3	1	2	3	2	3	1	3	1	3	30
Greenberg et al. (2011)	1	3	2	3	2	0	3	2	1	0	3	0	1	21
Gulliver et al. (2016)	1	3	2	3	1	1	3	3	3	0	3	2	2	27
Hale (2021)[a]	1	3	3	3	2	2	3	3	1	0	3	0	3	27
Hohner (2017)[a]	1	3	1	3	2	1	1	2	2	0	2	0	2	20
Milliard et al. (2020)	2	2	3	3	2	0	3	2	3	2	3	2	2	29
QAS (2013)[b]	0	2	2	3	2	2	2	3	2	0	0	3	0	21
Sayers et al. (2019)	1	3	2	2	1	2	3	3	1	0	3	0	3	24
Tynan et al. (2018)	1	3	2	2	2	3	3	1	2	0	3	3	3	28
Watson & Andrews (2018)	2	3	2	2	1	1	3	1	1	1	3	0	3	23
Total out of 36[c]	15	33	26	33	19	18	33	27	22	7	32	13	25	
Percentage of maximum possible score achieved[d]	42%	92%	72%	92%	53%	50%	92%	75%	61%	19%	89%	36%	69%	

Note. C = criterion; NA = not applicable; QAS = Queensland Ambulance Service. Studies/reports that were not appraised for quality as they did not report any empirical evaluative outcome data (e.g., only provided a descriptive overview of the peer support program) included the following: Baker et al. (2021), Castellano (2012), Guay et al. (2017), Money et al. (2011), QAS (2018), Scully (2011) and Whybrow et al. (2015).

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

[c] = total score of 36 refers to number of studies/reports appraised for quality (i.e., 12 studies) multiplied by the maximum score for each criterion (i.e., 3)

[d] = Percentage of maximum possible score achieved refers to the total score for each criterion (i.e., score of 15 for C1) divided by the maximum total score (i.e., 36)

Appendix D

Program evaluation and outcomes

Table 7. Table of outcomes of included studies.

Author	Program	Program evaluation
Agarwal et al. (2020)	StRaW	**Design**: Qualitative interviews with staff members completing StRaW training (*n* = 9) **Outcome:** Perceptions of StRaW program **Findings**: StRaW training positively impacted individual's ability to support their colleagues and their own mental wellbeing
Baker et al. (2021)	Airman's Edge PSP	**Design**: A program evaluation is currently underway in an ongoing RCT in military personnel **Outcome:** Quantitative outcomes (e.g., suicide behaviour/ideation, PTSD, depression) and objective indicators (e.g., program utilization) and subjective indicators (e.g., perceptions of work)
Clarner et al. (2017)	PFA	**Design**: Quantitative historical cohort study of public transportation operators (*n* = 259) **Outcome**: Sickness absence **Findings**: Peer support had a positive effect on sickness absence following PTE, and was found to be most beneficial after less severe PTE
Duranceau (2017)[a]	OSISS	**Design**: Cross-sectional quantitative survey on military personnel completed via interview (*n* = 6,700 Regular members; *n* = 1,500 Reservists) **Outcome**: Program utilization, perceived level of help **Findings:** 1.21% of personnel reported seeking help from an OSISS Peer Support Coordinator in the past 12 months. 41% reported that the perceived level of help received was helpful, while 20% reported that it was not at all helpful.
Guay et al. (2017)	MYSS-UI peer programme	**Design**: A prospective cohort study is currently underway to evaluate program effectiveness in youth social services employees. It will use a mixed-method approach (surveys and interviews) to compare outcomes of individuals who used or did not use the peer support program following a PTE. **Outcomes**: Aggression, PTSD, perceived stress, depression, anxiety, work functioning
Gulliver et al. (2016)	Project Reach out	**Design**: RCT on firefighters (*n* = 171) randomised to either: (a) Reach Out training group format; (b) Reach Out training video format; (c) behavioural health video (control condition). **Outcomes**: Connecting firefighters with treatment, treatment effectiveness **Findings**: Significantly more successful interventions at follow-up in

Author	Program	Program evaluation
		both Reach Out training formats compared to the control condition. The video-based training was associated with greatest effectiveness
Hale (2021)[a]	Hartford Police PSP	**Design**: Quantitative surveys with sworn police officers (*n* = 99) **Outcomes**: Utilization, satisfaction, and perceptions around confidentiality and stigma **Findings:** 34% of personnel said they had used the peer support service, with 88% noting that they were satisfied to very satisfied with the program. The majority of personnel who used the peer support program reported they would accept a referral to the mental health provider. No difference was found in perceived stigma between personnel who had used the service and those who had not. Around half of personnel reported that the peer support program should continue in its current form
Hohner (2017)[a]	Police Departm ent PSP	**Design**: Mixed-methods: online survey (*n* = 71) and interviews (*n* = 16) with police peer support team members **Outcomes**: Perceived implementation barriers F**indings**: The purpose of the program needs to be clearly defined, organisational endorsement is required for successful implementation and barriers to implementation include stigma, trust and confidentiality
Milliard et al. (2020)	York Regional Police's PSP	**Design**: Qualitative interviews of police peer supporters (*n* = 9) **Outcomes**: Program utilisation and impact **Findings**: Peer support was reported to contribute to mental health literacy and stigma reduction (i.e., officers were more comfortable to seek help following program implementation)
Money et al. (2011)[b]	NA	• It is vital to collect data on effectiveness of the program, including process and impact evaluations. • Metrics of success include participant satisfaction, program structure, health outcomes, frequencies of initial visits, return or follow-up visits, and number of referrals to other programs • **Caution**: surveys/other measures to evaluate programs may be counter-productive, they may raise concerns around confidentiality and reduce trust in the program
Sayers et al. (2019) Tynan et al. (2018)	Mates in Mining	**Design:** Quasi-Experimental studies (pre/post) in mining employees. **Outcomes**: • Training (*n* = 1280): perception of mental health stigma, help seeking behaviours, perception of workplace commitment to employee mental health (Tynan et al., 2018) • Implementation (*n* = 1651) (baseline, 6 months and 18 months following delivery of MIM): help seeking behaviours (Sayers et al., 2019) **Findings**: miners completing the MIM and supervision training reported increased confidence in identifying peers experiencing mental health difficulties, felt more comfortable to start a conversation around mental health and recommend support services. Following implementation of the program, improvements in likelihood of help seeking for mental health problems and reduced stigma towards mental health problems Program was found to be feasible and acceptable to miners • 1275 miners completed in the MATES general awareness and connector training

Author	Program	Program evaluation
		• 117 supervisors completed training supervision training
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	**Design**: Self-report questionnaire and focus groups with paramedics (*n* = 1042) led by an external review committee. Formal external evaluations have been conducted 10 and 20 years after program inception. The following findings are from the 20 year review (QAS, 2013). Data collection is confidential and non-identifying. **Outcomes**: Staff satisfaction and validated measures of mental health (e.g., depression, anxiety) **Findings**: Overall, the Staff Support Program, including the PSP, is valued and well utilized. Between Jan-Dec 2011, 44% of personnel accessed the PSP; significantly greater satisfaction in Priority One services was reported in personnel who accessed peer supporters compared to those who did not; 27% of personnel said that they could seek out peer supporters if they felt like they needed support; personnel who accessed peer supporters had greater satisfaction in their work, reported a greater sense of connection to their work were less likely to report burnout. **Recommendations***: Review committee endorsed the Staff Support Program to remain in its current form with continued independent evaluation, no changes were proposed for the recruitment, training (including refresher training) and monthly supervision for the PSP.
Greenberg et al. (2011) Watson & Andrews (2018) Whybrow et al. (2015)	TRiM	**Design**: Review **Mixed findings:** • No evidence that TRiM led to worsening in psychological health. • May have a positive effect on organizational functioning. However findings from a RCT (Greenberg et al., 2010) indicate slight significant impacts on psychological health and stigma reduction. • TRiM is acceptable and suitable to military and police populations • TriM may reduce sickness absence following traumatic event

Notes. MYSS-UI = Montreal Youth Social Services-University Institute; MIM = Mates in Mining; OSISS = Operational Stress Injury Social Support; NA = not applicable; PFA = Psychological first aid; PSP = peer support program; QAS = Queensland Ambulance Service; StRaW = Sustaining Resilience at Work; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation.

*See QAS (2013) report for full list of recommendations.

Supplementary Table 8. Distribution of Creamer et al. (2012) recommendations and subcomponents across eligible peer-reviewed studies and grey literature reports

	Agarwal	Baker	Castellano	Clarner	Duranceau[a]	Greenberg	Guay	Gulliver	Hale[a]	Hohner[a]	Milliard	Money[b]	QAS 2013[b]	QAS 2018[b]	Sayers	Scully	Tynan	Watson	Whybrow
1. The goals of peer support	x	x	x	x	x	x	x	x	x			x		x	x		x	x	o
(1a) provide an empathetic, listening ear;	x	x	x	x	x			x				x		x					
(1b) provide low level psychological intervention	x	x		x	x		x		x			x		x	x		x		
(1c) identify colleagues who may be at risk to themselves or others	x	x	x			x	x	x				x		x			x	x	
(1d) facilitate pathways to professional help			x	x	x	x		x				x		x			x	x	
2. Selection of peer supporters		x	x		x				x	o	x	x	x	x		x			
(2a) be a member of the target population		x	x		x				x		x			x		x			
(2b) be someone with considerable experience within the field of work of the target population					x						x								
(2c) be respected by his/her peers (colleagues)		x									x			x		x			
(2d) undergo an application and selection process prior to appointment		x							x	x	x	x	x	x		x			
3. Training and Accreditation	x	x	x	o	x	x	x	x	x	o		x	o	x	x	x	x	x	

	Agarwal	Baker	Castellano	Clarner	Duranceau[a]	Greenberg	Guay	Gulliver	Hale[a]	Hohner[a]	Milliard	Money[b]	QAS 2013[b]	QAS 2018[b]	Sayers	Scully	Tynan	Watson	Whybrow
(3a) be trained in basic skills to fulfil their role	x	x	x	x	x	x	x	x	x	x		x	x	x	x	x	x	x	
(3b) meet specific standards in that training before commencing their role									o				x	x		x			
(3c) participate in on-going training, supervision, review, and accreditation		x	x	x					x			x	x	x		x			
4. Role of Mental Health Professionals		x	x		x		o	x	x	x			x	x	x		x		
(4a) occupy the position of clinical director																			
(4b) be involved in supervision and training		x	x		x			x	x	x			x	x	x		x		
5. Role of peer supporters	x		x	o		o			x	x		x	x	x	o	x	o		
(5a) not limit their activities to high-risk incidents - part of routine employee health and welfare	x													x					
(5b) not generally see "clients" on an ongoing basis but offer referral pathways			x											x					
(5c) maintain confidentiality	x		x						x	x		x	x	x		x			
6. Access to peer supporters			o	x	o			o	x			o		x					
(6a) Routinely offered as the initial point of contact after exposure to a PTE				x					x					x					
(6b) Ability to self-select their peer supporter																			

	Agarwal	Baker	Castellano	Clarner	Duranceau[a]	Greenberg	Guay	Gulliver	Hale[a]	Hohner[a]	Milliard	Money[b]	QAS 2013[b]	QAS 2018[b]	Sayers	Scully	Tynan	Watson	Whybrow
7. Looking after peer supporters		x	x						o			o	x	x		x			
(7a) not be available on call 24 hours per day																			
(7b) be easily able to access care for themselves from a MHP														x		x			
(7c) be easily able to access expert advice from a clinician																			
(7d) engage in regular peer supervision within the program		x	x										x	x		x			
8. Program evaluation	o	o		o	o		o	o	o	o	o	o	x		o		o	o	o
(8a) independent evaluator on a regular basis													x						
9. Implementation					x	x			x	x	x	x				x		x	
(9a) Facilitators					x	x					x	x				x			
(9b) Barriers						x			x	x								x	

Note. x = study adheres to recommendation and subcomponents of peer support following Creamer et al. (2012) guidelines; o = study described aspect of peer support program that aligned with Creamer et al. (2012) overall recommendation, but did not describe a recommendation subcomponent; MHP = mental health practitioner; PTE = potentially traumatic event.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Appendix E

Supplementary Table 9. *Summary of evidence*

1. The goals of peer support

Author	Program	The goals of peer support
Agarwal et al. (2020)	StRaW	• Provide an **empathetic, listening ear** to support colleagues and encourage resilience • **Identify**, prevent, and minimize the effect of everyday stressors on well-being • Provide **low level psychological intervention** (i.e., mentoring peers to positive, resilience enhancing actions, including positive coping)
Baker et al. (2021)	Airman's Edge PSP	• Provide an **empathetic, listening ea**r to promote positive health-related behaviour • **Identify colleagues who may be at risk** • Provide **low level psychological intervention** (i.e., motivational interviewing skills) • Reduce suicidal behaviours
Castellano (2012)	Reciprocal Peer Support	• Provide an **empathetic, listening ear** to foster connection (i.e., pure, non-judgemental presence) • **Identify** colleagues who may be at risk through information gathering and risk assessment • **Facilitate pathways to professional help** through case management and referrals • Resilience affirmation, praise, and advocacy
Clarner et al. (2017)	PFA	• Provide an **empathetic, listening ear** • Provide **low level psychological intervention** (i.e., PFA) • **Facilitate pathways to professional help** • Provide protection from bystanders
Duranceau (2017)[a]	OSISS	• Provide an **empathetic, listening ear** (i.e., active listening) • **Facilitate pathways to professional help,** as an adjunct to mental healthcare • Provide **low level psychological intervention** (i.e., crisis management)
Greenberg et al. (2011)	MYSS-UI peer programme	• **Identify** colleagues who may be at risk • **Provide low level psychological intervention** to prevent and mitigate the development of post-traumatic reactions, acute stress and PTSD among workers who experienced PTE (i.e., peers with clinical experience provide post-traumatic counselling, including brief CBT)
Gulliver et al. (2016)	Project Reach out	• **Identify** colleagues who may be at risk (Assess phase) • Provide an **empathetic, listening ear** (Approach phase)

Phoenix AUSTRALIA

Author	Program	The goals of peer support
		• **Facilitate pathways to professional help** (Act phase) • Reduce stigma
Hale (2021)[a]	Hartford Police PSP	• Provide **low level psychological intervention** (i.e., crisis intervention training) • Preventative (i.e., reach colleagues before problems start occurring)
Money et al. (2011)[b]	NA	• Provide an **empathetic, listening ear** within an environment of credibility and trust (within shared experience) • **Identify** colleagues who may be at risk • **Facilitate pathways to professional help** • Provide **low level psychological intervention** (i.e., crisis management, support groups) • Mentoring, engagement and information exchange • Promote awareness and reduce stigma
Sayers et al. (2019) Tynan et al. (2018)	Mates in Mining	• **Identify** colleagues who may be at risk • Reduce suicidal behaviours • **Facilitate pathways to professional help** • Provide **low level psychological intervention** (i.e., Applied Suicide Intervention Skills Training) • Promote awareness of mental health • Reduce stigma
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	• Provide an **empathetic, listening ear** to foster perceived support • Provide **low level psychological intervention** (e.g., reflective, intentional listening; problem solving; information sharing and psychoeducation) • **Identify** colleagues who may be at risk and reduce suicidal behaviours • **Facilitate pathways to professional help** • Reduce stigma • Positive influence on culture • Reduce barriers to support
Greenberg et al. (2011) Watson & Andrews (2018) Whybrow et al. (2015)	TRiM	• **Identify** colleagues who may be at risk for developing psychological disorders following exposure to a PTE • **Facilitate pathways to professional help** • Encourage long-term organisational cultural change (i.e., reduce stigma) Note. Does not aim to reduce psychological distress

Notes. MYSS-UI = Montreal Youth Social Services-University Institute; OSISS = Operational Stress Injury Social Support; NA = not applicable; PFA = Psychological first aid; PSP = peer support program; QAS = Queensland Ambulance Service; StRaW = Sustaining Resilience at Work; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): Peer supporters should: (1a) provide an empathetic, listening ear; (1b) provide low level psychological intervention; (1c) identify colleagues who may be at risk to themselves or others; and (1d) facilitate pathways to professional help.

2. Selection of peer supporters

Author	Program	Selection of peer supporters
Baker et al. (2021)	Airman's Edge PSP	• **Member of target population** • **Respected by peers** • Undergo an **application and selection process** prior to appointment (e.g., nomination by squadron leaders and service members) • Important attributes: communication and listening skills, leadership potential, demonstrated calmness under pressure, ability to conduct briefings/presentations
Castellano (2012)	Reciprocal Peer Support	• Inactive **member of the target population** • **S**hared life experience • Important attributes: empathy, active listening skills, direct/indirect communication
Duranceau (2017)[a]	OSISS	• **Member of the target population** (i.e., has experience with an operational stress injury but is stable/further along in their recovery) • Be someone with **considerable experience within the field of work** of the target population
Hale (2021)[a]	Hartford Police PSP	• **Member of the target population** • Undergo an **application and selection process** prior to appointment (e.g., self-recommendation letter, psychological testing, interview with human resources, an EAP mental health representative and the peer support coordinator) • Successfully complete training and agree to ongoing training • Important attributes: Maintain confidentiality and can manage time effectively

Author	Program	Selection of peer supporters
Hohner (2017)[a]	Police Department PSP	• Undergo an **application and selection process** prior to appointment (e.g., committee solicited nominations for peer team selection) Note. Criteria used to select a peer supporter is unclear
Milliard et al. (2020)	York Regional Police's PSP	• **Member of the target population** • **Considerable experience in the field** (have at least 5 years of service) • **Respected by his/her colleagues** (nominated by a peer) • Undergo an **application and selection process** prior to appointment (e.g., nominated by a peer, interview by a suitably constituted panel including two peer-team members and a clinical psychologist, undergoing a safeguard assessment) • Must have lived (personal or professional) experience with a traumatic event
Money et al. (2011)[b]	NA	• Undergo an **application and selection process** prior to appointment (e.g., interview by a suitably constituted panel including administrative staff, mental health professional, current peer supporter) • Important attributes: communication and listening skills, leadership ability/potential, ability to stay calm under pressure, previous experience or training, stable/in recovery for any psychological health issues
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	• **Member of target population** • **Respected by peers** • **S**hared experience • Undergo an **application and selection process** prior to appointment (e.g., written application, self-selected or recommended, referee reports from immediate supervisor, a colleague and a peer supporter, interview with an internal and external Priority One counsellor, final interview following training to determine suitability) • Important attributes: resilience, not suffering from mental health issues (e.g., PTSD), willing to assist colleagues in difficult/confronting circumstances Selected from all levels in QAS • Peer Support Officer Coordinator selected in each Local Ambulance Service Network (LASN). They are the point of contact for Priority One State Office, the LASN peer support external counselling supervisor, the LASN peer support officer group, and the LASN manager

Notes. OSISS = Operational Stress Injury Social Support; NA = not applicable; PSP = peer support program; QAS = Queensland Ambulance Service.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): In order to become a peer supporter, the individual should: (2a) be a member of the target population, (2b) be someone with considerable experience within the field of work of the target population, (2c) be respected by his/her peers (colleagues), and (2d) undergo an application and selection process prior to appointment that should include interview by a suitably constituted panel.

3. Training and Accreditation

Author	Program	Training and Accreditation
Agarwal et al. (2020)	StRaW	2-day training in **basic skills** to fulfil their role, including: • Effects of stress and mental health problems on individuals at work • Training in structured interview for distress • How to practically manage stressed individuals • Mentoring positivity and resilience enhancing actions • Guidance for recognising need for professional intervention
Baker et al. (2021)	Airman's Edge PSP	3-day training in **basic skills** to fulfil their role, including: • MI skills (e.g., open-ended questions, summary statements, decisional balance exercises, readiness rulers) • Crisis response planning • Psychoeducation (e.g., sleep disturbance, social support and meaning in life) • Participate in **on-going supervision**
Castellano (2012)	Reciprocal Peer Support	Trained in **basic skills** to fulfil their role, including: • Cultural competence • Communication skills • Managing crisis

Author	Program	Training and Accreditation
		• Peer support principles • Recovery/resilience tools • Stigma • Self-care practices • Participate in **on-going training and supervision**
Clarner et al. (2017)	PFA	Trained in **basic skills** to fulfil their role, including: • 16-hour PFA session (specifics not reported) • Participate in **on-going training** with advanced PFA training every 1–2 years
Duranceau (2017)[a]	OSISS	Trained in **basic skills to fulfil their role**, including • Active listening • Problem solving • Crisis management • **Referral options** • Therapeutic boundaries • Self-care practices
Guay et al. (2017)	MYSS-UI peer programme	Trained in **basic skills to fulfil their role**, peer helpers trained in key cognitive and behavioural intervention strategies for acute stress Training includes: • Understanding post-traumatic events and stress • Understand the professional, personal and family consequences • Defusing procedures and debriefings • Immediate post-intervention measures • Beck socratic questioning • Meichenbaum stress inoculation
Gulliver et al. (2016)	Project Reach out	• Delivered in two formats (in-person group or video) • Single, 90min training session

Author	Program	Training and Accreditation
		Trained in **basic skills** to fulfil their role, including • Assess phase: how to identify a peer experiencing mental health difficulties (e.g., depression, alcohol misuse), including changes in mood, behaviour • Approach phase: learn how to engage distressed peers a confidential and nonconfrontational way (based on motivational interviewing principles) • Act phase: learn how to strengthen personnel's commitment to behaviour change and information about referral options
Hale (2021)[a]	Hartford Police PSP	Three tiers of training in **basic skills** to fulfil their role, including • 2-hour training with peer support coordinator and social worker • Crisis intervention training • Critical stress incident management training and additional 40 hours of training • Participate in **on-going training** (e.g., annual refresher course) • Meet **specific standards** in that training **before commencing** their role (e.g., attend all training) Criteria for deselection: • Breaches of confidentiality • Failure to attend training • Loss of good standing within the department
Hohner (2017)[a]	Police Department PSP	• 3-day training, including **basic skills** to fulfil their role (specifics not reported)
Money et al. (2011)[b]	NA	Trained in **basic skills** to fulfil their role, including: • Listening skills • Crisis procedures and how to facilitate a support group • Stress-related injuries • Substance abuse

Author	Program	Training and Accreditation
		• Confidentiality • **Referral options** • Participate in **on-going training** (annually) Note. Training should align with needs of the organisation
Sayers et al. (2019) Tynan et al. (2018)	Mates in Mining	Trained in **basic skills** to fulfil their role, including three tiers of training • All workers complete 1-hour general awareness training, including: awareness of mental illness and suicide; warning signs; encourage help seeking • Volunteers ("connectors") complete 4-hour gate keeper training, including skills on identifying risk and techniques for engaging peers • Selected volunteers complete 2-day applied suicide intervention skills training' (ASIST) • Supervisor training, including introduction to mental health and how to manage staff with mental health issues
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	6-day in person training, including: • Components of PFA, humanistic counselling; strength focused counselling; narrative counselling; and mindfulness techniques, micro counselling • Trained in **basic skills** to fulfil their role**:** communication skills, essential counselling skills (reflecting, attending, questioning providing feedback), impact of their own loss/grief on their work if they encounter a bereaved colleague, concepts of stress, distress, critical incident stress, PTSD, impacts of shift work and health approaches to physical/mental health in context of ambulance service work, understanding of suicidality, confidentiality • **Referral** options within Priority One Program • Meet **specific standards** in that training **before commencing** their role (i.e., final interview following training to determine suitability) • Participate in **on-going training** (bi-annual refresher training and workshops) **and supervision** (group and individual)

Author	Program	Training and Accreditation
		Peer Support Officer Coordinator • Additional 2-day training, to further develop leadership capacity
Greenberg et al. (2011) Watson & Andrews (2018) Whybrow et al. (2015)	TRiM	3-5 day training in **basic skills** to fulfil their role, including: • Psychological risk assessment (10-item scale to help personnel process the facts of the event and their thoughts/feelings in chronological order) • Basic training in trauma psychology

Notes. MYSS-UI = Montreal Youth Social Services-University Institute; OSISS = Operational Stress Injury Social Support; NA = not applicable; PFA = Psychological first aid; PSP = peer support program; QAS = Queensland Ambulance Service; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): Peer supporters should (3a) be trained in basic skills to fulfil their role (such as listening skills, psychological first aid, information about referral options); (3b) meet specific standards in that training before commencing their role; and (3c) participate in on-going training, supervision, review, and accreditation.

4. Role of Mental Health Professionals

Author	Program	Role of Mental Health Professionals
Baker et al. (2021)	Airman's Edge PSP	• Certified peer instructors are involved in **supervision and training**
Castellano (2012)	Reciprocal Peer Support	• Partnered with peers to offer specialist advice and referral pathways • Involved in **supervision and training**
Duranceau (2017)[a]	OSISS	• Involved in **training**
Guay et al. (2017)	MYSS-UI peer programme	• MYSS-UI peers with clinical experience responsible for clinical aspects of the intervention

Author	Program	Role of Mental Health Professionals
Gulliver et al. (2016)	Project Reach out	• Involved in **training**
Hale (2021)[a]	Hartford Police PSP	• Involved in **supervision and training**
Hohner (2017)[a]	Police Department PSP	• Involved in **training**
Sayers et al. (2019) Tynan et al. (2018)	Mates in Mining	• Be involved in **training** Note. Supervision was not conducted by a mental health professional
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	• Involved in **supervision**. Guidelines for supervision have been developed (e.g., expectations of external Priority One counsellors as supervisors)

Notes. MYSS-UI = Montreal Youth Social Services-University Institute; OSISS = Operational Stress Injury Social Support; PSP = peer support program; QAS = Queensland Ambulance Service; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by (Creamer et al., 2012): Mental health professionals should: (4a) occupy the position of clinical director, and (4b) be involved in supervision and training

5. Role of peer supporters

Author	Program	Role of peer supporters
Agarwal et al. (2020)	StRaW	• Volunteers • **Part of routine employee health and welfare**

Author	Program	Role of peer supporters
		• Maintain **confidentiality**
Castellano (2012)	Reciprocal Peer Support	• Volunteers for a trial period of 6 months before employed as a peer • Access to **specialist advice** and mental health professional to **offer referral pathways** • Maintain **confidentiality**
Clarner et al. (2017)	PFA	• Volunteer
Hale (2021)[a]	Hartford Police PSP	• Volunteers • **Maintain confidentiality**
Hohner (2017)[a]	Police Department PSP	• Primarily for critical incidents • **Maintain confidentiality** (e.g., when considering where to meet peer)
Money et al. (2011)[b]	NA	• Volunteer • Written job description of peer support role • Role boundaries (e.g., set limits on interactions) • **Maintain confidentiality,** which helps overcome stigma and fear of repercussions. Should have confidentiality policies (e.g., do not record contact on employment record, limit sharing with supervisors)
Sayers et al. (2019) Tynan et al. (2018)	Mates in Mining	• Volunteers
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority one	• Volunteers • Maintain **confidentiality** • Knows limits of their role as a peer supporter and **refers appropriately** • Part of r**outine employee health and welfare** • Peer support officer code of conduct has been developed, outlining: code of ethics, roles and responsibilities, values and respect, confidentiality, supervision, entitlements
Greenberg et al. (2011) Watson & Andrews (2018) Whybrow et al. (2015)	TRiM	• Volunteer non-medical staff (ideally from managerial position)

Notes. NA = not applicable; PFA = Psychological first aid; PSP = peer support program; QAS = Queensland Ambulance Service; StRaW = Sustaining Resilience at Work; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): Peer supporters should (5a) not limit their activities to high-risk incidents but, rather, should also be part of routine employee health and welfare; (5b) not generally see "clients" on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases; and (5c) maintain confidentiality (except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others).

6. Access to peer supporters

Author	Program	Access to peer supporters
Castellano (2012)	Reciprocal Peer Support	• Match peers based on shared experiences
Clarner et al. (2017)	PFA	• Peer supporters notified within 1 hour of PTE as **initial point of contact**
Duranceau (2017)[a]	OSISS	• Involved in outreach work (e.g., peer support groups, information sessions)
Gulliver et al. (2016)	Project Reach out	• Act phase activated when personnel have responded positively to approach phase
Hale (2021)[a]	Hartford Police PSP	• Offered as the **initial point of contact** after exposure to a high-risk incident
Money et al. (2011)[b]	NA	• There should be easy access to peer supporters, in terms of physical location and operation hours
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	• **Initial point of contact** for personnel in personal or emotional distress • 'On duty' PSO activated to follow-up critical incidents (ideally within 24- 48 hours) to provide defusing, normalization of reactions and offer a referral pathway

Notes. OSISS = Operational Stress Injury Social Support; NA = not applicable; PFA = Psychological first aid; PSP = peer support program; QAS = Queensland Ambulance Service; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): Peer supporters should normally be offered as the initial point of contact after exposure to a high-risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters.

7. Looking after peer supporters

Author	Program	Looking after peer supporters
Baker et al. (2021)	Airman's Edge PSP	• Engage in **regular peer supervision** to receive support, discuss barriers, monitor outcomes and program fidelity
Castellano (2012)	Reciprocal Peer Support	• Engage in **regular peer supervision**
Hale (2021)[a]	Hartford Police PSP	• Encourage temporary leave of absence when peer supporters are in circumstances that may interfere with their peer support role
Money et al. (2011)[b]	NA	• Facilitate connection between peer supporters, including conference calls, newsletters, online groups
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	• Engage in **regular (monthly) peer supervision**. Topics includes recognition of trauma symptoms, self-awareness and mindfulness, trauma processing and change/adaptation • Required to attend 75% of group supervision sessions and two individual supervision sessions annually • Easily able to **access care for themselves** from a mental health practitioner • Support from Peer Support Officer Coordinator Note. Asked to make a commitment to be available after hours when necessary, but are able to take TOIL

Notes. NA = not applicable; PSP = peer support program; QAS = Queensland Ambulance Service.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): In recognition of the potential demands of the work, peer supporters should (7a) not be available on call 24 hours per day, (7b) be easily able to access care for themselves from a mental health practitioner if required, (7c) be easily able to access expert advice from a clinician, and (7d) engage in regular peer supervision within the program.

8. Program evaluation

Author	Program	Program evaluation
Agarwal et al. (2020)	StRaW	**Design**: Qualitative interviews with staff members completing StRaW training (*n* = 9) **Outcome:** Perceptions of StRaW program **Findings**: StRaW training positively impacted individual's ability to support their colleagues and their own mental wellbeing
Baker et al. (2021)	Airman's Edge PSP	**Design**: A program evaluation is currently underway in an ongoing RCT in military personnel **Outcome:** Quantitative outcomes (e.g., suicide behaviour/ideation, PTSD, depression) and objective indicators (e.g., program utilization) and subjective indicators (e.g., perceptions of work)
Clarner et al. (2017)	PFA	**Design**: Quantitative historical cohort study of public transportation operators (*n* = 259) **Outcome**: Sickness absence **Findings**: Peer support had a positive effect on sickness absence following PTE, and was found to be most beneficial after less severe PTE
Duranceau (2017)[a]	OSISS	**Design**: Cross-sectional quantitative survey on military personnel completed via interview (*n* = 6,700 Regular members; *n* = 1,500 Reservists) **Outcome**: Program utilization, perceived level of help **Findings:** 1.21% of personnel reported seeking help from an OSISS Peer Support Coordinator in the past 12 months. 41% reported that the perceived level of help received was helpful, while 20% reported that it was not at all helpful.

Author	Program	Program evaluation
Guay et al. (2017)	MYSS-UI peer programme	**Design**: A prospective cohort study is currently underway to evaluate program effectiveness in youth social services employees. It will use a mixed-method approach (surveys and interviews) to compare outcomes of individuals who used or did not use the peer support program following a PTE. **Outcomes**: Aggression, PTSD, perceived stress, depression, anxiety, work functioning
Gulliver et al. (2016)	Project Reach out	**Design**: RCT on firefighters (*n* = 171) randomised to either: (a) Reach Out training group format; (b) Reach Out training video format; (c) behavioural health video (control condition). **Outcomes**: Connecting firefighters with treatment, treatment effectiveness **Findings**: Significantly more successful interventions at follow-up in both Reach Out training formats compared to the control condition. The video-based training was associated with greatest effectiveness
Hale (2021)[a]	Hartford Police PSP	**Design**: Quantitative surveys with sworn police officers (*n* = 99) **Outcomes**: Utilization, satisfaction, and perceptions around confidentiality and stigma **Findings:** 34% of personnel said they had used the peer support service, with 88% noting that they were satisfied to very satisfied with the program. The majority of personnel who used the peer support program reported they would accept a referral to the mental health provider. No difference was found in perceived stigma between personnel who had used the service and those who had not. Around half of personnel reported that the peer support program should continue in its current form
Hohner (2017)[a]	Police Department PSP	**Design**: Mixed-methods: online survey (*n* = 71) and interviews (*n* = 16) with police peer support team members **Outcomes**: Perceived implementation barriers **Findings**: The purpose of the program needs to be clearly defined, organisational endorsement is required for successful implementation and barriers to implementation include stigma, trust and confidentiality
Milliard et al. (2020)	York Regional Police's PSP	**Design**: Qualitative interviews of police peer supporters (*n* = 9) **Outcomes**: Program utilisation and impact **Findings**: Peer support was reported to contribute to mental health literacy and stigma reduction (i.e., officers were more comfortable to seek help following program implementation)

Author	Program	Program evaluation
Money et al. (2011)[b]	NA	• It is vital to collect data on effectiveness of the program, including process and impact evaluations. • Metrics of success include participant satisfaction, program structure, health outcomes, frequencies of initial visits, return or follow-up visits, and number of referrals to other programs • **Caution**: surveys/other measures to evaluate programs may be counter-productive, they may raise concerns around confidentiality and reduce trust in the program
Sayers et al. (2019) Tynan et al. (2018)	Mates in Mining	**Design:** Quasi-Experimental studies (pre/post) in mining employees. **Outcomes**: • Training (*n* = 1280): perception of mental health stigma, help seeking behaviours, perception of workplace commitment to employee mental health (Tynan et al., 2018) • Implementation (*n* = 1651) (baseline, 6 months and 18 months following delivery of MIM): help seeking behaviours (Sayers et al., 2019) **Findings**: miners completing the MIM and supervision training reported increased confidence in identifying peers experiencing mental health difficulties, felt more comfortable to start a conversation around mental health and recommend support services. Following implementation of the program, improvements in likelihood of help seeking for mental health problems and reduced stigma towards mental health problems Program was found to be feasible and acceptable to miners • 1275 miners completed in the MATES general awareness and connector training • 117 supervisors completed training supervision training
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	**Design**: Self-report questionnaire and focus groups with paramedics (*n* = 1042) led by an external review committee. Formal external evaluations have been conducted 10 and 20 years after program inception. The following findings are from the 20 year review (QAS, 2013). Data collection is confidential and non-identifying. **Outcomes**: Staff satisfaction and validated measures of mental health (e.g., depression, anxiety) **Findings**: Overall, the Staff Support Program, including the PSP, is valued and well utilized. Between Jan-Dec 2011, 44% of personnel accessed the PSP; significantly greater satisfaction in Priority One services was reported in personnel who accessed peer supporters compared to those who did not; 27% of personnel said that they could seek out

Author	Program	Program evaluation
		peer supporters if they felt like they needed support; personnel who accessed peer supporters had greater satisfaction in their work, reported a greater sense of connection to their work were less likely to report burnout. **Recommendations***: Review committee endorsed the Staff Support Program to remain in its current form with continued independent evaluation, no changes were proposed for the recruitment, training (including refresher training) and monthly supervision for the PSP.
Greenberg et al. (2011) Watson & Andrews (2018) Whybrow et al. (2015)	TRiM	**Design**: Review **Mixed findings:** • No evidence that TRiM led to worsening in psychological health. • May have a positive effect on organizational functioning. However findings from a RCT (Greenberg et al., 2010) indicate slight significant impacts on psychological health and stigma reduction. • TRiM is acceptable and suitable to military and police populations • TriM may reduce sickness absence following traumatic event

Notes. MYSS-UI = Montreal Youth Social Services-University Institute; MIM = Mates in Mining; OSISS = Operational Stress Injury Social Support; NA = not applicable; PFA = Psychological first aid; PSP = peer support program; QAS = Queensland Ambulance Service; StRaW = Sustaining Resilience at Work; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Bolded items correspond with the subcomponents of the recommendations outlined by Creamer et al (2012): Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation.

*See QAS (2013) report for full list of recommendations.

9. Organisational considerations

Author	Program	Program implementation
Duranceau (2017)[a]	OSISS	• Facilitators to seeking peer support Peer support services are available to rural and remote regions, who encounter access barriers to professional mental health care
Hale (2021)[a]	Hartford Police PSP	• Barriers to seeking peer support: Stigma and confidentiality • Other: Steering committee should be used to help guide program development (e.g., goals, objectives) and implementation, including how to maintain funding overtime
Hohner (2017)[a]	Police Department PSP	• Barriers to seeking peer support: trust, confidentiality, stigma attached to mental health, lack of management by-in. • Issues with confidentiality around meeting, e.g., in order to meet, both officers may have to show themselves as unavailable to respond to a call • Barriers to peer selection and training: limited time capacity of peer workers, inability to interview all nominees, difficulty is scheduling training • Promotion: information sessions, introducing program at in-service training, posting biographies of peer supporters on intranet (in a location where only those who wanted to access there service could find them). Although the biographies served to connect peers based on shared experiences, some peer supporters found the biographies too personal and potentially stigmatising.
Milliard et al. (2020)	York Regional Police's PSP	• Facilitators to seeking peer support: peer support is strengthened by the perceived credibility of peer supporters (e.g., shared lived experience) and subsequent trustworthiness
Money et al. (2011)[b]	NA	Facilitators to seeking peer support ("key ingredients"): • Providing social support: emotional support, information and advice, practical assistance, help understanding/interpreting events • Experiential knowledge: derived from actual experience, resulting in greater perceived credibility • Trust: greater trust in peer supports than health professionals • Confidentiality: protecting confidentiality is vital • Easy access: physical location (convenient) and hours of operation

Author	Program	Program implementation
		• Other: Delivery may be in-person, on phone, video-conference. Need adequate planning and preparation, including identifying the needs of target population and align program goals to the needs, develop processes and policies
QAS (2013)[b] QAS (2018)[b] Scully (2011)	Priority One	• Facilitators to seeking peer support: well known peer support program has contributed to a shift in cultural attitude towards mental health and treatment seeking; peer support officers are likely to be known by personnel
Greenberg et al. (2011) Watson & Andrews (2018) Whybrow et al. (2015)	TRiM	• Barriers to seeking support: fears that seeking help may harm their career, peers will have lower confidence

Notes. OSISS = Operational Stress Injury Social Support; NA = not applicable; PSP = peer support program; QAS = Queensland Ambulance Service; TRiM = Trauma Risk Management.

[a] = Unpublished dissertations identified through the database search or grey literature search.

[b] = Grey literature reports.

Appendix F

Peer Support Programs Self-Evaluation Tool

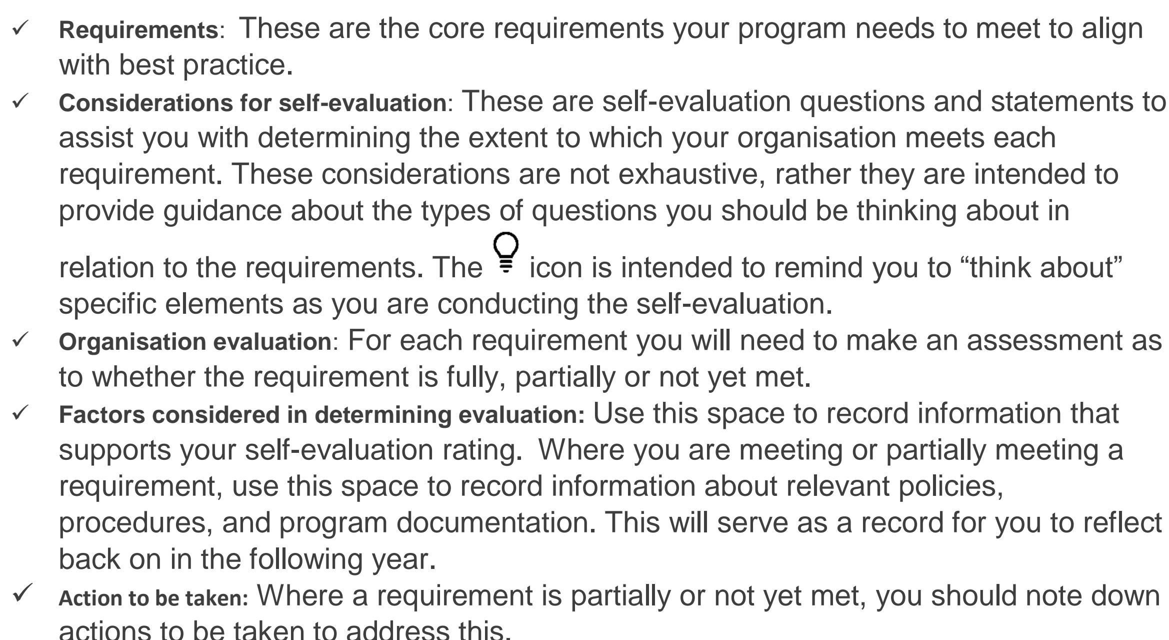
Instructions for use:

The purpose of this tool is to aid your organisation in assessing your peer support program against best practice guidelines. It presents the core requirements needed to meet best practice, across 11 program elements.

Not all organisations are at the same maturity with their peer support program and nor do all peer support programs need to look exactly alike – the function and needs of your organisation must be front of mind when using this tool. The tool will allow you to identify areas of strength and areas for improvement to align your program to best practice. It can also be used as a guide to support you in the development of a new peer support program or in the redesign or re-establishment of a peer support program.

This self-evaluation should be performed by your organisation's peer support program coordinator, or someone with a good working knowledge and understanding of the program, in consultation with representatives from the peer support workers – their perspective is critical in assessing the implementation and quality of your program. The tool is intended to be used annually as part of routine program quality assurance processes, allowing you to track your program's development over time.

The tool consists of a series of worksheets representing each program element. Each worksheet follows the same format:



- ✓ **Requirements**: These are the core requirements your program needs to meet to align with best practice.
- ✓ **Considerations for self-evaluation**: These are self-evaluation questions and statements to assist you with determining the extent to which your organisation meets each requirement. These considerations are not exhaustive, rather they are intended to provide guidance about the types of questions you should be thinking about in relation to the requirements. The icon is intended to remind you to "think about" specific elements as you are conducting the self-evaluation.
- ✓ **Organisation evaluation**: For each requirement you will need to make an assessment as to whether the requirement is fully, partially or not yet met.
- ✓ **Factors considered in determining evaluation:** Use this space to record information that supports your self-evaluation rating. Where you are meeting or partially meeting a requirement, use this space to record information about relevant policies, procedures, and program documentation. This will serve as a record for you to reflect back on in the following year.
- ✓ **Action to be taken:** Where a requirement is partially or not yet met, you should note down actions to be taken to address this.

Record of the evaluation:

Conducted by	
Date	

Model and structure of the peer support program

Requirements:

- Day-to-day and emergency/significant incident response peer support needs have informed the development and structure of our peer support program
- The model of the peer support program has been tailored to reflect the role and function of peers within our organisation
- Within our program structure there is a designated role with responsibility for ongoing program coordination
- The model and structure of our peer support program is still relevant for our organisation

Considerations for self-evaluation:

- Does our peer support program address the needs of our workforce in relation to what we do day-to-day and in emergency/significant incident response?
  - Do we have a good understanding of the day-to-day peer support needs of our workforce?
  - What type of role does our organisation play during emergency/significant incident response, and is there capacity and need for specified peer roles?
- Does our program structure include funding/capacity for a role to oversee and coordinate the program?
- Has anything changed since our last self-evaluation that is relevant to the model and structure of our peer support program?

Organisation evaluation:

The structure of our peer support program is suitable for the day-to-day needs of our organisation

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

The structure of our peer support program is suitable during an emergency response event

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our peer support program has been tailored to reflect the role and function of peers within our organisation

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our peer support program is still relevant for our organisation

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our program has a designated peer support coordinator

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:

Action to be taken:

Goals of peer support and the role of peer supporters

Requirements:

- Clearly articulated and documented goals of our peer support program
- Clearly defined role of peer supporters, linked to the goals of our peer support program

Considerations for self-evaluation:

- Do our goals align with best practice:
  - Providing an empathetic, listening ear
  - Facilitating pathways to professional help
  - Identifying colleagues who may be at risk to themselves or others
- Is it relevant to the role of our peers for them to be providing low level psychological intervention such as:
  - Psychological first aid
- Are our goals documented and can they be understood by everyone in our organisation? Is this documentation current, accessible and easy to find?
- Are the roles of our peer supporters clearly defined and consistent across program documentation? Is there supporting evidence of this?

Day-to-day peer response as well as emergency peer response

Variety of peer roles that relate to different skill levels and sets depending on the functions they perform

Organisation evaluation:

The goals of our peer support program are clearly articulated and documented

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

The role of our peer supporters is clearly defined and linked to the goals of our peer support program

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:

Action to be taken:

Selection of peer supporters

Requirements:

- Intake of peers at regularly determined intervals with policy for additional intake where need identified
- Clearly documented nomination, application, assessment and selection policy and process
- Peers are representative of our workforce

Considerations for self-evaluation:

- Do we have a process for the intake of peers? Does it allow for additional intake when need identified?
- Do we have an application and selection process that is:
  - Linked to key selection criteria
  - Merit-based (i.e. some individuals may not be deemed suitable)
  - Responsive to organisational (including geographical) need and demand
  - Transparent and formally documented.
- To become a peer supporter, the individual should:
  - be a member of the workforce
  - have the requisite attributes to be a peer supporter
  - be respected (recommended/referred) by their colleagues
  - undergo an interview by a suitably constituted panel
- Do our core skills and attributes of peers include:
  - Strong communication and listening skills
  - Willingness to assist colleagues in difficult/confronting circumstances
  - Demonstrated time management skills
  - Ability to maintain confidentiality
- Are our peers representative of our workforce? (demographics of peers, location and level of peer experience)

Are there different types of peers in your organisation, and do your application and selection processes reflect this

Consideration of the mental health and wellbeing of peers in the selection process

Organisation evaluation:

Intake of peers occurs at regularly determined intervals and we have a policy for additional intake when needed

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our nomination, application, assessment and selection policy and process is clearly documented

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our peers are representative of our workforce

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:

Action to be taken:

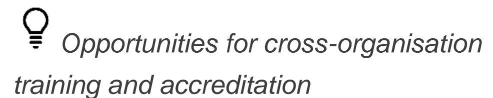
Training and accreditation

Requirements:

- Training is explicitly linked to core competencies that reflect the peer role description and includes basic skills training in how to:
    - Provide an empathic, listening ear
    - Facilitate pathways to professional help
    - Identify colleagues who may be at risk to themselves or others
    - Provide low level psychological intervention (*only where this is a defined role of the peer*)
- Training is based on current best practice evidence-informed education and training tools, programs and practices
- There are clearly defined processes for demonstrating competency with a requirement to meet documented standards prior to commencing role
- Routine skills practice and development are embedded, including refresher training

Considerations for self-evaluation:

- Is our training aligned with core competencies relevant to peer role and responsibility statements?
- Does our training include clearly defined minimum standards of competency and include a way to assess peers against these prior to role commencement?
- Is the training that our peers receive current and evidence-informed? Is it delivered by subject matter experts?
- Do we provide opportunities for regular skills practice and development?
- Does our program have a mechanism for reviewing core competencies on a regular basis?
- Does our program have a mechanism for identifying and responding to additional training needs?



Organisation evaluation:

Our training is explicitly linked to core competencies that reflect the peer role description and includes basic skills training for these roles

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our training is based on current best practice evidence-informed education and training tools, programs and practices

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

There are clearly defined processes for demonstrating competency with a requirement to meet documented standards prior to commencing role

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our program includes routine skills practice and development opportunities, including refresher training ☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement
Factors considered in determining evaluation
Action to be taken:

Looking after peer supporters

Requirements:

- Annual review process that is focussed on:
  - Workload of peers
  - Mental health and wellbeing of the peer workforce
  - Concerns of peers
  - Assessment of resting or sabbatical where required
- Peers should operate under policies detailing:
  - On-call schedules and requirements
  - Information about and how to access care for themselves
  - Where to access expert advice from a mental health clinician
  - When and how to engage in regular supervision
- Mandatory participation in regular formal supervision with a mental health practitioner, peer program coordinator or another more senior peer
- Process for ad hoc or informal supervision
- Mechanisms for regular reward and recognition of peer supporters

Considerations for self-evaluation:

- Does our program include a structured annual review process, and is participation a requirement for all peers in order to continue in their role?
- Does our peer support program have a policy that addresses the requirements, and is this explained to peers and made accessible and available to them?
- Supervision:
  - Do we have a formal supervision policy and process?
  - Are there minimum supervision participation requirements for peers?
  - Is there a nominated point of contact for ad-hoc supervision that is easily accessible?
- Reward and recognition:
  - Have we identified opportunities to reward and recognise our peers on a regular basis?

Organisation evaluation:

Our program includes a formal annual review process for all peers

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our program includes policies that cover on-call schedules and requirements, information about and how to access care for themselves, where to access expert advice from a mental health clinician, when and how to engage in regular supervision

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement ***Our peers are required to participate in regular formal supervision*** ☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement ***Our program documentation includes information and processes for ad-hoc and informal supervision*** ☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement ***We provide reward and recognition to our peers on a regular basis*** ☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement
Factors considered in determining evaluation:
Action to be taken:

Access to peer supporters

Requirements:

- Knowledge of the peer support program (including scope, members and engagement with) is provided in multiple formats on multiple platforms
- Regular organisational updates on the peer support program

Considerations for self-evaluation:

- Do we disseminate information about our program broadly across our organisation?
- Are regular updates and promotion of our program provided in organisation wide communications?
- Are our peers and the peer support program embedded in usual organisational processes and activities (such as staff induction, staff wellbeing activities etc)?
- Do we routinely review program information to ensure it is up to date?

Both formal and informal means of communication

Inclusion of information about the peer support program as part of staff induction processes

Involving peer supporters in mental health and wellbeing activities and presentations

Organisation evaluation:

We provide up-to-date information about our peer support program in multiple formats on multiple platforms

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our organisation provides regular updates and reporting on our peer support program

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:

Action to be taken:

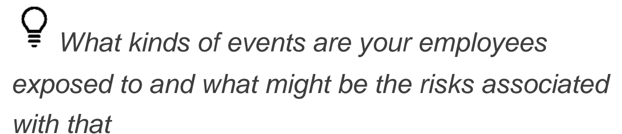
Role of mental health professionals

Requirements:

- Internal or external program oversight/involvement by mental health professionals
- Access to clinical supervision and/or support for all peers
- Clear processes for peers to triage employees in the event of risk identification and pathways for referral

Considerations for self-evaluation:

- Does our organisation have access to trained mental health professionals (internal or external) to support our program:
  - Are they easily accessible to our peers for clinical supervision and/or support?
  - Are they involved in program oversight?
  - Do we provide regular opportunities for peers to connect and network with these mental health professionals?
- Is our program embedded within a mental health and wellbeing team?
- Do we have a documented process for peers to triage employees to mental health professionals?



Organisation evaluation:

Our program has internal or external oversight and involvement by mental health professionals

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

We provide access to clinical supervision and/or support for all peers

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

We have documented processes that guide peers to triage employees in the event of risk identification and pathways for referral

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:
Action to be taken:

Peer program evaluation

Requirements:

- Outcome and impact evaluations should be undertaken by a body independent to the organisation (every 2-4 years)
- Routine review of peer support program utilisation should be undertaken by organisations
- Organisations should undertake an annual self-assessment of their peer support program

Considerations for self-evaluation:

- Program maturity:
  - For more mature programs, has an evaluation previously been conducted or is one planned?
  - For less mature programs, is there a plan for a future evaluation?
- Does our organisation routinely collect data and report on utilisation of our program?
- Do we have a process and capacity for ongoing annual review of our program using this self-evaluation tool?

Organisation evaluation:

Our program has an evaluation framework with a plan for when formal evaluations should be conducted

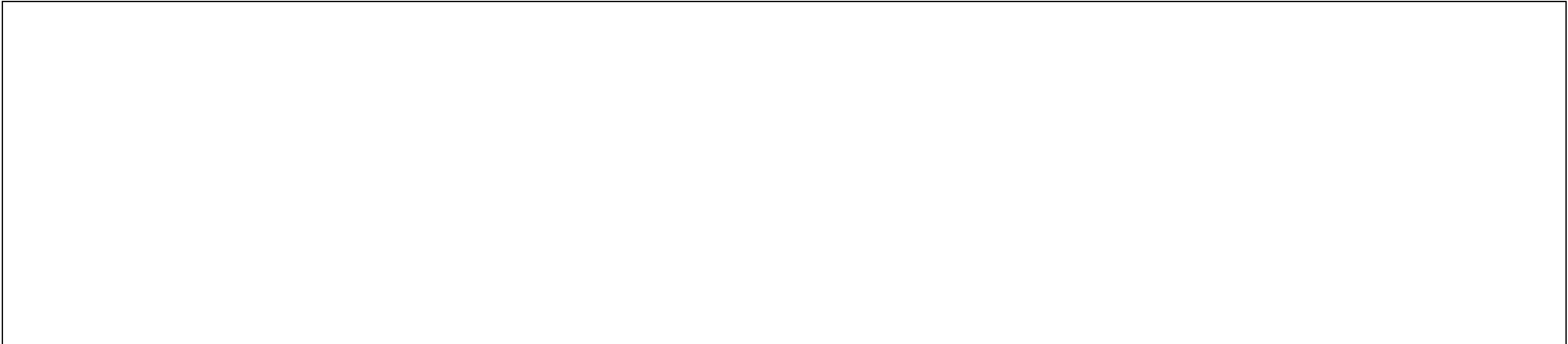
☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our organisation has a process for reviewing the utilisation of our peer support program on a regular basis

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:

Action to be taken:



Program data collection

Requirements:

- Clearly documented rationale for any data collected, including consideration of its:
  - Value
  - Use
  - Application
  - Management (including confidentiality protocols, data access and storage)
- Easily accessible for peer supporters
- Breadth of information collected clearly linked to program quality assurance activities

Considerations for self-evaluation:

- Does our program have a data collection and management policy?
- Is there a mechanism for routine data collection that is easily accessible by all peers?
- Do we have a formal process for reporting on program outcomes and to assess whether our goals are being met?

Rationale for why data is collected and how it is used

Capacity to complete in different locations

Potential metrics of success may include: workforce health outcomes, workforce satisfaction, frequency of use, number/type of referrals

Organisation evaluation:

Our program has a mechanism for the routine collection of data on peer activities and utilisation

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our data collection mechanism is easily accessible by peers

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

The data collected on our peer program is regularly reported and linked to ongoing quality assurance activities

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:
Action to be taken:

Barriers and enablers of peer support programs

Requirements:

- An assessment of the barriers and enablers to the utilisation of our peer support program has been undertaken and the outcomes have been addressed

Considerations for self-evaluation:

- Does our peer support program:
  - Fit with the current culture and needs of our organisation
  - Fit within our current organisational structures
  - Engage peers in continuous improvement processes
  - Mitigate the impact of stigma
- Have we considered other potential barriers and enablers to utilisation of our peer support program specific to our organisation?
- Are possible barriers and enablers to the utilisation of our program routinely considered and addressed?

Organisation evaluation:

Barriers and enablers are routinely considered and addressed

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:

Action to be taken:

Recommendations for enabling a multi-agency response

Requirements:

- Shared documentation of peer support capability for agreed multi-organisation partners including:
  - Number of peers
  - roles and core activities
  - training, accreditation and experience of peers
- Documented agreement of core competencies underlying training, and processes for cross-organisation access to resources for peers
- Clearly documented coordination and engagement process and bi-annual cross-organisation connection meetings

Considerations for self-evaluation:

- Do we have a regularly updated record of:
  - Number of peers
  - Roles and core activities of peers
  - Training, accreditation and experience of peers
- Have we considered opportunities for cross-organisation training and supervision?
- Does our peer support program coordinator have regular opportunities to connect with other coordinators in the sector?
- Do our peers have regular opportunities to connect with other peers across the sector?
- If our peers support employees from another organisation, do we have clear processes to manage and capture data on this?

Organisation evaluation:

Our organisation has up-to-date information on our peer support capabilities aligned with this requirement

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our organisations have agreed on the use of core competencies, associated training and resources across our programs

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our organisations have documented coordination and engagement process for when multi-agency responses are required

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our organisations facilitate bi-annual meetings between our peer support program coordinators

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Our organisations facilitate regular opportunities for peer supporters to connect across the sector

☐ Meeting requirement ☐ Somewhat meeting requirement ☐ Not yet meeting requirement

Factors considered in determining evaluation:

Action to be taken: