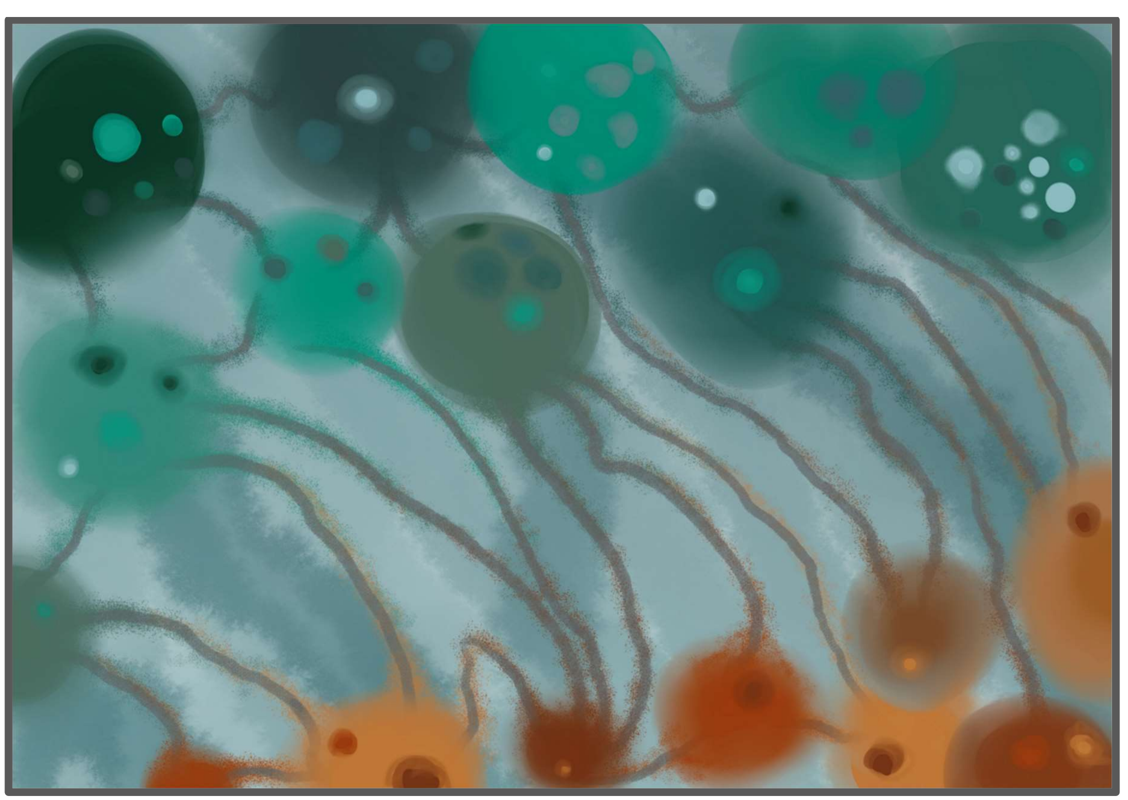
Peer-Supported Transfer of Care (Peer-STOC)

Independent Evaluation



"Bridges" by Kim Ramjan

FINAL REPORT July 2021

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EXECUTIVE SUMMARY

Overview of the Program: Peer Supported Transfer of Care (Peer-STOC) is a NSW wide initiative funded by a $2.7M annual commitment from the NSW Ministry of Health. Peer-STOC is designed to provide additional person-centred and recovery focused supports to individuals with complex mental health needs during a 6-week period of transition to home or community after an inpatient admission. Peer workers are employed by Local Health Districts and Health Networks and embedded within multi-disciplinary community or inpatient teams to deliver this innovative program.

Aim of the Evaluation: Our research team from The University of Sydney and Australian National University was engaged to examine program impacts and outcomes as well as any strengths and/or challenges to implementation, sustainability and expansion or scale-up.

Evaluation Approach: This was an 18-month, co-designed and co-delivered evaluation. The evaluation team was comprised of predominantly lived experience reearchers and a Lived Experience Advisory Panel (LEAP) supported development, interpretation and translation aspects of the project. A mixed methods approach was used. We drew upon a breadth of stakeholder perspectives, service useage data and individual health related outcome data. Specific methods of analyses are detailed in the body of the report.

Findings:

Service Use:

For this part of the evaluation, we accessed service utilisation data via InforMH, System Information and Analytics Branch, NSW Ministry of Health. We received data for a total of 987 Peer-STOC participants and for a comparison group of 4,122 individuals who were similar to the Peer-STOC participants, but had not received Peer-STOC support. Having data from the comparison group enabled us to explore whether Peer-STOC supports made a substantial impact on service utilisation outcomes above and beyond what might have happened naturally over time. Data for Peer-STOC participants could only be extracted in Local Health Districts (LHD) / Specialty Health Networks (SHN) where Peer-STOC service units had been set up in the eMR. This was the case in 12 of the 18 LHDs/SHNs which means that not all Peer-STOC participants will have been identified and not all Peer-STOC worker activities will have been captured.

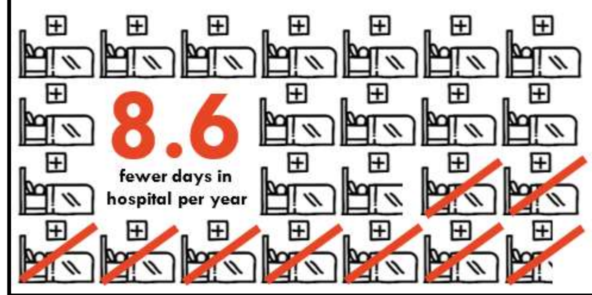
We explored service use in terms of hospital admissions, emergency department presentations and contacts with community mental health services in the 12 months before and the 12 months after discharge from hospital or first connection with Peer-STOC.

Hospital admissions

A primary aim of the Peer-STOC program is to reduce readmission to hospital. To explore whether Peer-STOC achieved this aim, we compared Peer-STOC partipcants to the comparison group who did not receive Peer-STOC. We examined the number of readmissions within 28 days after discharge and the number of hospital admissions and number of days in hospital in the 12 months following discharge or first engagement with Peer-STOC.

Peer-STOC participants were **significantly less likely to be readmitted to hospital within 28 days of discharge.** Peer-STOC participants were 32% less likely to be readmitted than individuals in the comparison group. Only 1 in 10 Peer-STOC participants were readmitted within 28 days following discharge. This is compared to 1 in 7 people in the comparison group being readmitted. These results suggest that Peer-STOC has met its primary aim of supporting people to manage better in the community and not need readmission in the month following discharge.

Peer-STOC participants also had **significantly fewer admissions to hospital over the 12 months after discharge or connection with Peer-STOC**. Peer-STOC participants **spent 8.6 fewer days in hospital** than people in the comparison group (an average of 14.8 days in the 12 month follow up period compared to and average of 23.4 days for individuals in the comparison group – see Table 1.6.)

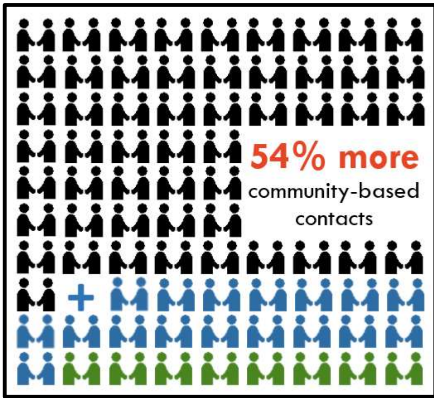


Emergency department presentations

We also explored the number of mental health / psychiatric-related presentations to emergency departments in the follow up period. In the "pre-contact" phase Peer-STOC participants had a substantially higher frequency of presentations to emergency departments. This made comparison between the Peer-STOC and comparison groups difficult. However, the overall result for this analysis was that **there was no real change in the number of emergency department presentations** from the 12 months before or 12 months after contact with Peer-STOC in either the Peer-STOC participant or comparison group.

Community mental health contacts

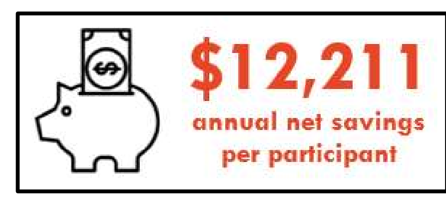
Another aim of Peer-STOC was to support increased engagement with community-based services. Therefore, we examined the number of contacts with community mental health services in the follow up period. **Peer-STOC participants had a significantly higher number of community-based mental health service contacts in the follow up period** than individuals in the comparison group. Individuals in the comparison group had an average of 52 contacts in the follow up period compared with an average of 77 contacts for Peer-STOC participants. Even when contacts only involving Peer-STOC workers were excluded (an average of 8 contacts per person), Peer-STOC participants still had a significantly higher number of community-based contacts than people in the comparison group.



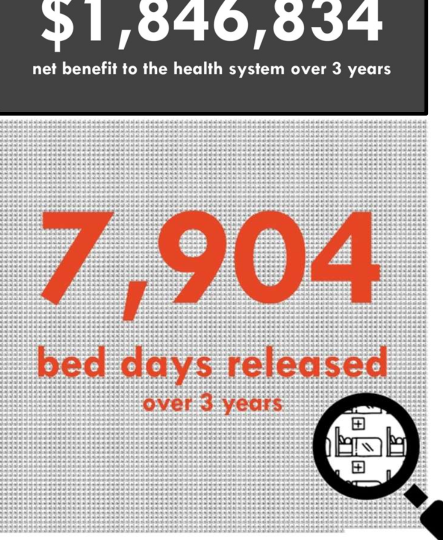
Economic impact related to service use:

Important note: when reviewing these results, it should be noted that as not all Peer-STOC contacts were accessible to the project team (i.e., Peer-STOC contact data were only accessible from 12 of the 18 LHDs / SHNs across the state and some of these did not have Peer-STOC data accessible across the full period of the first three years of roll out). This means that **estimates presented in this section of the report are almost certainly underestimates of the benefits of Peer-STOC**, and in some cases, are potentially dramatically understated. For full details of the analyses and assumptions underlying these estimates, please see full details presented in Chapter 1 of the full evaluation report.

Cost-Benefit analysis



The reduction in the number of inpatient bed days associated with Peer-STOC leads to the program being highly cost-beneficial. Although it is difficult to accurately estimate the program funds spent each year per Peer-STOC participant, the amount is likely to lie between $994 and $5,998. By comparison, every year Peer-STOC avoids hospital costs of $18,210 per participant. This means, that even if we apply the highest possible program funding amount per participant for Peer-STOC, the program is associated with **net savings of at least $12, 211 per participant per year**.



Impact on NSW Health budget

Over the first three years of Peer-STOC NSW Health invested $7.92M in the program, which included one-off establishment costs in Year 1 of the program. Over the same three-year period Peer-STOC has been associated with savings to the NSW health system of at least $9.77M which is **equivalent to the release of 7,904 hospital bed days**. This represents **a net budget impact (saving) of $1.85M over the first 3 years of the program.** The release of this resource would be expected to ease pressure on the mental health system, providing access to necessary services for individuals who might otherwise have gone without.

Suggestion for future data collection

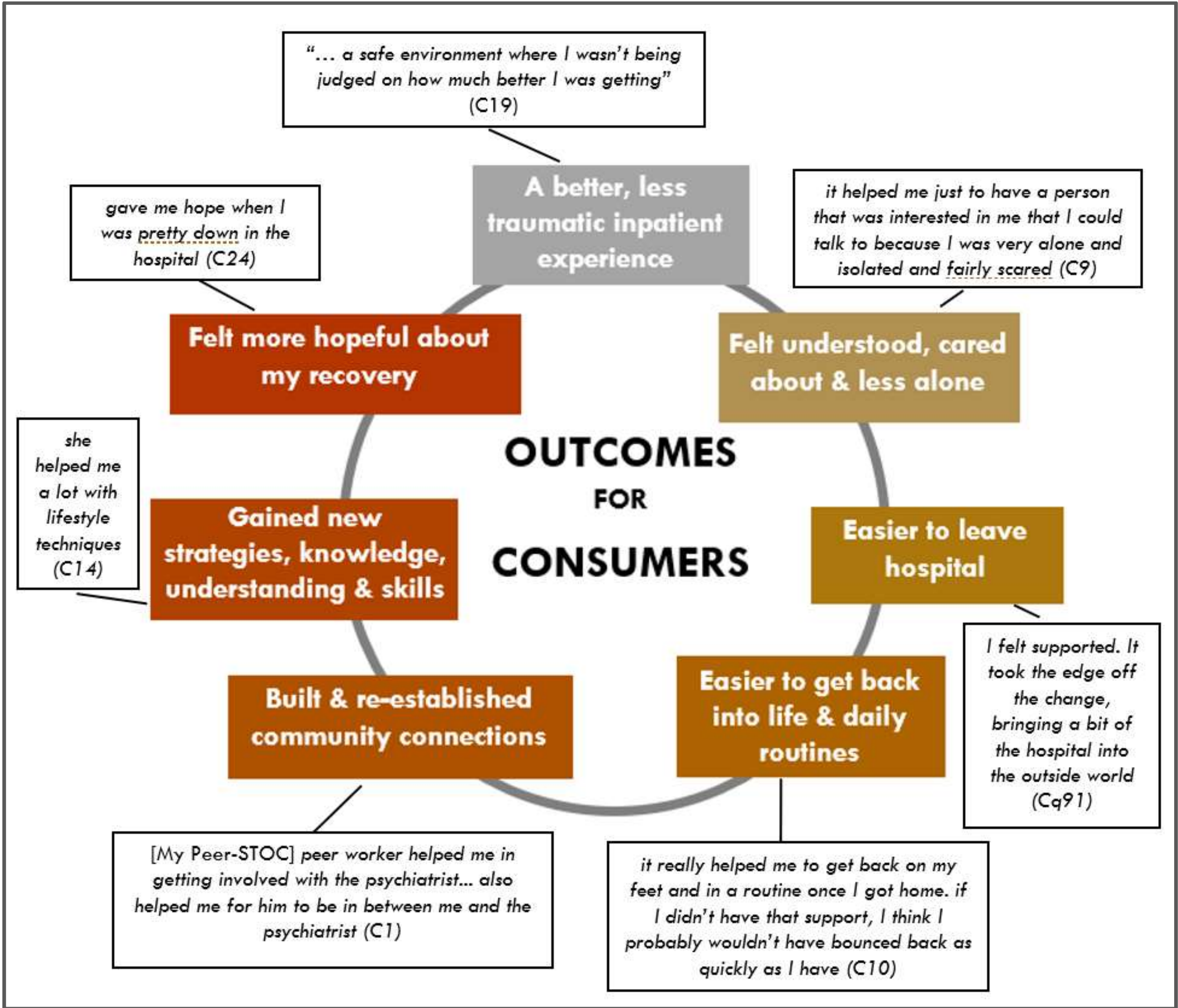
As noted above, analyses were limited given limitations in data availability for Peer-STOC contacts. To support more accurate analyses of the impacts of Peer-STOC to be completed in the future, all LHDs / SHNs should establish specific Peer-STOC teams / service entities in the eMR so that all service contact data can be accurately captured and extracted.

Consumer related outcomes:

1. What people said - Findings from the qualitative data

Across 58 interviews and 82 questionnaires, consumers themselves, peer workers and other workers repeatedly and consistently described positive outcomes and impacts of the Peer-STOC program on consumers.

These outcomes included: a) a better, less traumatic inpatient experience; b) felt understood, cared about and less alone; c) easier to leave hospital; d) easier to get back into life and daily routines; e) built and re-established community connections; f) gained new strategies, knowledge, understanding and skills; g) felt more hopeful about my recovery. These nine themes are provided in the figure below with a single example quote to illuminate each. A detailed description of each theme is presented in Chapter 2 of the report.



Note. C = consumer interviewed; Cq = consumer completed questionnaire

2. What was measured - results from routinely collected outcome measures.

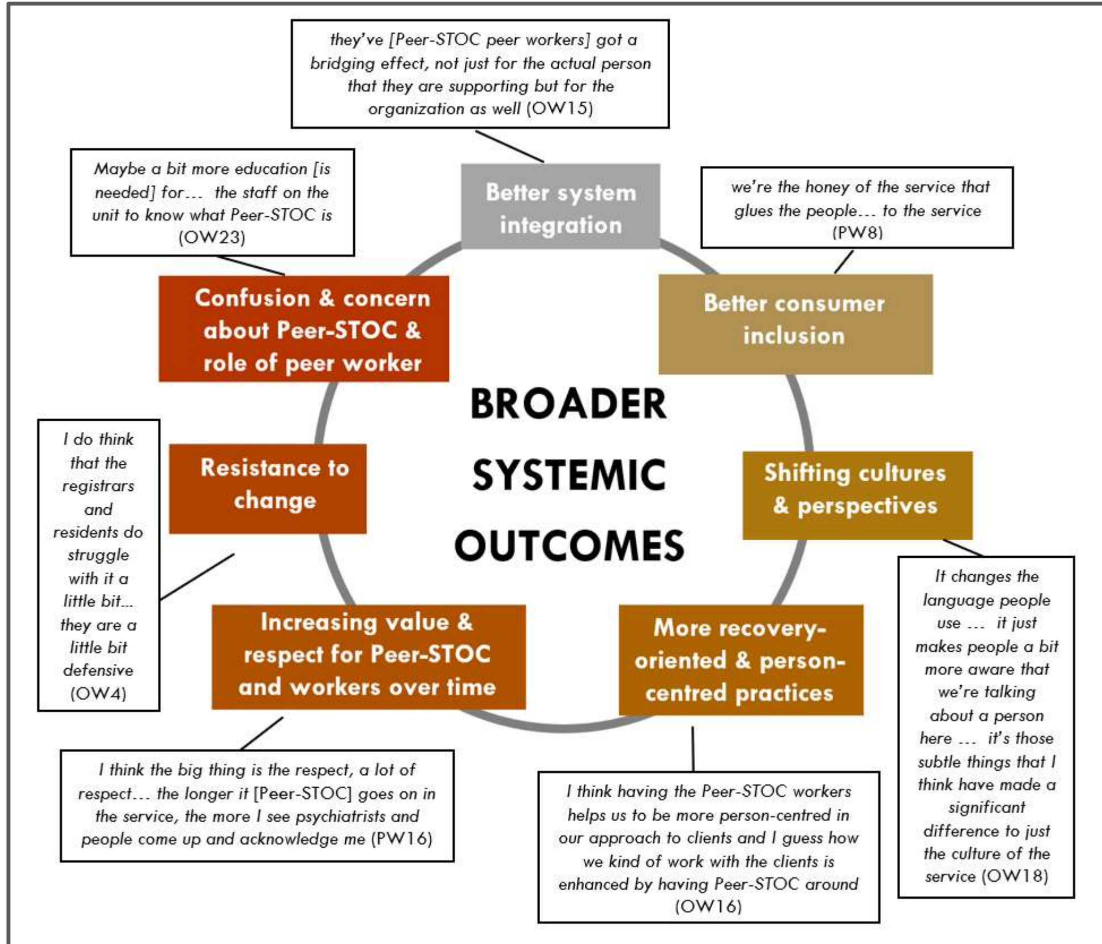
The dataset received from InforMH for the service utlisation component of this project also included data on completed outcome measures for the Peer-STOC participant and comparison groups. These included the Kessler Psychological Distress Scale (K10), Health of the Nation Outcome Scale (HoNOS) and Life Skills Profile (LSP) measures. There were **very low completion rates**. Generally, **less than 5% of participants had measures completed at baseline and at each of the follow up periods**. This meant that it was **not possible to complete meaningful analyses** of these outcome measures. Of the analyses completed, there were few changes over time for the Peer-STOC participant group or the comparison group.

However, some Peer-STOC programs also used the Recovery Assessment Scale – Domains and Stages (RAS-DS) as an additional outcome measure. The RAS-DS is a self-report measure of mental health recovery and can be used to evaluate the impact of Peer-STOC on participants' recovery as well as to facilitate recovery-focused discussion and goal setting.

Data were provided by three LHDs for a total of 41 participants. Measures were completed at the commencement of engagement with the Peer-STOC program and then again at completion. At completion, **participants reported a significant increase in each of the four domains of recovery and in their total recovery scores**. The **'mastering my illness' domain demonstrated the most substantial improvement**, suggesting that engaging with Peer-STOC may support more effective self-management and mastery of coping with the effects of symptoms on daily life. Overall, there was a 13% improvement in scores from commencement to completion, which is higher than has been reported in other programs.

Given that outcomes for the RAS-DS were quite positive and there was limited change in other outcome measures, this could suggest that to accurately capture the full impact of Peer-STOC, self-reported mental health recovery may be the most suitable outcome measure to be used.

Flow on Outcomes or Impacts on the System more broadly:



Note. *OW = other worker interviewed; PW = Peer-STOC peer worker interviewed*

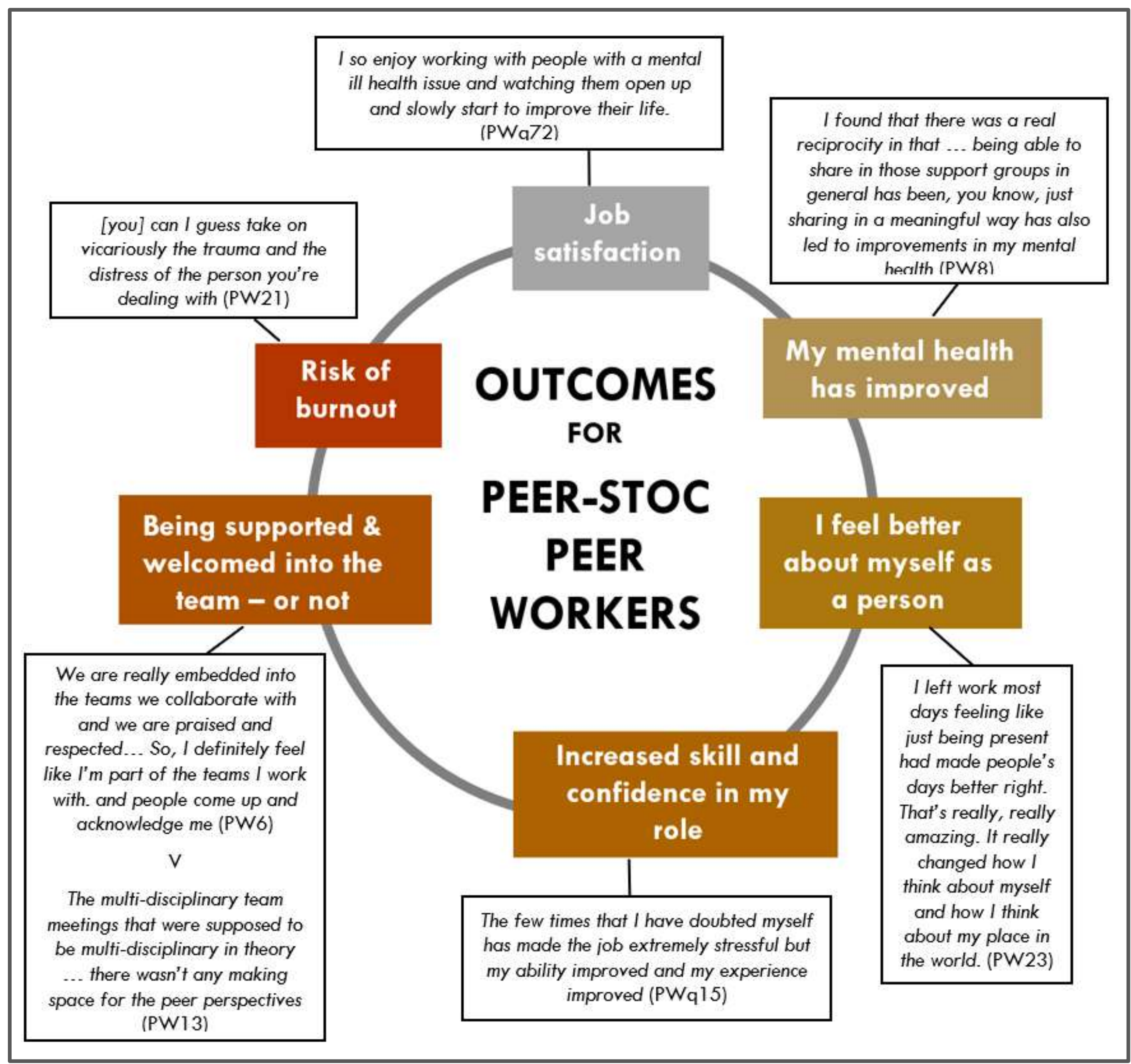
Repeatedly in interviews and questionnaires, Peer-STOC peer workers and other workers, included a broad spectrum of mental health staff such as allied health, clinical and peer workers outside of the Peer-STOC program, said that the program and Peer-STOC peer workers created **bridges across the mental health system** and **bridges between consumers and services.**

Positive system changes attributed to Peer-STOC included: a) Better system integration; b) Better consumer engagement; c) Shifting cultures and perspectives; d) More recovery-oriented and person-centred practices; and e) Increasing value and respect for Peer-STOC and peer workers over time. While positive system changes or impacts dominated, from the perspectives of both Other Workers and Peer-STOC peer workers, they also described potential system changes or impacts being limited by barriers. These barriers or negative outcomes included a) Resistance to change and b) Confusion and concern about Peer-STOC and the role of the peer worker. These themes are provided in the figure above with a single example quote to illuminate each. A detailed description of each theme is presented in Chapter 3 of the report.

Flow on Outcomes or Impacts on Peer-STOC peer workers:

The Peer-STOC program has also resulted in outcomes for, or had an impact upon, the Peer-STOC peer workers themselves. These impacts or changes were noticed and described both by peer workers themselves as well as by other health workers who engaged with them. Positive Peer-STOC peer worker outcomes included a) job satisfaction; b) My mental health has improved; c) I feel better about myself as a person; d) increased skill and confidence in my role; and e) Being supported and welcomed into the team.

While outcomes for peer workers were predominantly positive, this was not the case for all. It was Peer-STOC peer workers who had a clearly understood and defined role, were valued, and respected by colleagues and had support networks (both peer and other) who were more likely to describe positive outcomes for themselves. Where their experience was one of exclusion, unmanageable workloads and lack of support and supervision, peer workers were more likely to describe negative outcomes: f) not being supported or welcomed into the team - isolation and exclusion, and g) risk of burn-out. Again, these themes are provided in the figure below with a single example quote to illuminate each. A detailed description of each theme is presented in Chapter 3 of the report.



Note. PW = Peer-STOC peer worker interviewed; PWq = Peer-STOC peer worker completed questionnaire

The Implementation of Peer-STOC – strengths and suggestions:

Information on the implementation of the Peer-STOC program was gathered in interviews with consumers, peer workers and other workers, including senior managers, decision-makers and clinicians. To ensure a comprehensive exploration of program implementation, this part of the evaluation used the Consolidated Framework for Implementation Research (CFIR)[1] to guide investigation and analysis. The CFIR draws together core elements of several implementation frameworks and consists of a detailed set of constructs that cover program implementation at multiple levels, from the system-level to the individual. It also explores the influence of program and process factors on implementation success. Its five primary domains allow easy identification of *where* in the system action may be required.

As described below, the specific domains were:

1. The Peer-STOC model (CFIR Intervention Characteristics)
2. NSW mental health system (CFIR Outer Setting)
3. LHD/SHN characteristics, culture and climate (CFIR Inner Setting)
4. Personal attitudes and beliefs influencing implementation (CFIR Characteristics of Individuals)
5. Planning, engagement, leadership and evaluation (CFIR Process)

Findings indicate many areas of implementation strength. The Peer-STOC program was seated in a strong peer ideology, with sufficient flexibility to allow tailoring to the needs of LHDs/SHNs and their specific populations, and well-aligned with the NSW Living Well Strategic Plan. There was considerable variation in the maturity of both peer work and the Peer-STOC program specifically across LHD/SHNs, contributing to substantial differences in the culture and climate for implementation. Exemplary models had sophisticated supervision arrangements (a combination of peer, clinical, internal and external supervision), availability of senior/more experienced peer workers for mentoring, opportunities for networking amongst Peer-STOC workers, and documentation to guide processes. However, LHD/SHNs with smaller and/or more newly established peer workforces and Peer-STOC programs lacked many of these characteristics, which often led peer workers to feel isolated and lacking support, and without clear role direction. Across many LHD/SHNs, there was a good sense of integration into multidisciplinary teams, clinical "champions" who assisted with acceptance and a positive organisational culture, but program-wide this was tempered by some areas where peer workers were treated indifferently or with hostility.

Specific areas of strength, and participants' suggestions for improvements are summarised below according to CFIR domain. Findings are described in full, with supporting quotes in Chapter 4 of the report.

Domain 1: Peer-STOC Model (Intervention Characteristics) – *"It's got good genes"*

Strengths:

- Peer-STOC is strongly based in peer-directed ideology
- Flexibility in the use of formalised tools and approaches, in order to meet individual needs of consumers, and working styles of peer workers

- Some LHD/SHNs exercised flexibility with the 6-week time frame to meet local and individual consumer needs, while maintaining the key nature of Peer-STOC as a transition service, not an ongoing service

Suggestions:

- Ensure Peer-STOC workforce meets consumer needs across all LHD/SHNs, particularly focusing on inpatient in-reach, referral pathways and prompt post-discharge follow-up
- Engage peer workers in the process of developing Models of Care for every LHD/SHN
- Develop a central 'bank' of documentation and processes based on strong models, available for program implementation and to support induction of new Peer-STOC workers
- Ensure clinicians and peer workers have agreed boundaries for the scope of peer work and level of autonomy for peer workers
- Provide equitable allocation of funding for implementation, programs and materials across LHD/SHNs, and support exemplary models to share successes

Domain 2: NSW Mental Health System (Outer Setting) – *"We…walk along with the person while they're navigating that"*

Strengths:

- The Peer-STOC model is uniquely designed to support all priority areas of the Living Well Strategic Plan
- Support to complete the Cert IV in Mental Health Peer work is a core investment

Suggestions:

- Greater investment is needed in peer leadership to support peer workers, particularly when developing connections with other organisations and services outside Peer-STOC

Domain 3: LHD/SHN Characteristics, culture and climate (Inner Setting) – *"It's hard…to speak up about cultural change when you are the newest and the lowest paid"*

Strengths:

- Supervision is a critical area requiring significant planning and investment, and quite sophisticated in some LHDs, which should be exemplars for the entire program. These exemplars included line management, clinical supervision and peer supervision, including options for group and reflective practice, and supervision external to the area in which the peer worker was situated
- Flexibility for full- or part-time positions for peer workers was appreciated
- Some LHDs had a very positive organisational culture, fostered by "champions" in clinical and management roles, supporting the successful integration of Peer-STOC workers. This is vital to shift attitudes in less receptive or resistant LHDs

- Areas where peer workers were not working alone, or had access to a network of other peer workers provided valued peer support and reflective practice opportunities. This could be expanded through a Peer-STOC community of practice reportedly being developed, support for formal peer worker conferences, and assistance for Peer-STOC peer workers to attend

Suggestions:

- Every LHD/SHN should be encouraged to develop a supervisory model in consultation with peer workers and management, based on existing exemplary models, and support senior peer workers to undergo management training to become effective supervisors
- Develop a peer worker specific award such as used in QLD, that appropriately recognises the skills and experience of peer workers, appropriately reflects the challenges of the Peer-STOC role and recognises qualifications and graduate degrees
- Open up higher levels of the award rate for more experienced peer workers, to provide scope for career progression and attract and retain more highly skilled peer workers to the Peer-STOC program
- Examine geographical limitations or boundaries between LHD/SHNs, especially in rural and regional areas to prevent people "falling through cracks" between inpatient and community care
- Optimise eMR for peer work referrals and outcomes
- Maintain an ongoing process of staff education, particularly by peer workers, about peer work and Peer-STOC to ensure cultural change and a flow of referrals

Domain 4: Personal attitudes and beliefs influencing Peer-STOC implementation (Characteristics of Individuals) – *"...respect me as a fellow person who's trying to help someone with mental distress"*

Strengths:

- A shared sense of hope and recovery were the core attributes of a good peer worker and present across the state
- Many peer workers, particularly in the exemplary models, felt embedded within teams and that they had a choice on who to consult for clinical or supervisory issues

Suggestions

- Attention should be paid to areas where clinician and manager attitudes indicate lack of understanding and/or respect for peer work, to focus on individual support and education
- Feedback channels and management of workplace issues need to be included in all supervisory frameworks so that peer workers are clear about who they should turn to when they have particular issues, whether clinical or peer related

Domain 5: Planning, engagement, leadership and evaluation (Process) – "*We…took the mindset of we wouldn't know if the Peer-STOC system and support would work unless we just gave it a really good red-hot go*"

Strengths:

- LHD/SHNs with "champions" who provided implementation leadership were more likely to provide a good environment. Champions of the program should be recognised and supported to network across the state, and create a resource to those who wish to be champions but who are unsure where to begin
- Likewise, LHD/SHNs with senior peer workers to oversee planning, documentation and processes had smoother early implementation. It would be beneficial to embed senior peer worker roles across the program, at each LHD or at a minimum during planning and early implementation including peer worker recruitment and training

Suggestions:

- Sharing of documentation, processes and training opportunities for staff about peer work may assist in preparing an LHD/SHN with a less developed peer workforce
- Aligning engagement, referral and exit processes across LHD/SHNs, with guidelines and templates, may assist with further embedding peer workers within multidisciplinary teams, and increasing respect for the role
- Better guidelines might be required at the program level for roles and responsibilities in implementation: who is responsible for what aspect and stage of the implementation at the local level
- Develop models of data collection that capture a range of data, both qualitative and quantitative, formal and informal feedback, which may be used as a resource by consumers, peer workers and clinicians in evaluation

Reference

1. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. Implementation science : IS. 2009 Aug 7;4:50.

Peer-Supported Transfer of Care (Peer-STOC)

Key outcome findings from the independent evaluation

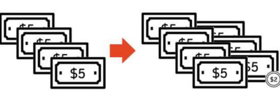
A/Prof Nicola Hancock[1], A/Prof Justin Scanlan[1], A/Prof Michelle Banfield[2], Bridget Berry[1], Dr Georgia Pike-Rowney[2], Dr Sarah Norris[1] & Amber Salisbury[1]

[1] The University of Sydney, [2] Australian National University

Impacts on the mental health system

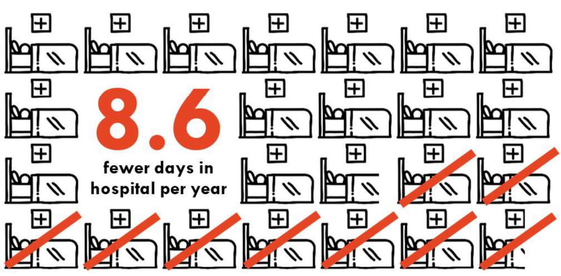
7,904
bed days released
over 3 years

$1,846,834
net benefit to the health system over 3 years



for every **$1 invested** in Peer-STOC it returned **$1.85 in benefits**

Outcomes for consumers



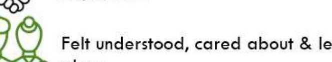
8.6
fewer days in hospital per year

32% fewer
individuals readmitted within 28 days

$12,211
annual net savings per participant

Themes from interviews & surveys (n = 140)

- A better less traumatic inpatient experience
- Felt understood, cared about & less alone
- Easier to leave hospital
- Easier to get back into daily life & routines
- Built & re-established community connections
- Gained new strategies, knowledge, understanding & skills
- More hopeful about my recovery



54% more
community-based contacts

↑13% recovery

- ↑ 11% doing things I value
- ↑ 13% looking forward
- ↑ 20% mastering my illness
- ↑ 9% connecting and belonging

Other outcomes

Themes from interviews & surveys (n = 140)

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Infographic developed by Justin Scanlan

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Abbreviations

C	Consumer who participated in an interview
Cq	Consumer who completed a questionnaire
CMO	Community managed organisations
ED	Emergency Departments
HoNOS	Health of the Nation Outcomes Scale
K10	Kessler Psychological Distress Scale
LEAP	Lived experience advisory panel
LHD	Local Health District
LSP	Life Skills Profile
MH	Mental Health
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisations
OW	Other mental health workers who are / were working alongside or interacted with the Peer-STOC initiative and participated in an interview
OWq	Other Worker who completed a questionnaire
Peer-STOC	Peer Supported Transfer of Care
PW	Peer-STOC peer worker who participated in an interview
PWq	Peer-STOC peer worker who completed a questionnaire
RAS-DS	Recovery Assessment Scale – Domains and Stages
SHN	Specialty Health Network

PROJECT BACKGROUND AND AIMS:

Context

A number of drivers led to implementation of the Peer Supported Transfer of Care (Peer-STOC) initiative. Two of these were identified problems in need of resolution. Two were identified opportunities and emerging evidence.

The **poor current outcomes for people who are transitioning back to community from acute adult mental health in-patient care** is the primary driver. Poor outcomes are evidenced by the ongoing high rates of re-admission (currently 14.6%) within 28 days of being discharged from acute adult mental health care [1], and the heightened risks of both homelessness and suicide [2, 3].

Second, there is significant **pressure on community mental health teams** due to the high numbers of consumers requiring ongoing care coordination and follow up within 7 days of discharge from acute care. Lack of connection with community-based treatment and support is considered to be a significant factor associated with the poor outcomes described above[4, 5].

Alongside these need-based drivers are drivers stemming from new ways of working and new understandings or evidence.

In recognition of national and international mental health sector reform initiatives, there has been a **growth in the peer workforce** internationally as well as across Australia [6]. Growing and supporting a peer-workforce is central to one of five key strategic directions of the NSW Strategic Framework and Workforce Plan for Mental Health (2018–2022), aligning with similar priorities within the both State and National Mental Health Commission Strategic Plans [7, 8].

Emerging evidence from increasingly rigorous studies demonstrate that a **peer workforce can have a positive impact on consumer outcomes** [9-13]. In a recent rebuttal to a critical reflection on the paucity of evidence for peer-worker impacts, Davidson and colleagues [14] sumarised the evidence from over 30 studies that have found positive effects of peer support across numerous outcome domains including engaging people in caring relationships, improving relationships between clients and outpatient providers, increasing engagement in non-acute and less costly care, decreasing substance use, decreasing unmet needs, increasing hope, empowerment, self-efficacy, social functioning, quality of and satisfaction with life, and activation for self-care.

Peer-STOC

The Peer-STOC initiative was developed by the Mental Health Branch of the Ministry of Health. Peer-STOC was designed to provide additional person-centred and recovery focused supports to individuals with complex mental health needs during the period of transition to home or community after an inpatient admission. Peer-workers were to be employed by Local Health Districts and embedded within multi-disciplinary community teams to deliver this innovative program. The Peer-STOC delivered support were to commence with in-reach to build rapport, discuss wellbeing strategies and collaboratively identify supports needed to transition into the

community. This transitional support was to continue for up to 6 weeks post-discharge aligning with the princples of Step Up / Step Down care. This included making referrals to a range of community-based services for ongoing support if required (Step Down), or escalating concerns over consumer wellbeing to clinical staff within Community Mental Health teams for assertive follow up to support hospital avoidance (Step Up). Priority for referral to Peer STOC was to be given to those people with no formal community supports at the time of discharge.

The Aims of this Evaluation

Peer-STOC is an innovative NSW wide initiative funded by a $2.7M annual commitment from the NSW Ministry of Health. It commenced roll-out in 2017. In this early period of roll-out and development, it was critical to understand the **impacts and outcomes** of the program as well as any **strengths and/or challenges to implementation, sustainability and expansion or scale-up**. It is also important to examine whether Peer-STOC provides **value for money**.

OVERALL DESIGN & METHODS

This was an 18-month, co-designed and co-delivered evaluation. A mixed methods approach was used. We drew upon a breadth of stakeholder perspectives, service useage data and individual health related outcome data.

Our approach

Co-production. In line with the co-designed and co-delivered principles underpinning the Peer-STOC program, our research team comprised research expertise both with and without lived experience of mental illness and mental health service use. Our team has a strong track record of working in collaborative co-design partnerships.

In addition, a lived experience advisory panel (LEAP) of people with direct lived experience of mental health service use was employed to advise the project team at regular intervals throughout the evaluation.

While some outcome 'points' and processes were necessarily determined by the Ministry priorities and the data available through NSW Health, others were identified and refined through genuine engagement with the panel of people with direct lived experience of mental health service use as well as experience in the delivery and use of Peer-STOC.

Implementation Science. Health systems are complex settings and the introduction of a new model of service delivery with expansion of an emerging workforce, the peer workforce, required a process or implementation component to the evaluation. Our use of a modified, pre-established implementation science framework (detailed at the start of Chapter 4) enabled the examination of contextual factors and processes that influenced implementation and outcomes.

Our Plan Overview

The evaluation comprised four aligned and complimentary streams:

1) **Service Use related Outcomes and the Economic Implications**
   Service use data for Peer-STOC participants and a comparison group who did not receive Peer-STOC was extracted from the Health Information Exchange data warehouse by staff from InforMH. These datasets included information on inpatient hospitalisation, emergency department presentations and community mental health service contacts. Analyses examined differences in outcomes between Peer-STOC participants and the comparison group in terms of service utilisation. Results from these analyses were combined with funding and program design information from NSW Health to inform a cost-benefit analysis (at the level of individual consumers) and a budget impact analysis (for the NSW health system) to describe the ecomonic impacts associated with Peer-STOC.

2) **Consumer Health, Recovery and Well-being related Outcomes**
   To examine consumers' health, recovery and wellbeing outcomes, we took a mixed method approach. Consumer, peer worker and other worker perspectives were sought through interviews and an online questionnaire. These data were analysed thematically using constant comparative methods. Note. To reduce participant burden and project costs, these qualitative data and initial thematic analyses were used

across streams 2, 3 and 4. We also analysed routinely collected outcome measures to examine change over time. Measures extracted from the Health Information Exhange (associated with the dataset used in stream 1) included the Kessler Psychological Dtress Scale (K10), Health of the Nation Outcomes Scale (HoNOS) and Life Skill Profile (LSP). LHDs who used the Recovery Assessment Scale – Domains and Stages (RAS-DS) also provided de-identified data to the research team for analysis.

3) **Flow-on Outcomes or Impacts of the program – on the System more broadly and on the Peer Workers themselves**

   To understand the flow-on impacts of the program on the mental health system and on Peer-STOC peer workers, we drew upon the same data set and analyses described in 2) above.

4) **Implementation and Process evaluation - with an eye to future recommendations.**

   The first step involved the same data set and analyses as streams 2 and 3 above. Following this, themes and data were interogated against the Consolidated Framework for Implementation Research (CFIR). The CFIR details a comprehensive list of implementation themes, known as 'constructs', organised under five key domains, that were adapted for use in the Peer-STOC evaluation:

   I. INTERVENTION CHARACTERISTICS: characteristics of the Peer-STOC model itself

   II. OUTER SETTING: the broad external context and understanding of peer work and consumer needs

   III. INNER SETTING: internal context of LHDs, such governance, supervision, resources and culture

   IV. CHARACTERISTICS OF INDIVIDUALS: attitudes, identity, self-efficacy, understanding and beliefs

   V. PROCESS: implementation planning, stakeholder engagement, leadership, and evaluation

   Note. The CFIR was used at multiple stages of the research process: in the early stages to inform the design of the interview guide; as a comparative tool when interviewing participants to ensure themes were relevant information was being gathered; and as a tool for detailed analysis and development of themes. The framework has proven to be particularly helpful when looking at implementation in such a variety of local contexts, environments and location.

More detailed methods for each of the above four streams are provided at the front of the relevant following chapter.

CHAPTER 1: SERVICE USE OUTCOMES and ECONOMIC EVALUATION

This chapter outlines the analysis approach and outcomes associated with the Peer-STOC program in terms of service utilisation and economic costs and benefits. To complete these analyses, the main data sources were information extracted from the statewide Health Information Exchange about hospital admissions, emergency department presentaitons and community mental health contacts, and information from NSW Health regarding program funds released since program establishment.

RESULTS AT A GLANCE

✓ Peer-STOC participants were **significantly less likely to be readmitted** within 28 days than individuals in the comparison group

✓ Peer-STOC participants had **significantly fewer admissions** than individuals in the comparison group in each of the follow up periods

✓ Peer-STOC participants had **significantly fewer days in hospital** than individuals in the comparison group in each of the follow up periods

✗ There were **no changes in emergency department** presentations

✓ Peer-STOC participants had **significantly greater numbers of community-based contacts** than individuals in the comparison group in each of the follow up periods

✓ Peer-STOC was associated with a **net benefit of at least $12,211 per participant per year**

✓ Over its first three years, **every dollar invested in the Peer-STOC program** has been associated with **benefits to the NSW health system of at least $1.85**.

✓ The **health system benefits** of the Peer-STOC program over its first three years are equivalent to the **release of 7,904 bed days** across the State

? The **value-for-money** associated with an **increased number of community-based contacts** as a consequence of Peer-STOC is real, but cannot be captured adequately in a cost-benefit analysis

Aims

The overarching aim of this element of the project was to investigate whether being engaged with the Peer-STOC program:

a) had a positive impact on service utilisation
   i. reduced number and duration of psychiatric-related hospital admissions;
   ii. reduced psychiatric-related emergency department presentations; and
   iii. enhanced connection with community mental health services
b) resulted in economic benefits
   i. costs avoided in terms of psychiatric/mental health presentations to emergency departments or re-admissions to hospital
   ii. that Peer-STOC represents value for money with the total costs to deliver the program yielding acceptable benefits in terms of total health outcomes for participants and total healthcare costs avoided

Data sources

The main data for this part of the project were extracted from the Health Information Exchange (HIE) data warehouse by Senior Data Analysts from InforMH, a department of the System Information & Analytics Branch, Patient Experience and System Performance Division, NSW Ministry of Health. The data extracted included:

- information about mental health-related hospital admissions (from the Admitted Patient Data Collection)
- information about mental health-related presentations to emergency departments (from the Emergency Department Data Collection)
- information about community mental health contacts (from the Mental Health Ambulatory Data Collection)

Additional data were provided by the NSW Health regarding the funds released to each LHD and SHN sicne program establishment in the 2017-2018 financial year.

Participant identification and data extraction

Identification of "Peer-STOC participants" and a matched set of comparison participants was completed by the Senior Data Analyst at InforMH. "Peer-STOC participants" were identified from the dataset as individuals who had three or more service contacts with Peer-STOC teams. This was possible in 12 out of 18 Local Health Districts / Specialty Health Networks. In the remaining 6 LHDs/SHNs, Peer-STOC workers reported their activity within other teams, so it was not possible to identify contacts with Peer-STOC workers within the dataset.

Given that the Peer-STOC model is based around transition support at the time of discharge from an inpatient admission, the "index admission" was defined as the inpatient admission immediately prior to the person's first community-based contact with a Peer-STOC worker.

Following identification of "Peer-STOC participants", a set of matched comparison participants (made up of individuals who did not have contact with Peer-STOC teams recorded) was extracted. This included two comparison participants for each "Peer-STOC participant". The matching process was based on the following characteristics: sex, age, Mental Health diagnosis

group, year and month of index episode, LHD / SHN of the index admission, number of hospital episodes and hospital days in the preceding 2 years and number of community based mental health contacts in the preceding 2 years. Each comparison person could only be matched with one Peer-STOC participant (i.e., the approach used a "greedy" matching algorithm).

Initially a direct "case-control" matching process was attempted. However, this process was unsuccessful in finding a sufficient number of matched comparison participants. Therefore, a propensity score matching approach was used. The final model demonstrated good fit, with an Area Under the Curve value of 0.94.

Limitations in the dataset

Several limitations in the dataset should be acknowledged. Most notably was the fact that Peer-STOC contacts could only be identified in 12 of the 18 LHDs / SHNs across the state. This means that not all Peer-STOC participants could be identified. This also means that some of the "comparison group" may have also received Peer-STOC, but could not be identified as they were in LHDs / SHNs in which Peer-STOC teams had not been established in the medical record. Secondly, information about private hospital admissions was not included, so admissions to private hospital facilities could not be included in analyses. Finally, mortality data were not available within the datasets used in this study. Therefore, it was not possible to identify participants who may have died. Although these limitations are important, there is no reason to think that there would be any systematic differences between the Peer-STOC participants and the comparison group in relation to any of these factors that would favour the Peer-STOC participant group in a way that would lead to overestimation of their outcomes. Indeed, all of the limitations in the data set likely *underestimate* the outcomes for the Peer-STOC participant group.

Participant demographics

The dataset transferred from InforMH to the research team included data for 6,138 people. This included 2,061 individuals who had been identified as "Peer-STOC participants" and 4,122 comparison participants. Preliminary exploration of these data identified that a substantial proportion of individuals who had initially been identified as "Peer-STOC participants" only had contact with Peer-STOC workers while they were in hospital. As Peer-STOC was intended to be a community-based, transition support program, individuals who only has contact with Peer-STOC workers while in hospital were considered to not have received the Peer-STOC intervention, so were excluded from the dataset. This resulted in a final dataset of 987 Peer-STOC participants and 4,122 comparison participants.

Additionally, despite the Peer-STOC program being designed to provide community-based transition support around the time of discharge from a hospital admission, there were a number of Peer-STOC participants who commenced contact with Peer-STOC workers at a time that was not associated with discharge from a hospital admission (for some participants their first contact with Peer-STOC was several years after their most recent hospital admission). Information provided by Peer-STOC workers and other mental health workers in qualitative interviews for other parts of this project suggested that this flexible approach was adopted in several services – often to provide increased support to consumers who were experiencing

increased difficulties and who may have been at risk of hospitalisation. As this approach to service provision was different from the original design of Peer-STOC, these participants were identified and subgroup analyses completed in addition to analyses with the entire group. In this report, these participant subgroups are defined as follows:

- **Transition Support Peer-STOC participants** – individuals who received Peer-STOC support around the time of discharge from an inpatient admission (operationalised in the analysis as first community-based contact with a Peer-STOC worker within 28 days of discharge)
- **Other Support Peer-STOC participants** – individuals who received support from Peer-STOC workers that was not around the time of discharge from an inpatient admission (operationalised in the analysis as first community-based contact with a Peer-STOC worker more than 28 days after discharge from last hospital admission).

Using the definitions above, there were 611 Transition Support Peer-STOC participants and 376 Other Support Peer-STOC participants. Demographic information for Peer-STOC participants (by subgroup and for the whole group) and the comparison group are listed in Table 1.1 below.

Table 1.1 Demographic and prior service utilisation characteristics of Peer-STOC participants and the comparison group

	Transition Support Peer-STOC participants (n = 611)	Other Support Peer-STOC participants (n = 376)	All Peer-STOC participants (n = 987)	Comparison group (n = 4122)
Sex [*n* (%)]				
Female	346 (56.6%)***	194 (51.6%)	540 (54.7%)***	1954 (47.4%)
Male	265 (43.4%)***	182 (48.4%)	447 (45.3%)***	2168 (52.6%)
Age [Mean (S.D.)]	39.6 (14.2)	38.9 (13.1)	39.3 (13.8)	38.8 (17.2)
Primary diagnosis [*n* (%)]				
Schizophrenia, schizotypal and delusional disorders	198 (32.4%)*	199 (52.9%)***	397 (40.2%)***	1163 (28.2%)
Mood [affective] disorders	173 (28.3%)*	65 (17.3%)*	238 (24.1%)	904 (21.9%)
Manic Episode / Bipolar Disorder	*77 (12.6%)***	*41 (10.9%)*	*118 (12.0%)***	*347 (8.4%)*
Depressive Episode / Recurrent Depression	*86 (14.1%)*	*22 (5.9%)****	*108 (10.9%)*	*520 (12.6%)*
Other mood disorder	*10 (1.6%)*	*2 (0.5%)*	*12 (1.2%)*	*37 (0.9%)*
Mental and behavioural disorders due to psychoactive substance use	57 (9.3%)	34 (9.0%)	91 (9.2%)	468 (11.4%)
Neurotic, stress-related and somatoform disorders	87 (14.2%)	22 (5.9%)***	109 (11.0%)**	614 (14.9%)
Disorders of adult personality and behaviour	39 (6.4%)	23 (6.1%)	62 (6.3%)	274 (6.6%)
Suicidal Ideation	9 (1.5%)	5 (1.3%)	14 (1.4%)	91 (2.2%)
Other	41 (6.7%)***	28 (7.4%)***	69 (7.0%)***	602 (14.6%)
Missing	7 (1.1%)***	0 (0.0%)	7 (0.7%)**	6 (0.1%)
Service utilisation in previous two years [Mean (S.D.)]				
Number of inpatient admissions	3.0 (4.2)	2.6 (3.1)	2.8 (3.8)*	3.3 (6.6)
Number of inpatient bed days	53.4 (84.3)	67.1 (108.7)**	58.6 (94.5)***	45.5 (83.6)
Number of ED presentations	2.2 (5.0)***	2.8 (5.1)***	2.5 (5.0)***	0.3 (2.1)
Number of community contacts	66.0 (123.1)*	141.1 (139.0)***	94.6 (134.4)***	52.1 (112.6)

Notes: * p < .05; ** p < .01; *** p < .001: significant differences in pairwise comparisons between Peer-STOC participants and the comparison group.

In terms of demographics and prior health service utilisation, there were some differences between the Peer-STOC participants and the comparison group.

In comparison to the "comparison group", Peer-STOC participants (whole group, and each subgroup):

- were more likely to be women
- were more likely to have a primary diagnosis in the category of Schizophrenia, schizotypal or delusional disorders
- had a greater number of presentations to the emergency department in the two years prior to their "index episode"
- had a greater number of community contacts in the two years prior to their "index episode"

In comparison to the "comparison group", Transition Support Peer-STOC participants:

- were more likely to have a primary diagnosis in the category of mood disorders, largely driven by a higher proportion of individuals with a primary diagnosis of manic episode or bipolar disorder

In comparison to the "comparison group", Other Support Peer-STOC participants:

- were less likely to have a primary diagnosis in the category of mood disorders, largely driven by a smaller proportion of individuals with a primary diagnosis of depressive episode or recurrent depressive disorder
- had a greater number of inpatient bed days in the two years prior to their "index episode"

Local Health Districts / Specialty Health Networks

As mentioned above, Peer-STOC data could be identified from a total of 12 LHDs / SHNs where a Peer-STOC team had been established in the Electronic Medical Record. This included 10 out of 15 LHDs and 2 out of 3 SHNs. A summary of the number of Peer-STOC contacts from each LHD / SHN is listed in Table 1.2. Ninety percent of all recorded Peer-STOC contacts came from seven LHDs / SHNs, and more than 65% came from three LHDs.

Table 1.2 Frequency of Peer-STOC contacts recorded by each LHD / SHN

LHD or SHN	Frequency	Percent	Date of first Peer-STOC contact recorded
LHD / SHN 1	6804	39.7%	29-Oct-18
LHD / SHN 2	2662	15.5%	26-Oct-18
LHD / SHN 3	1741	10.2%	12-Dec-17
LHD / SHN 4	1586	9.3%	28-Sep-18
LHD / SHN 5	982	5.7%	23-Nov-18
LHD / SHN 6	956	5.6%	20-Nov-18
LHD / SHN 7	943	5.5%	22-Aug-18
LHD / SHN 8	725	4.2%	17-Jul-19
LHD / SHN 9	519	3.0%	1-Oct-19
LHD / SHN 10	189	1.1%	13-Mar-20
LHD / SHN 11	15	0.1%	15-Feb-19
LHD / SHN 12	13	0.1%	5-Dec-19
Total	**17135**	**100%**	

SERVICE USE

Analyses and Results

Analyses presented in this section explore changes over time for Peer-STOC participants and individuals in the comparison group. These analyses are important, as one of the main aims of Peer-STOC is to reduce hospital readmission. Additionally, it was hypothesised that individuals receiving Peer-STOC support would also have a reduced number of mental health / psychiatric-related presentations to emergency departments and would have stronger connections with community-based supports, reflected by increased numbers of community based contacts in the follow-up period.

Terminology and operational definitions

To assist with understanding the information presented in this section, the following terms have been used and operationalised in the analysis as described:

- ***Transition Support Peer-STOC participants*** – individuals who received Peer-STOC support around the time of discharge from an inpatient admission (operationalised as first community-based contact with Peer-STOC worker within 28 days of discharge)
- ***Other Support Peer-STOC participants*** – individuals who received support from Peer-STOC workers that was not around the time of discharge from an inpatient admission (operationalised as first community-based contact with Peer-STOC worker more than 28 days after discharge from last hospital admission).
- ***Index admission*** – for Transition Support Peer-STOC participants, this is the admission directly preceding their first community-based contact with a Peer-STOC worker; for comparison group participants, this is the admission that was used as the "match episode" in the matching process. For Other Support Peer-STOC participants, there was no "index admission", as Peer-STOC contact did not directly follow an inpatient admission.
- ***Pre- Post demarcation*** – for Transition Support Peer-STOC participants and the Comparison group, the demarcation point for "pre" and "post" analyses was the day of discharge from the "index admission". For Other Support Peer-STOC participants, the demarcation point was the day of first community-based contact with a Peer-STOC worker. For community contacts and emergency department presentations, "before" data were captured as prior to the index admission date. Contacts / emergency department presentations that occurred during the index admission were not included in analyses. Emergency department presentations immediately preceding the index admission (i.e., where the Emergency Department presentation led to the person being admitted for the index admission) were also excluded.
- ***Follow-up period*** – analyses for various follow up periods were completed. This was 3 months, 6 months and 12 months. A two-year follow up period was initially also planned, however, the number of participants who had data for the 2 year follow up period was very low and led to unreliable analyses. Therefore, this follow up period has not been included. As 28-day readmission is a key performance indicator, a 28-day period was also used for analyses related to readmission. For all analyses involving a "follow up" period, number of follow up days was calculated for each participant by calculating the number of days from the date of discharge from the index admission up to the point of data extraction (18 February 2021). Follow up analyses only included those participants whose discharge date was at least 91 days, 183 days or 365 days prior to the data extraction date for the 3-month, 6-month and 12-month follow up analyses respectively.

Hospital readmission

Research Question: Does engagement with Peer-STOC reduce the rate of psychiatric hospital readmission or the number of admitted patient bed days (in public hospitals)?

28-Day re-admission rates

Hypothesis: Peer-STOC participants will have lower rates of 28-day readmissions in comparison to participants in the comparison group who did not receive Peer-STOC support.

Analysis approach: Those participants who had one (or more) psychiatric-related admissions within 28 days of discharge from the "index admission" were identified. Chi-square analysis were used to determine if there was a significantly lower rate of readmission for Peer-STOC participants in relation to the comparison group. For this analysis, two separate approaches were used. The first approach included same-day readmissions (where the discharge date of the "index episode" of care was the same as the admission date for another episode of care) and the second approach did not include same day readmissions. For the second approach (excluding same day readmission), days to first readmission was calculated based on the first admission that was at least one day after the previous discharge.

Results: Summary statistics for 28-day readmission rates are presented in Table 1.3 and Figure 1.1. Not including same-day readmissions, 10.3% of Peer-STOC participants were readmitted within 28 days of discharge, compared with 15.1% of comparison group participants. Overall, this suggests that proportion of Peer-STOC participants readmitted within 28 days 31.8% lower than for the comparison group.

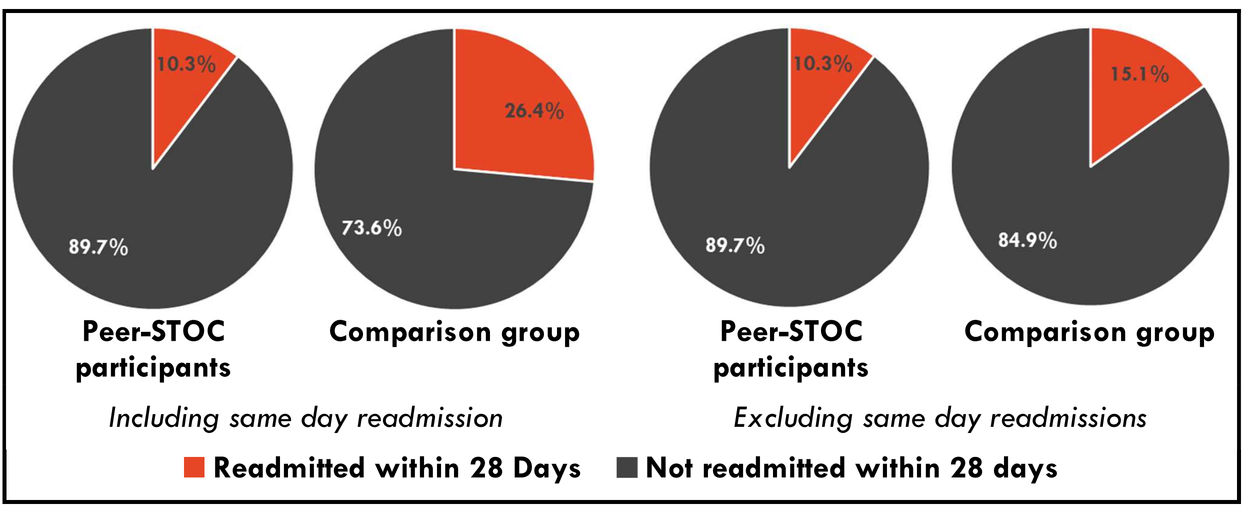
KEY RESULT: **Readmission rates were significantly lower for Peer-STOC participants in comparison to the comparison group.**

These results suggest that Peer-STOC support enabled participants to manage the transition from hospital to home more effectively than individuals in the comparison group.

Table 1.3 28-day readmission rates

	Transition Support Peer-STOC participants	Comparison group	Between group comparisons (chi-square)
Readmission within 28 days (Including same-day readmission)			
Yes	63 (10.3%)	1090 (26.4%)	$\chi^2 = 74.9$, $p < .001$***
No	547 (89.7%)	3032 (73.6%)	
Readmission within 28 days (Excluding same day readmission)			
Yes	63 (10.3%)	623 (15.1%)	$\chi^2 = 9.9$, $p = .002$**
No	547 (89.7%)	3491 (84.9%)	

Figure 1.1 Comparison of 28-Day readmission rates



Number of hospital admissions

Hypothesis: Peer-STOC participants will show reduced psychiatric-related hospital admissions (to public hospitals) in the follow up period in comparison to participants in the comparison group who did not receive Peer-STOC support.

Analysis approach: Firstly, the number of psychiatric-related admissions for each participant in the 3 months, 6 months and 12 months prior to the discharge from the "index admission" (or, for "Other Support Peer-STOC participants, from the date of first community-based contact with Peer-STOC) were calculated. Next, the number of readmissions in each follow up period (3 months, 6 months and 12 months) were calculated. Poisson regressions were used to determine if there was a significantly lower number of admissions for Peer-STOC participants in relation to the comparison group. In each Poisson regression, number of readmissions in the follow up period was the dependent variable and number of admissions in the relevant "pre-index" time period was included as a covariate. To quantify the overall change in number of admissions prior to the index admission, mean change in number of admissions was also calculated for the Peer-STOC participant and comparison group.

Results: Table 1.4 presents the average number of admissions for Peer-STOC participants and the comparison group. These results are also presented visually in Figure 1.2.

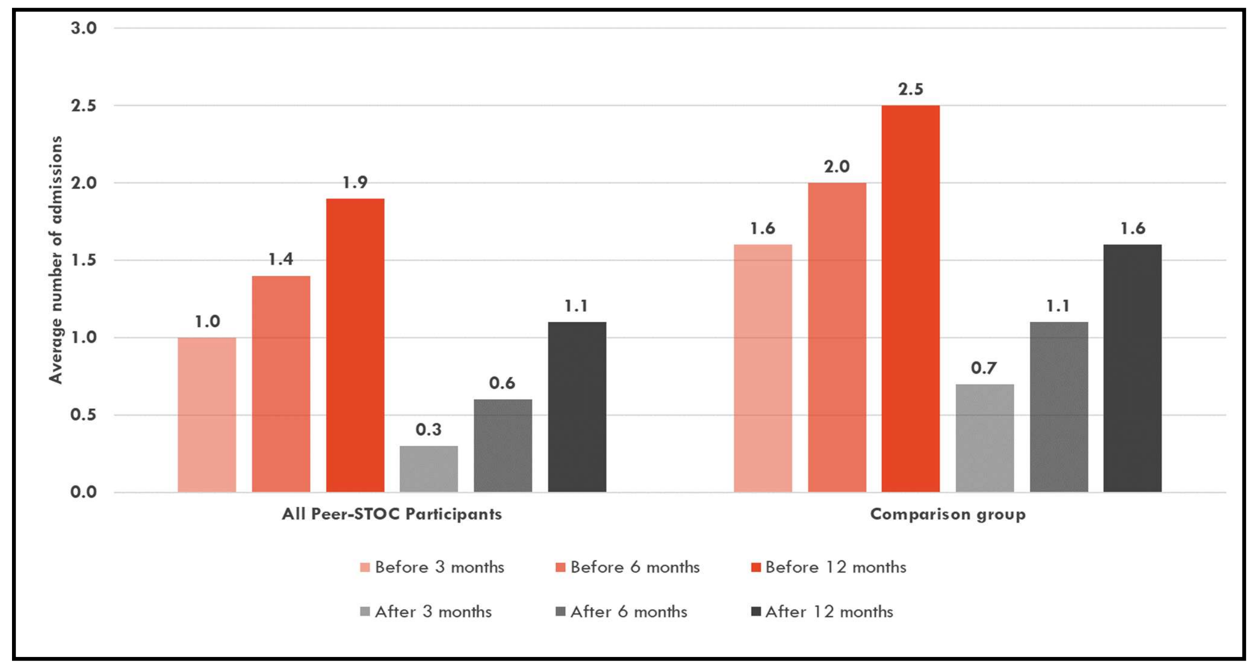
> ***KEY RESULT:*** **Peer-STOC participants had significantly fewer readmissions than comparison participants at the 3-month, 6-month and 12-month follow up periods.**

Table 1.4 Average number of admissions before and after "index date" and between-group comparisons

	Before		After		Change and comparison with "Comparison group"† (Wald Chi-Squared)
	n	Average admissions Mean (S.D.)	n	Average admissions Mean (S.D.)	
Transition Support Peer-STOC Participants					
3 months	611	1.5 (0.9)	566	0.4 (1.0)	-1.1; W = 46.9, p < .001
6 months	611	1.7 (1.5)	486	0.7 (1.5)	-1.0; W = 20.6, p < .001
12 months	611	2.2 (2.5)	327	1.2 (2.4)	-1.0; W = 10.9, p = .001
Other Support Peer-STOC Participants					
3 months	375	0.4 (0.6)	351	0.3 (0.7)	-0.1 W = 44.1, p < .001
6 months	376	0.8 (1.1)	324	0.5 (1.1)	-0.3 W = 51.7, p < .001
12 months	376	1.4 (1.6)	244	0.9 (1.7)	-0.5; W = 32.5, p < .001
All Peer-STOC Participants					
3 months	986	1.0 (1.0)	917	0.3 (0.9)	-0.7; W = 84.4, p < .001
6 months	987	1.4 (1.4)	810	0.6 (1.4)	-0.8; W = 59.8, p < .001
12 months	987	1.9 (2.3)	571	1.1 (2.1)	-0.8; W = 35.9, p < .001
Comparison group					
3 months	4122	1.6 (2.2)	4038	0.7 (2.3)	-0.9; n/a
6 months	4122	2.0 (3.4)	3841	1.1 (3.2)	-0.9; n/a
12 months	4122	2.5 (4.7)	3486	1.6 (4.4)	-0.9; n/a

Note: † based on Poisson regression on number of admissions in each period after "index date", with covariate of number of admissions in the corresponding period before "index date"

Figure 1.2 Comparison of "before" and "after" number of hospital admissions for different groups



Days in hospital

Hypothesis: Peer-STOC participants will show reduced psychiatric-related admitted patient bed days (in public hospitals) in the follow up period in comparison to participants in the comparison group who did not receive Peer-STOC support.

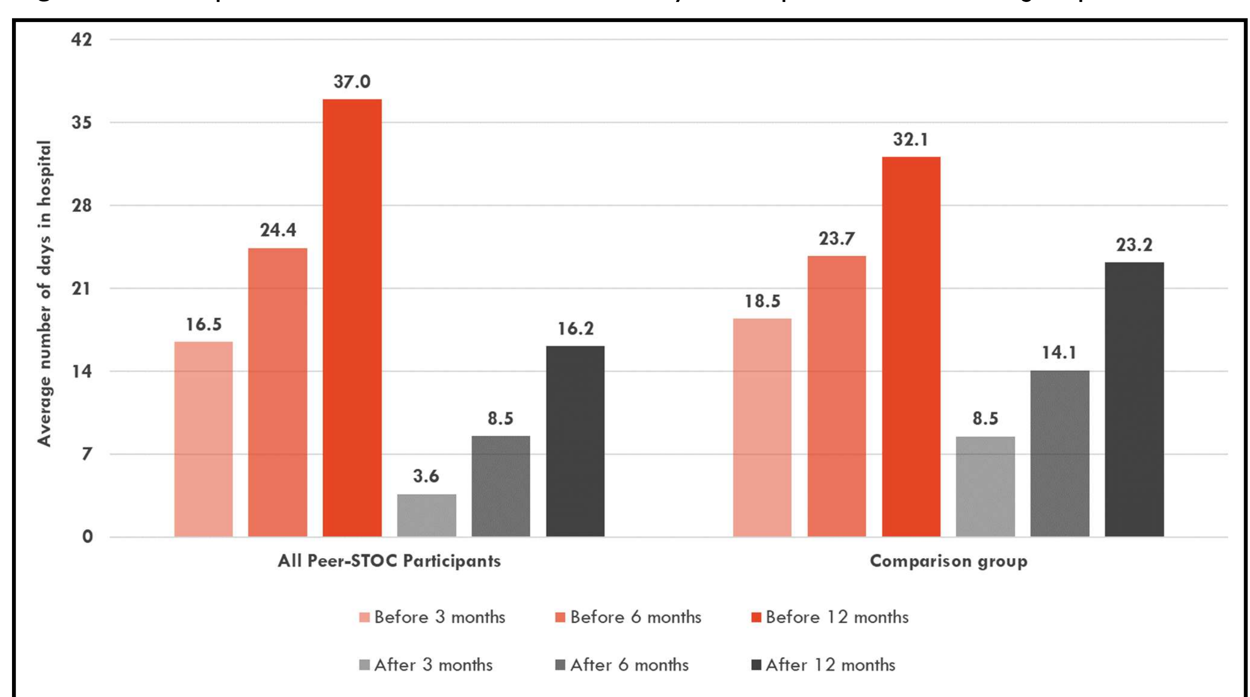
Analysis approach: Hospital bed days were calculated for psychiatric-related admissions in the 12 months, 6 months and 3months prior to the index episode discharge date and for each of the follow-up periods (3 months, 6 months and 12 months) following the index episode discharge date. Between-group differences were analysed using an ANCOVA with "number of bed days in the follow up period" as dependent variable and "baseline bed days" (e.g., number of bed days in the relevant preceding period) entered as a covariate. Where an admission crossed over the pre or post "cut point" for the period (i.e., 91 days, 183 days or 365 days), then the relevant proportion of bed days from the admission was counted.

Results: Table 1.5 includes a summary of average days in hospital in the 3 months, 6 months and 12 months before and after each person's "index date". All groups showed an average decrease in days in hospital in the follow up periods, however, the size of decreases were typically more substantial for the Peer-STOC participant groups. For the Transition Support Peer-STOC participant group, the average reduction in admitted bed days in the 12 months following initial Peer-STOC contact was over 23 days when compared with the 12 months preceding engagement with Peer-STOC (from 39 days to 16 days). A similar average reduction of almost 21 days was seen in the combined "All Peer-STOC participants" group. This compares to an average reduction of only 9 days for the comparison group. These changes are shown visually in the graph in Figure 1.3.

Table 1.5 Average admitted days before and after "index date"

	Before		After		Before-After Change, Days (%)
	n	Average bed days Mean (S.D.)	n	Average bed days Mean (S.D.)	
Transition Support Peer-STOC Participants					
3 months	611	23.2 (22.0)	566	3.8 (10.3)	-19.4 (-83.5%)
6 months	611	30.1 (35.6)	486	9.0 (20.9)	-21.1 (-70.2%)
12 months	611	39.1 (54.6)	327	15.9 (37.5)	-23.2 (-59.3%)
Other Support Peer-STOC Participants					
3 months	375	5.5 (12.4)	351	3.3 (11.0)	-2.2 (-39.4%)
6 months	376	15.3 (27.3)	324	7.9 (21.8)	-7.4 (-48.2%)
12 months	376	33.5 (53.7)	244	16.5 (38.7)	-17.0 (-50.8%)
All Peer-STOC Participants					
3 months	986	16.5 (20.8)	917	3.6 (10.6)	-12.8 (-77.9%)
6 months	987	24.4 (33.5)	810	8.5 (21.3)	-15.9 (-65.0%)
12 months	987	37.0 (54.3)	571	16.2 (38.0)	-20.8 (-56.3%)
Comparison group					
3 months	4122	18.5 (22.0)	4038	8.5 (18.9)	-10.0 (-53.9%)
6 months	4122	23.7 (32.8)	3841	14.1 (31.7)	-9.7 (-40.6%)
12 months	4122	32.1 (52.1)	3486	23.2 (54.2)	-8.9 (-27.7%)

Figure 1.3 Comparison of "before" and "after" days in hospital for different groups



More detailed analyses of "before" and "after" days in hospital allowed for comparisons between Peer-STOC participants and the comparison group. Results from the between-groups ANCOVAs are summarised in Table 1.6 and Figure 1.4.

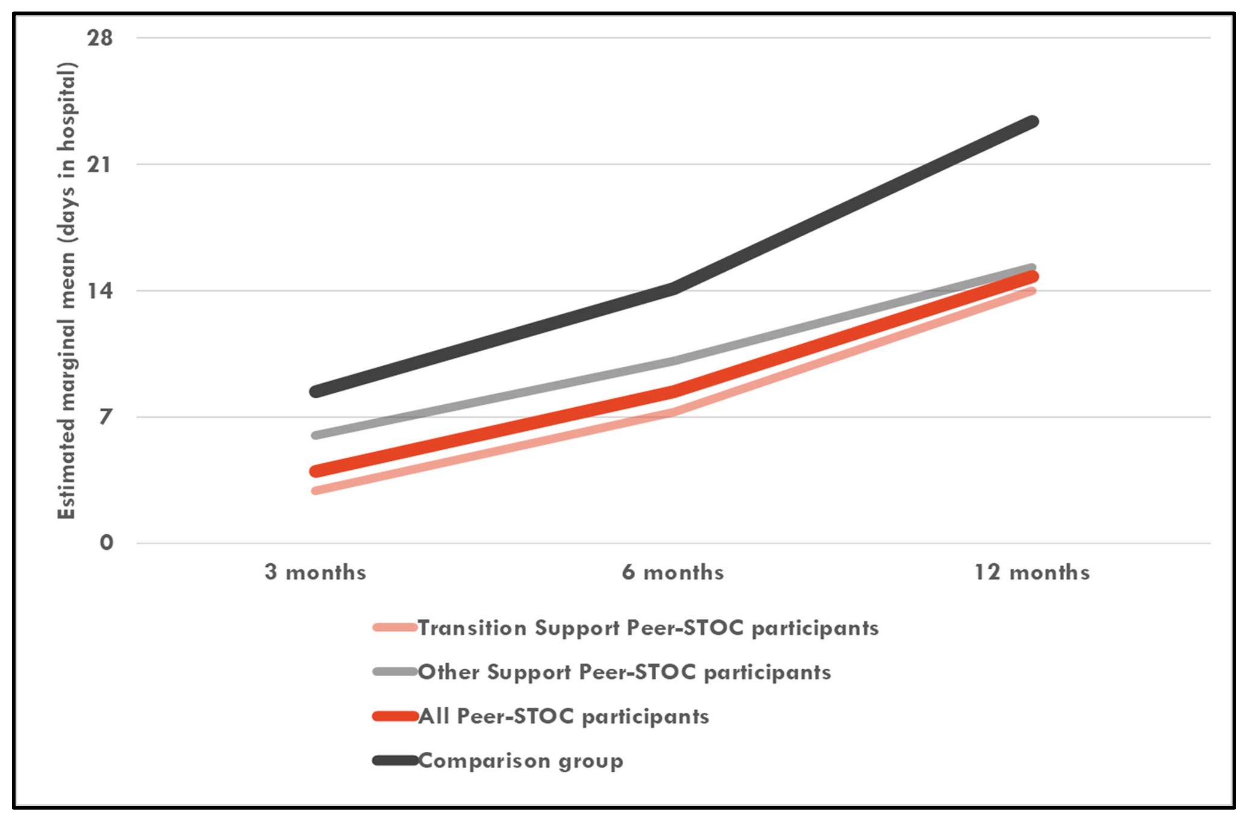
KEY RESULT: **both Transition Support Peer-STOC participants and Other Support Peer-STOC participants had significantly fewer days in hospital than individuals in the comparison group for each follow up period.**

At the 12 month follow up point, the estimated mean (an estimated number of days in hospital after the index date, corrected for the number of days in hospital in the before index periods) for Peer-STOC participants (14.8 days in hospital) was 8.6 days less than for the comparison group (23.4 days in hospital). Spread across the 987 Peer-STOC participants whose data were available for this project, this would equate to 8,488 fewer days in hospital over the course of one year.

Table 1.6 Estimated days in hospital after "index date" (Estimated Means from the Analysis of Covariance) and between group comparison results

	Estimated Means (Std. Error)			Between-group comparisons
Time Point	**Transition Support Peer-STOC participants**	**Comparison group**	**Incremental Mean Difference**	
3 months	2.9 (0.7)	8.6 (0.3)	-5.7	F = 52.4, p < .001
6 months	7.3 (1.3)	14.3 (0.5)	-7.0	F = 15.5, p < .001
12 months	14.0 (2.7)	23.4 (0.8)	-9.4	F = 11.5, p = .001
	Other Support Peer-STOC participants	**Comparison group**	**Incremental Mean Difference**	
3 months	6.0 (1.0)	8.3 (0.3)	-2.3	F = 4.9, p = .026
6 months	10.1 (1.6)	13.9 (0.5)	-3.8	F = 4.9, p = .026
12 months	15.3 (3.1)	23.3 (0.8)	-8.0	F = 6.1, p = .013
	All Peer-STOC participants	**Comparison group**	**Incremental Mean Difference**	
3 months	4.0 (0.6)	8.4 (0.3)	-4.4	F = 50.8, p < .001
6 months	8.4 (1.0)	14.1 (0.5)	-5.7	F = 27.1, p < .001
12 months	14.8 (2.0)	23.4 (0.8)	-8.6	F = 16.2, p < .001

Figure 1.4 Comparison between Peer-STOC participants and comparison group: estimated means for days in hospital after "index date"



Number of Emergency Department presentations

Research Question: Does engagement with Peer-STOC reduce the frequency of psychiatric / mental health presentations to emergency departments in public hospitals?

Hypothesis: Peer-STOC participants will have fewer psychiatric-related public hospital emergency department presentations in the follow up period in comparison to participants in the comparison group who did not receive Peer-STOC support.

Analysis approach: Number of psychiatric / mental health related presentations to emergency departments for the 3 months, 6 months and 12 months prior to the "index admission" as well as each of the follow-up periods (3 months, 6 months, 12 months) was calculated for each participant. Poisson regressions were used to determine if there was a significantly lower number of presentations for the Peer-STOC participant group in relation to the comparison group. In each Poisson regression, number of presentations in the follow up period was the dependent variable and number of presentations in the relevant "pre-index" time period was included as a covariate. To quantify the overall change in number of presentations prior to the index admission, mean change in number of presentations will be determined for the Peer-STOC participant and comparison group.

Results: Results are summarised in Table 1.7 and presented visually in Figure 1.5. As noted previously, during the period before the "index date", Peer-STOC participants had a significantly greater number of emergency department presentations. Given these very substantial differences in the period before the "index date", between group comparisons were difficult to interpret. Although results from the analyses suggest that, in the follow up period, Peer-STOC participants were more likely to have emergency department presentations, change over time for each of the participant groups was limited.

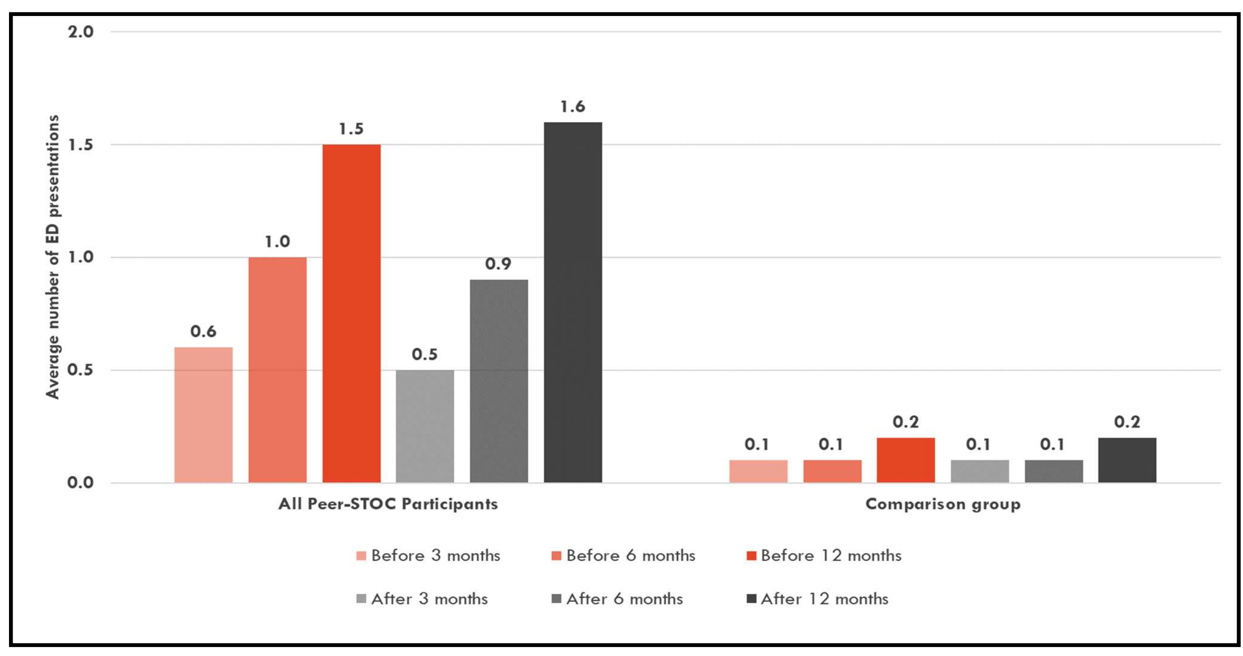
> ***KEY RESULT:*** **There was little change from the "before" to "after" periods in the number of psychiatric / mental health related presentations to emergency departments for the Peer-STOC groups versus the comparison group.**
>
> However, there were substantial differences in the number of emergency department presentations in the "before" period between the Peer-STOC and comparison groups, which make the true impact of Peer-STOC difficult to assess for this outcome.

Table 1.7 Average numbers of emergency presentations, Peer-STOC and comparison participants

	Before		After		Comparison with "Comparison group"† (Wald Chi-Squared)
	n	Average number of presentations Mean (S.D.)	n	Average number of presentations Mean (S.D.)	
Transition Support Peer-STOC Participants					
3 months	611	0.7 (1.5)	566	0.5 (1.3)	W = 247.1, p < .001
6 months	611	1.0 (2.2)	486	0.9 (2.4)	W = 463.1, p < .001
12 months	611	1.5 (3.5)	327	1.5 (4.4)	W = 564.4, p < .001
Other Support Peer-STOC Participants					
3 months	376	0.5 (1.1)	351	0.4 (1.5)	W = 197.2, p < .001
6 months	376	0.9 (1.8)	324	0.9 (3.0)	W = 323.9, p < .001
12 months	376	1.6 (3.2)	244	1.7 (6.7)	W = 258.6, p < .001
All Peer-STOC Participants					
3 months	987	0.6 (1.4)	917	0.5 (1.4)	W = 333.9, p < .001
6 months	987	1.0 (2.0)	810	0.9 (2.6)	W = 649.9, p < .001
12 months	987	1.5 (3.4)	571	1.6 (5.5)	W = 920.8, p < .001
Comparison group					
3 months	4122	0.1 (0.5)	4038	0.1 (0.5)	n/a
6 months	4122	0.1 (0.8)	3841	0.1 (0.7)	n/a
12 months	4122	0.2 (1.1)	3486	0.2 (1.2)	n/a

Note: † based on Poisson regression on number of ED presentations in each period after "index date", with covariate of number of ED presentations in the corresponding period before "index date"

Figure 1.5 Comparison of "before" and "after" number of psychiatric-related presentations to emergency department presentations for different groups



Community Contacts

Research Question: Is engagement with Peer-STOC associated with more frequent connection with community-based mental health services?

Hypothesis: Peer-STOC participants will have a greater number of community contacts in the follow up period when compared with participants in the comparison group.

Analysis approach: Number of community mental health contacts was calculated for each person and chunked into each of the follow up periods (3 months, 6 months and 12 months). Poisson regressions were used to determine if there was a significantly higher number of contacts for Peer-STOC participants as compared with the comparison group. In each Poisson regression, number of contacts in the follow up period was the dependent variable and number of contacts in the relevant "pre-index" time period was included as a covariate. To quantify the overall change in number of contacts prior to the index admission, mean change in number of contacts was determined for the Peer-STOC participant and comparison group.

Given that contacts with the Peer-STOC worker could potentially create a false impression of increase frequency of connection with community-based mental health services", number of contacts was calculated in three different ways. These were: (a) all contacts (number of contacts, including contacts involving Peer-STOC workers); (b) contacts that included other mental health staff (i.e., excluding contacts that only involved Peer-STOC workers); and (c) only contacts that involved Peer-STOC workers.

Results: Table 1.8 shows all community-based contacts before and after the "index admission" for Peer-STOC and comparison participants. In all cases, Peer-STOC participants had significantly higher numbers of contacts in the follow up periods. As these figures could be inflated by contacts with the Peer-STOC workers themselves, analyses were also completed where Peer-STOC worker only contacts were excluded from the dataset. Results from these analyses are presented in Table 1.9 and these also indicate that, even when contacts with Peer-STOC workers were not counted, Peer-STOC participants still had a larger number of community-based contacts than comparison participants. In both analyses, Other Support Peer-STOC participants had fewer community-based contacts than individuals in the comparison group.

KEY RESULT: **Even when contacts with Peer-STOC workers were not counted, Peer-STOC participants still had a larger number of community-based contacts than individuals in the comparison group.**

It should be noted that for the Other Support Peer-STOC participants, there was little change in the "pre" and "post" numbers of contacts. This suggests that Other Support Peer-STOC participants were already having significant contact with mental health workers prior to contact with Peer-STOC. For these participants, it appears that contacts with Peer-STOC workers took the place of some other contacts with mental health workers.

Table 1.8 All community-based contacts (including Peer-STOC contacts) before and after "index admission"

	Before		After		Change and Comparison with "Comparison group"† (Wald Chi-Squared)
	n	Average contacts Mean (S.D.)	n	Average contacts Mean (S.D.)	
Transition Support Peer-STOC Participants					
3 months	611	12.9 (18.7)	566	29.2 (21.7)	16.3; W = 2554.5, p < .001
6 months	611	21.7 (34.1)	486	44.1 (36.6)	22.4; W = 2465.4, p < .001
12 months	611	38.4 (65.5)	327	68.3 (60.0)	29.9; W = 1634.1, p < .001
Other Support Peer-STOC Participants					
3 months	376	25.0 (19.9)	351	28.7 (20.9)	3.7; W = 702.7, p <.001
6 months	376	47.2 (37.1)	324	50.5 (38.2)	3.3; W = 1502.2, p < .001
12 months	376	82.7 (71.9)	244	87.9 (68.4)	5.2; W = 2348.5, p < .001
All Peer-STOC Participants					
3 months	987	17.5 (20.0)	917	29.0 (21.4)	11.5; W = 2762.9, p < .001
6 months	987	31.4 (37.4)	810	46.7 (37.4)	15.3; W = 3511.3, p < .001
12 months	987	55.3 (71.3)	571	76.7 (64.4)	21.4; W = 3559.0, p < .001
Comparison group					
3 months	4122	12.1 (22.6)	4038	19.6 (26.9)	7.5; n/a
6 months	4122	20.2 (38.3)	3841	31.5 (47.3)	11.3; n/a
12 months	4122	33.4 (66.7)	3486	51.8 (84.1)	18.4; n/a

Note: † based on Poisson regression on number of community contacts in each period after "index date", with covariate of number of community contacts in the corresponding period before "index date"

Table 1.9 Community based contacts (excluding contacts that only involved Peer-STOC workers) before and after "index admission"

	Before		After		Change and Comparison with "Comparison group"† (Wald Chi-Squared)
	n	Average contacts Mean (S.D.)	n	Average contacts Mean (S.D.)	
Transition Support Peer-STOC Participants					
3 months	611	12.7 (18.5)	566	23.3 (21.0)	10.6; W = 513.1, p < .001
6 months	611	21.4 (33.8)	486	37.3 (35.7)	15.9; W = 643.9, p < .001
12 months	611	38.0 (65.4)	327	59.8 (57.5)	21.8; W = 427.4, p < .001
Other Support Peer-STOC Participants					
3 months	376	24.9 (19.7)	351	25.0 (20.3)	0.1; W = 164.8, p < .001
6 months	376	46.8 (37.0)	324	45.2 (37.3)	-1.6; W = 613.0, p < .001
12 months	376	82.0 (71.7)	244	80.1 (66.4)	-1.9; W = 1242.9, p < .001
All Peer-STOC Participants					
3 months	987	17.3 (19.9)	917	24.0 (20.8)	6.7; W = 539.1, p < .001
6 months	987	31.1 (37.2)	810	40.5 (36.5)	9.4; W = 1131.3, p < .001
12 months	987	54.8 (71.1)	571	68.7 (62.3)	13.9; W = 1410.4, p < .001
Comparison group					
3 months	4122	12.1 (22.6)	4038	19.6 (26.9)	7.5; n/a
6 months	4122	20.2 (38.3)	3841	31.5 (47.3)	11.3; n/a
12 months	4122	33.4 (66.7)	3486	51.8 (84.1)	18.4; n/a

Note: † based on Poisson regression on number of community contacts in each period after "index date", with covariate of number of community contacts in the corresponding period before "index date".

ECONOMIC EVALUATION

An economic evaluation enables an informed consideration of the value-for-money of Peer-STOC. From the outset it was recognised that the specific approach to the economic evaluation would be determined by the nature and completeness of the data, noting the strong preference of NSW Treasury for a Cost-Benefit Analysis that includes the economic, environmental and social impacts of an intervention.

The economic evaluation has been directly informed by the service utilisation analysis described above, and qualitative findings from the other streams of the Evaluation.

Overall approach

Within the economic stream, the first step was to develop an agreed protocol for conducting the economic analysis. In drafting this protocol the team explored the availability of relevant cost, outcome and resource use data.

The specific research questions asked in the economic evaluation were:

- What are the cost consequences for participants engaging in Peer-STOC?
- What is the overall cost-benefit of Peer-STOC?

The hypotheses tested were that (1) Peer-STOC participants will avoid costs associated with psychiatric/mental health presentations or re-admissions to hospital, and (2) that Peer-STOC will represent value for money as the total costs to deliver the program will yield acceptable benefits in terms of total health outcomes for participants and total healthcare costs avoided.

A cost-benefit analysis was undertaken from the perspective of the NSW health system (**Table 1.10**), where 'cost' refers to the funds released to deliver the Peer-STOC program, and 'benefit' refers to changes in health resource utilisation (i.e. 'cost consequences') by Peer-STOC participants. A one-year time horizon was chosen due to the small sample size and unreliability of the data at or after 2 years from the index admission. As the time horizon was one year no discounting was required.

Two base case economic analyses have been undertaken. These differ in terms of the definition of the comparison made, as follows:

- **Base Case A**: Peer-STOC participants act as their own controls, whereby data from the 12 months after the index admission ('After') are compared with data from the 12 months prior to index admission ('Before').
- **Base Case B**: The Comparison group acts as the control, whereby the incremental mean differences are used to derive the cost consequences of Peer-STOC.

As shown in Chapter 2 (Consumer health recovery and wellbeing outcomes) there were limited data available for measures routinely collected within NSW mental health services. No measures were collected that are transformable to health-related utility, which in turn can be used to drive quality-adjusted life years (QALYs). Consequently, a cost-utility analysis of the Peer-STOC has not been undertaken.

Table 1.10 Characteristics of the base case economic evaluations

	Base Case A	**Base Case B**
Perspective	NSW health system	NSW health system
Population	Peer-STOC participants: whole cohort, Transition Support and Other Support participants	Peer-STOC participants: whole cohort, Transition Support and Other Support participants
Intervention	Peer-STOC program	Peer-STOC program
Control	Peer-STOC participants, pre-program	Comparison group
Clinical outcomes	The mean difference in health service utilisation between the12 months before the Peer-STOC index admission and the 12 months after	The incremental mean difference in health service utilisation at 12 months
Economic outcomes	Mean costs avoided per Peer-STOC participant	Incremental change in costs per Peer-STOC participant
Time horizon	One year	One year
Discounting	N/A	N/A

Sensitivity analyses of the economic evaluation have been undertaken around program costs (using the intended cost per participant rather than the recorded cost per participant; and upscaling the number of Peer-STOC peer worker client-related hours to account for likely underreporting / lack of access to this measure) and around program benefits (the inclusion of costs associated with community contacts other than Peer-STOC workers).

In addition, the net cost-benefit of Peer-STOC at a state-wide level has been estimated, and is expressed in monetary terms as well as in terms of the number of inpatient days released per year of the program.

Methods

Program costs and program benefits have been calculated as described below. Both STATA (statistical software program) and Microsoft Excel (Excel) were used to perform the economic evaluation.

Program costs

Whole of program costs

The total program costs for the Peer-STOC program since establishment have been provided by NSW Health, reported by year and by LHD/SHN. As described in the *Program Overview and Recruitment Support Guide for the Peer-STOC program* (Nov 2017), NSW Health has committed $2.64M to fund the Peer-STOC initiative on a recurrent basis. The analysis of program costs undertaken for the purpose of the economic evaluation of the program is based on the years of funding in which all funds were allocated to staff costs and for which there are data for a full year: namely, 2018/19 and 2019/20.

The first financial year of funding was 2017/18 but release of funds did not occur until late 2017 and there were delays in recruitment of peer workers for many LHD/SHNs. Consequently, it is our understanding that NSW Health did not expect the full amounts

released in 2017/18 to be expended on staff costs and instead expected that all local program establishment costs (e.g. purchase of computers, infrastructure, training) would be taken from this first year funding. The most recent year of funding (2020/21) was not complete at the time the dataset was provided to the evaluation team (i.e. February 2021).

The stated objectives of the Peer-STOC initiative were to supplement the services provided by community-based mental health teams, by providing funding for additional peer worker positions that would be integrated within existing teams. Each LHD and SHN was allocated one of three tiers of funding with annual targets for the employment of peer-workers to deliver Peer-STOC, and for the additional number of client-related hours provided as a consequence of Peer-STOC funding (see Table 1.11).

At a State-wide level, the total annual funds released for Peer-STOC over 4 years are $10.56M with a total target of 31,722 Peer-STOC client-related hours delivered by a total average peer-worker FTE of 35.10 (minimum 28.80, maximum 41.40) per year. The average funded cost per client-related hour is therefore $83.22 (range $83.13 to $83.39) for each year of the Program.

Each LHD/SHN is required to submit 6-monthly reports that detail the total client-related hours recorded for Peer-STOC, and the position title and FTE of all Peer-STOC workers. The LHDs/SHNs do not have targets in terms of the number of consumers who participate in the Peer-STOC program. It is the expectation of NSW Health that Peer-STOC client-related hours will represent 65% of the total hours worked by each Peer-STOC worker. Client-related hours include all contact with Peer-STOC consumers, and all time spent travelling to consumer contacts, preparation of notes, meetings with health professionals and participation in multidisciplinary team (MDT) meetings.

Table 1.11 Annual funding amounts with associated targets for total annual client-related hours and peer worker employment, and the anticipated funded cost per client-related hour by tier of funding

Funding tier	Annual funding amount	Minimum client-related hours per year	FTE average (range)	Anticipated funded cost per client-related hour
Tier 1 (6 LHDs/SHNS)	$115,000	1,379	1.5 (1.2 – 1.8)	$83.39
Tier 2 (6 LHDs/SHNs)	$153,000	1,839	2.1 (1.7 – 2.4)	$83.20
Tier 3 (6 LHDs/SHNs)	$172,000	2,069	2.3 (1.9 – 2.7)	$83.13
All tiers	**$2,640,000**	**31,722**	**35.10 (28.80 – 41.40)**	**$83.22**

Abbreviations: FTE, full time equivalent

Program costs excluded from the economic evaluation

Based on discussions with NSW Health, it is our understanding that NSW Health expects the annual funds released for Peer-STOC to cover monthly peer supervision and training to ensure that all peer-workers achieve Certificate IV in Mental Health Peer Work. In addition, NSW

Health provides a Scholarship Program and Peer-STOC workers are eligible to apply for a scholarship to go towards the costs of training. Funds released to Peer-STOC workers via the Scholarships Program are not included in the current analysis.

Each LHD/SHN can apply for an escalation of funding equivalent to 2.0 – 2.5% per annum to cover inflation of input costs (e.g. staffing). However, as these amounts are funded separately by NSW Health, they are not included in the current analysis.

Program costs per Peer-STOC participant

The economic outcomes associated with Peer-STOC are expressed as the annual cost per Peer-STOC participant. Consequently, the program costs have been converted to the average cost per participant to enable the cost-benefit analysis to be undertaken on a per participant basis. Conversion of the program costs was undertaken as follows (separately for 2018/19 and 2019/20):

i. The total funds released in a year have been divided by the total number of client-related hours recorded (as identified by the research team) for the year, to derive the 'apparent funded cost per client-related hour'.
ii. The average annual program cost per participant is then calculated by multiplying the apparent funded cost per client-related hour by the average number of client-related hours per participant per year.
iii. Similar calculations were also undertaken at the level of individual LHDs/SHNs.

The term '*apparent* funded cost per client-related hour' is used to highlight the limitations with the available data: as the true number of Peer-STOC client-related hours could not be identified in the dataset (due to only 12 out of 18 LHDs / SHNs having Peer-STOC teams set up in the EMR and several other LHDs / SHNs having only established Peer-STOC teams in the EMR12 to 18 months prior to the evaluation), the 'true' funded cost per client-related hour will be lower the number used in the base case analysis. The implications of this for interpretation of the economic findings are discussed below.

<u>Client-related hours</u>

The number of **Peer-STOC worker** client-related hours is an *input* of the Peer-STOC program, not an outcome. Consequently, in the economic evaluation the number of client-related hours is included on the 'cost' side of the cost-benefit analysis. All Peer-STOC worker client-related hours were extracted from the quantitative dataset for the two analysis years (2018/19 and 2019/20).

By contrast, the number of client-related hours attributable to **healthcare workers other than Peer-STOC workers** (i.e. 'non Peer-STOC workers') has been handled in the economic evaluation as an *output* of the Peer-STOC program, and is therefore included in the 'benefit' side of the cost-benefit analysis. However, the interpretation of this measure is not straightforward as it also represents an outcome for Peer-STOC: an increased number of community contacts after hospital discharge represents a positive impact of the program. Thus, although the increased number of community contacts would be expected to reduce the monetary benefit of Peer-STOC, there is value-for-money in this expenditure that is not captured by the cost-benefit analysis. Because non Peer-STOC worker contacts are a mix of output and outcome they are not included in the base case analyses, but are included in sensitivity analyses.

All community-based/ambulatory non Peer-STOC worker client-related hours were extracted from the quantitative dataset for the two analysis years (2018/19 and 2019/20). As these hours are delivered by a range of healthcare workers, the type of health professional was also extracted. Hourly rates for each type of professional were sourced from NSW Health Pay scales and applied to the extracted data. Annual costs per participant were calculated for each year separately, and then the mean of these two years was derived for use in the sensitivity analyses.

Program benefits

Cost consequences of Peer-STOC

The costs 'before' and 'after' the Peer-STOC index admission have been informed directly by the analysis of health service utilisation described above. Appropriate unit costs were applied to each unit of health service use identified in the dataset as occurring before or after a consumer's initial community contact with the Peer-STOC worker. In line with the approach to the analysis of the quantitative data, the index admission itself was included in 'before' costs, and all costs accrued after discharge from the index admission were included in the 'after' costs. Similar data handling rules were applied to data from the Comparison group. Analyses were undertaken for the whole Peer-STOC cohort and separately for the Transition Support and Other Support Peer-STOC participants.

For public hospital services (emergency department presentations, admissions and outpatient episodes) cost weights have been applied using the National Weighted Activity Unit (NWAU, 2019). Descriptive statistics have been used to determine the average annual cost per person for the Peer-STOC group and the comparison group, expressed as overall costs and by cost component. All costs are expressed in 2019 Australian dollars.

<u>Total ED Presentations</u>

The total number of ED presentations for Peer-STOC participants was calculated for the whole cohort, and for Transition Support versus Other Support participants.

The following exclusions were made as per the health service utilisation analysis:

- Presentations to ED that were associated with "Index admissions" were excluded from the analysis
- Participants without a full 12 months of follow up were excluded from the *After* analysis

<u>Total Inpatient Admissions</u>

The total number of psychiatric-related admissions was calculated for Peer-STOC participants, 12 months before the Peer-STOC index admission and 12 months after. This was calculated for the whole cohort, and for Transition Support versus Other Support participants.

The following exclusions were made as per the health service utilisation analysis:

- Participants without a full 12 months of follow up were excluded from the *After* analysis

<u>Total ED and Inpatient Costs</u>

The datasets contained the 2019 version of National Weighted Activity Unit (NWAU) for each admission. The cost for each admission was estimated by multiplying the 2019 NWAU by the

2019/2020 National Efficient Price (NEP).[1] The mean cost per patient admitted was calculated. This cost was used as a proxy for patients with missing NWAU data. The sum of the costs for all admissions in a 12 month period was calculated.

Cost-benefit analysis

Base Case A

The total ED presentations and inpatient admissions and costs were inputted into Excel. The mean ED and inpatient cost per Peer-STOC participant was calculated by dividing the total number of ED presentations or inpatient admissions by the total number of patients in the relevant cohort. Noting, this is different to the mean cost per patient admitted.

The mean costs avoided for the whole cohort and Transition Support and Other Support participants were calculated by subtracting the costs in the *After* period from the costs in the *Before* period.

Base Case B

The mean change in resource use (ED presentations and admitted inpatient days) was taken from the service utilisation analysis.

The total inpatient days per Peer-STOC participant was calculated by multiplying the mean days in hospital per Peer-STOC participant by the total number of Peer-STOC participants in the relevant cohort. The mean inpatient cost per day was calculated by dividing the total inpatient costs by the total inpatient days. This was then applied to calculate the incremental change in cost per participant.

Sensitivity analyses

As noted earlier, during the service utilisation analysis it became apparent that it was not possible to identify all occasions of Peer-STOC worker contacts in the dataset. This biases the quantitative and economic analyses *against* Peer-STOC. In other words, the benefits of Peer-STOC are highly likely to be *under*-estimated and the costs per participant are highly likely to be substantially *over*-estimated. Consequently, the economic analyses based on the identifiable instances of Peer-STOC worker contact should be viewed as representing the 'worst case' of the program's economic impact.

Two sensitivity analyses have been conducted that represent the 'best case' and a case mid-way between the best and worst cases. The 'best case' analysis assumes that every LHD/SHN meets their respective target for client-related hours with the current funds released. For the 'midway case' LHDs/SHNs where it appeared their client-related related hours were <50% of their target had their client-related hours set to be 50% of their annual targets. LHDs/SHNs appearing to be achieving ≥50% of their target client-related hours were held at the rates as recorded in the dataset.

[1] https://www.ihpa.gov.au/publications/national-efficient-price-determination-2019-20

Budget impact analysis

The findings from the economic evaluation were then used to calculate the impact of Peer-STOC to the NSW public health system, expressed in terms of the cumulative number of psychiatric bed days released since the program was implemented. This analysis addresses hypothesis 2.

For each financial year the total savings realised by the Peer-STOC program have been estimated by expressing the total number of client-related hours as a number of participants (based on the average number of community based/ambulatory client-related hours per participant from Base Case analysis A [i.e. 11.95 hours]), and then multiplying the number of participants by the average saving per participant from the Base Case B analysis [i.e. $11,863]).

The number of inpatient bed days released each year has then been derived by dividing the total savings in a year by the average cost per day for a Peer-STOC participant from the Base Case B analysis (i.e. $1,236).

Findings

Program costs per participant

The total number of client-related hours recorded in the dataset was 5,022 hours in the first full year of the Peer-STOC program (2018/19) and 5,499 hours in the second full year of the program (see Table 1.12).

Using the identifiable Peer-STOC hours from the dataset, the average funds released per Peer-STOC client-related hour was $525.73 in 2018/19 and $480.13 in 2019/20. Consequently the mean funds released *per Peer-STOC participant* was approximately $6,000 in each of the two analysis years.

Whilst averages have been used to impute program costs per participant, it is acknowledged that the number of client-related hours per Peer-STOC participant varies widely and that this variation likely represents appropriate care.

Table 1.12 Calculation of the funds released per Peer-STOC participant

Year of analysis	Total number of Peer-STOC client-related hours	Number of Peer-STOC participants	Mean number of hours per participant	Funds released per Peer-STOC client-related hour	Funds released per Peer-STOC participant (mean)
2018/19	5,022	438	11.46	$525.73	$6,024.91
2019/20	5,499	442	12.44	$480.13	$5,972.76
Best case[1]			11.95	$83.22	$994.90

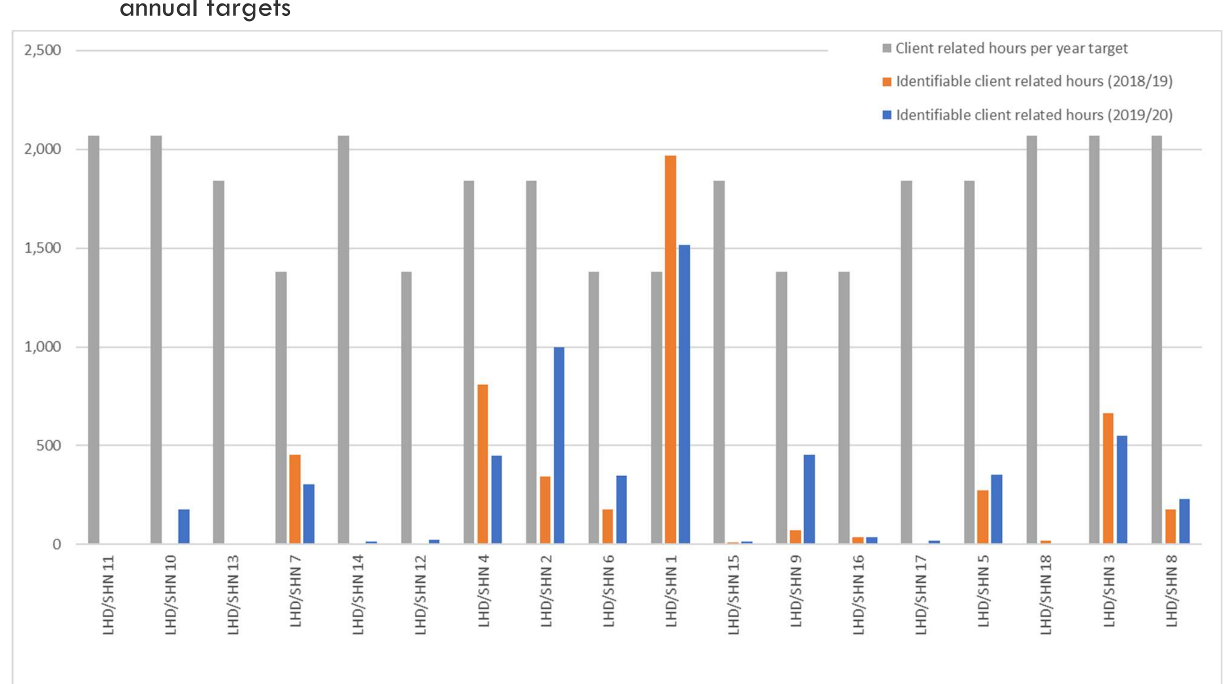
[1] see sensitivity analyses below

KEY RESULT: **Peer-STOC program funding per participant lies somewhere between $1,000 and $6,000.**

The number of identifiable client-related hours are shown in **Figure 1.1**, by LHD/SHN, together with the corresponding annual target for each LHD/SHN. As shown in the figure, there is one LHD/SHN that appears to have achieved its target number of client-related hours in both the second and third years of the program. This concurs with the findings from the qualitative stream where one LHD/SHN stood out as representing 'best practice' in terms of implementation and setting up their EMR to collect the requisite data to monito impact.

However, data for the other LHDs/SHNs need to be interpreted with extreme care, for the reasons described above.

Figure 1.6 Identifiable Peer-STOC client-related hours by LHD/SHN for 2018/19 and 2019/20, with annual targets



> ***KEY RESULT:*** **Data capture systems need to be set up and used appropriately across all LHD/SHNs before the data collected in this way can be relied on for monitoring of Peer-STOC program implementation.**

Cost consequences of Peer-STOC

The change in heath resource use and costs associated with these resources are shown in Table 1.13 and Table 1.14, respectively. It can be seen that the costs associated ED presentations and hospital admissions are lower in the 12 months after the Peer-STOC index admission than the 12 months before the admission. This observation holds for the whole cohort in the analysis, as well as for the two sub-groups of 'Transition Support' and 'Other Support' Peer-STOC participants.

Table 1.13 Extent of health resource use by all Peer-STOC participants in the 12 months before and after their index hospital admission

Group for analysis	Before		After	
	ED presentations	Hospital admissions	ED presentations	Hospital admissions
Whole cohort	(N=987)		(N=571)	
Total admissions	1,536	1,807	1,165	617
Mean length of stay (days)		37.0		16.2
'Transition Support' participants	(N=611)		(N=327)	
Total admissions (n)	922	1,323	693	393

Group for analysis	Before		After	
	ED presentations	Hospital admissions	ED presentations	Hospital admissions
Mean length of stay (days)		39.1		15.9
'Other Support' participants	(N=376)		(N=244)	
Total admissions (n)	614	484	472	224
Mean length of stay (days)		33.5		16.5

Note: differences in the sample size between the 'before' and 'after' comparisons are a consequence of some consumers not having data for the full 12 months after the index admission..

Table 1.14 Total costs associated with health resource use for Peer-STOC participants in the 12 months before and after their index hospital admission

Group for analysis	Before		After	
	ED presentations	Hospital admissions	ED presentations	Hospital admissions
All Peer-STOC participants	$1,197,467	$38,102,528	$907,201	$11,430,379
Transition Support Peer-STOC participants	$719,597	$27,075,940	$539,496	$6,853,967
Other Support Peer-STOC participants	$477,869	$11,026,589	$367,705	$4,576,412

The average annual cost consequences for Peer-STOC participants have been calculated in two ways, to align with the two Base Case analyses. For the Base Case A analysis, the mean costs of ED presentations and hospital admissions per participant have been derived for the 12 months before and after the index admission (**Table 1.15**), using the aggregated cost data in **Table 1.13** divided by the corresponding sample in **Table 1.14**. For this comparison, the total cost consequences for Peer-STOC participants were lower after the index admission than before the admission. This difference equated to $18,211 per participant for the whole cohort, $22,882 for the Transition Support Peer-STOC participants, and $10,334 for the Other Support Peer-Stoc participants.

Table 1.15 Base Case A results: average annual costs per Peer-STOC participant for ED presentations and hospital admissions for the 12 months before and after the index admission

Group for analysis	Before			After			Difference
	ED pres (mean)	Hospital admissions (mean)	Total (mean)	ED pres (mean)	Hospital admissions (mean)	Total (mean)	
All Peer-STOC participants	$1,213	$38,604	$39,817	$1,588	$20,018	$21,606	-$18,210.65
Transition Support	$1,177	$44,314	$45,491	$1,649	$20,960	$22,609	**-$22,881.90**

Group for analysis	Before			After			Difference
	ED pres (mean)	Hospital admissions (mean)	Total (mean)	ED pres (mean)	Hospital admissions (mean)	Total (mean)	
Peer-STOC participants							
Other Support Peer-STOC participants	$1,270	$29,326	$30,596	$1,506	$18,755	$20,262	-$10,334.19

For the Base Case B analysis, the mean cost of ED presentations and hospital admissions per participant have been derived from the mean incremental difference for Peer-STOC participants versus the Comparison group from the service utilisation analysis (see **Table 1.6**). As the quantitative evaluation found no significant difference in ED presentations for this comparison, this resource use has not been included in the economic analysis (**Table 1.16**). The mean cost per inpatient day was derived from the total inpatient costs divided by the corresponding number total number of inpatient days. For this comparison, the total cost consequences were lower for Peer-STOC participants than for the consumers in the Comparison group, with differences of $10,627 for the whole cohort, $12,391 for the Transition Support Peer-STOC participants, and $9,093 for the Other Support Peer-Stoc participants.

Table 1.16 Base Case B results: average annual costs for ED presentations and hospital admissions for Peer-STOC participants versus the Comparison group

Group for analysis	Change in resource use	Incremental change in costs per participant	
	Inpatient days (mean)	Cost per Inpatient day (mean)	Total costs (mean)
All Peer-STOC participants	-8.6	$1,235.69	-$10,627
Transition Support Peer-STOC participants	-9.4	$1,318.25	**-$12,391**
Other Support Peer-STOC participants	-8.0	$1,136.71	-$9,093

KEY RESULTS: **When the Peer-STOC program is delivered as intended (i.e. as transition support) it is associated with annual savings of between $12,391 and $22,882 per participant due to hospitalisations avoided.**

Even when Peer-STOC was delivered flexibly (often as Step-Up support), it still returned annual savings of between $9,039 and $10,334 per participant.

Cost-Benefit Analysis of the Peer-STOC program

The cost-benefit analysis[2] brings together the program costs and the benefits, in terms of cost consequences described in the sections above. For both base case analyses, the program costs and cost consequences are expressed as annual costs per participant. Base Case A of the cost-benefit analysis is shown in **Table 1.17** and Base Case B is shown in **Table 1.18**.

In Base Case A analysis, when the Peer-STOC program is delivered as intended, as transition support, it is associated with a net cost/benefit of -$16,896 per participant. In other words, Transition Support Peer-STOC is cost-saving at the level of an individual participant. The savings per participant are lower ($4,249) when Peer-STOC is not delivered as transition support.

What is also evident is that even though the funds released per participant are similar for Transition Support and Other Support Peer-STOC participants, the savings are greater when Peer-STOC is delivered as intended.

Table 1.17 Cost-Benefit analysis of the Peer-STOC program: Base Case A where Peer-STOC participants are their own controls

	Annual funds released per participant	Annual cost consequences per participant	Net cost/benefit
All Peer-STOC participants			
Peer-STOC 'Before'	$0.00	$39,817.62	
Peer-STOC 'After'	$5,998.89	$21,606.97	
Increment	$5,998.89	-$18,210.65	-$12,211.77
Transition Support Peer-STOC participants			
Peer-STOC 'Before'	$0.00	$45,491.88	
Peer-STOC 'After'	$5,985.85	$22,609.98	
Increment	$5,985.85	-$22,881.90	**-$16,896.05**
Other Support Peer-STOC participants			
Peer-STOC 'Before'	$0.00	$30,596.96	
Peer-STOC 'After'	$6,085.53	$20,262.77	
Increment	$6,085.53	-$10,334.19	-$4,248.66

A similar pattern of findings is observed for the more conservative Base Case B analysis: when Peer-STOC is delivered as transition support it is associated with savings of $6,406 per participant, and these savings are lower ($3,008) when Peer-STOC is not delivered as transition support.

[2] As defined by the University of York Health Economics Consortium (https://yhec.co.uk/resources/glossary/), in healthcare evaluation cost-benefit analysis (CBA) is a comparison of interventions and their consequences in which both costs and resulting benefits (health outcomes and others) are expressed in monetary terms. In the current analysis only benefits already expressed in monetary terms have been included. Monetary valuation of the health outcomes associated with Peer-STOC could be obtained through willingness to pay (WTP) surveys or discrete choice experiments (DCEs), but these are outside the scope of the current project.

Table 1.18 Cost-Benefit analysis of the Peer-STOC program: Base Case B where Peer-STOC participants are compared with the Comparison group

	Annual funds released per participant	Annual cost consequences per participant	Net cost/benefit
All Peer-STOC participants			
Peer-STOC 'Before'	$0.00		
Peer-STOC 'After'	$5,998.89		
Increment	$5,998.89	-$10,626.93	-$4,628.05
Transition Support Peer-STOC participants			
Peer-STOC 'Before'	$0.00		
Peer-STOC 'After'	$5,985.85		
Increment	$5,985.85	-$12,391.53	**-$6,405.68**
Other Support Peer-STOC participants			
Peer-STOC 'Before'	$0.00		
Peer-STOC 'After'	$6,085.53		
Increment	$6,085.53	-$9,093.71	-$3,008.19

KEY RESULT: **When considering the impact on resource utilisation alone, Peer-STOC as a transition support program is highly cost-beneficial: for each $5,986 invested per participant per year there are NSW health system savings of between $12,391 and $22,881, resulting in net health system savings of between $6,406 and $16,896 per participant per year.**

Cost-Benefit sensitivity analyses

A series of one-way sensitivity analyses have been undertaken around the Base Case A analysis (**Table 1.19**) and around the Base Case B analysis (**Table 1.20**). The same set of sensitivity analyses has been undertaken for each Base Case.

In sensitivity analysis 1 (the 'best case') it is assumed that all LHDs/SHNs have achieved their target number of client-related hours. This means that the program funds released are distributed over more client-related hours than were identifiable in the dataset, which reduces the funds released per participant from approximately $6,000 to $994. If it is assumed that the impact of Peer-STOC on service utilisation will be the same as derived from the dataset, the savings associated with the program would increase to $17,216 per participant (compared with $12,212 in the base case, for all Peer-STOC participants).

In sensitivity analysis 2 (the 'midway case'), the number of client-reported hours is assumed to be at least 50% in every LHD/SHN (as described in the Methods section).

In sensitivity analysis 3, the costs associated with client-related hours by non Peer-STOC workers are included in the 'benefit' side of the cost-benefit analysis (as described in the Methods section). The average annual cost per participant for non Peer-STOC worker hours in 2018/19 was $3,141 and in 2019/20 was $3,260. The mean of these two values ($3,200) was then added to the cost consequences included in the corresponding base case.

Table 1.19 One way sensitivity analyses around the Base Case A analysis

Sensitivity analysis name and description	**Annual program costs per participant**	**Annual cost consequences per participant**	**Net cost/benefit**
1. Best case Targets for client-related hours are achieved in all LHDs/SHNs			
Peer-STOC 'Before'	$0.00	$39,817.62	
Peer-STOC 'After'	$994.90	$21,606.97	
Increment	$994.90	-$18,210.65	**-$17,215.75**
2. Mid-way case At least 50% of targets for client-related hours are achieved in all LHDs/SHNs			
Peer-STOC 'Before'	$0.00	$39,817.62	
Peer-STOC 'After'	$1,882.41	$21,606.97	
Increment	$1,882.41	-$18,210.65	**-$16,328.25**
3. Non Peer-STOC workers Includes costs for client-related hours delivered in the community by health workers other than Peer-STOC workers			
Peer-STOC 'Before'	$0.00	$39,817.62	
Peer-STOC 'After'	$5,998.89	$26,377.98	
Increment	$5,998.89	-$13,439.65	**-$7,440.76**

Table 1.20 One way sensitivity analyses around the Base Case B analysis

Sensitivity analysis name and description	**Annual program costs per participant**	**Annual cost consequences per participant**	**Net cost/benefit**
1. Best case Targets for client-related hours are achieved in all LHDs/SHNs			
Peer-STOC 'Before'	$0.00		
Peer-STOC 'After'	$994.90		
Increment	$994.90	-$10,626.93	**-$9,632.03**
2. Mid-way case At least 50% of targets for client-related hours are achieved in all LHDs/SHNs			
Peer-STOC 'Before'	$0.00		
Peer-STOC 'After'	$1,882.41		
Increment	$1,882.41	-$10,626.93	**-$8,744.53**
3. Non Peer-STOC workers Includes costs for client-related hours delivered in the community by health workers other than Peer-STOC workers			
Peer-STOC 'Before'	$0.00		
Peer-STOC 'After'	$5,998.89		
Increment	$5,998.89	-$7,426.50	**-$1,427.61**

KEY RESULT: **If the funds released for Peer-STOC have actually delivered more client-related hours than are identifiable in the dataset, the savings to the NSW health system will be greater than estimated from the available data.**

KEY RESULT: **Even when the analysis includes the additional costs associated with increased community contacts (which are a positive impact of Peer-STOC), Peer-STOC remains cost-saving.**

Budget impact of Peer-STOC

The State-wide budget impact of the Peer-STOC program is shown in **Table 1.21**. This budget impact analysis compares the total funds released (by year) with the total savings realised in each year to yield the net budget impact by year and for the life of the program. The net budget impact is then expressed as the equivalent number of inpatient bed days released as a consequence of the program. This analysis is based on the findings from the most conservative analysis above, the Base Case B analysis.

When interpreting these findings, it must be kept in mind that the first year of the program started mid-way through the year and includes one-off establishment costs. Consequently, the savings realised in 2017/18 are not as high the savings realised in subsequent years. Furthermore, the timing of the evaluation meant that the dataset for 2020/21 includes only part of that year. Accordingly, the totals for the life of the program are based on the first years only.

It can be seen that by the third year of implementation the Peer-STOC program was associated with a Cost Benefit Ratio of 1.85 i.e. every $1 of investment in the NSW public health system was yielding $1.85 in benefits to that system. Furthermore, the extent of benefits realised is likely to be underestimated given the issues with the identifying Peer-STOC activity in the data. Consequently, the Cost Benefit Ratio for the program is likely to be higher than the estimates presented here.

Table 1.21 State-wide net budget impact of the Peer-STOC program since establishment

Financial year	Funds released	Benefits realised	Net budget impact	Total number of inpatient days released
2017/18[1]	$2,640,000	$415,133	$2,224,867	336
2018/19	$2,640,000	$4,463,832	-$1,823,832	3,612
2019/20	$2,640,000	$4,887,869	-$2,247,869	3,956
Totals for first 3 years	**$7,920,000**	**$9,766,834**	**-$1,846,834**	**7,904**
2020/21[2]	$2,640,000	$587,586	$2,052,414	476

Notes:
1 Funding for the first year of the program was only released in November 2017, and many LHDs/SHNs did not begin recruitment of Peer-STOC workers until mid 2018
[2] Figures for calculating savings and bed days released in 2020/21 were incomplete at the time of evaluation and are not included in the totals

KEY RESULTS: **Over its first three years, every dollar invested in the Peer-STOC program has been associated with benefits to the NSW health system of at least $1.85.**

The health system benefits of the Peer-STOC program over its first three years are equivalent to the release of 7,904 bed days across the State.

Discussion of economic findings

The overall conclusion from the economic and financial analyses above is that the Peer-STOC program is highly cost-beneficial. This conclusion holds under a number of sensitivity analyses and under the most rigorous approach to the cost-benefit analysis (i.e. Base Case B which is based on the mean incremental difference between Peer-STOC participants and the Comparison group).

Furthermore, any uncertainty in the economic findings favours the 'no Peer-STOC' group in each analysis, for example:

- The true number of client-related hours in the Peer-STOC group is likely to be an underestimate as not all hours can be identified in the dataset – this would underestimate the positive impact of Peer-STOC
- Individuals in the Comparison group may have received Peer-STOC support that could not be identified in the dataset – this would over-estimate the impact of 'no Peer-STOC' and hence appear to reduce the size of the difference between Peer-STOC and no Peer-STOC

In addition, broader societal impacts of Peer-STOC are not included. Inclusion of impacts such as return to the workforce and avoidance of imprisonment would only strengthen the conclusions around the net benefit of Peer-STOC.

CHAPTER 2:
CONSUMER HEALTH, RECOVERY and WELLBEING OUTCOMES

To understand the impact of Peer-STOC on consumers' health and recovery, we examined **1. What was Said** (interviews and questionnaires with consumers, peer workers and other workers who interfaced with the program), and **2. What was Measured** (routinely collected outcome measures).

RESULTS AT A GLANCE

What was said:

From all three stakeholder perspectives, Peer-STOC had **positive outcomes on the health, recovery and wellbeing of consumers who used the program**. These included:

- ✓ a better, less traumatic inpatient experience
- ✓ feeling understood, cared about and less alone
- ✓ easier to leave hospital and get back into life
- ✓ easier to back into life / return to daily routines
- ✓ helped me to build or re-establish community connections
- ✓ gained new strategies, knowledge, understandings, skills
- ✓ felt more hopeful about self and recovery

What was measured:

? Given the low completion rates for state-wide outcome measures (K10, HoNOS and LSP), it was not possible to make meaningful analyses of change over time on these outcomes

✓ Self-reported recovery (as measured by the RAS-DS) was substantially higher at the completion of Peer-STOC compared with self-reported mental health recovery at commencement of engagement with Peer-STOC

WHAT WAS SAID – findings from the qualitative data

Methods

Data collection

Note. Data collection for the qualitative component of the outcomes stream (reported here) and the implementation stream (reported in Chapter 4) were combined to reduce participant burden and evaluation costs.

Data collection included **both in-depth individual interviews and a brief open-ended on-line questionnaire** (using REDCap). The on-line questionnaire, completed by **82 people**, added another layer of data and maximised breadth of participation by reducing a few potential participation barriers.

58 individual, semi-structured interviews were conducted with participants who provided informed consent. Interviews ranged from 45 minutes to one hour per interview, and participants were offered a small gift voucher as a thank you for their time and contribution.

In-depth, individual interviews were conducted by two lived experience research team members. Interviews were conducted over the phone or via Zoom due to COVID restrictions and to enhance geographical reach. Interviews were audio-recorded with participant consent. Recordings were transcribed verbatim and entered, along with data from the questionnaires into NVivo.

Importantly, in keeping with co-design, the questions that formed the interview guide and on-line questionnaire were developed and refined in partnership with the LEAP team. A summary list of questions/areas of investigation is included in the appendices. As stated above, these lines of enquiry explored both implementation and outcome aspects.

Data analysis

Data collection and analysis were conducted concurrently to allow the research team to pursue lines of inquiry informed by earlier interviews and analyses. For the outcome stream data were analysed inductively with codes generated directly from the data. Data were thematically analysed using constant comparative analysis (CCA) and other rigorous methods drawn from constructivist grounded theory methods [16].

Methodological rigour was enhanced through frequent reflective discussions about the codes and their relationships. This occured routinuely within the immediate research team and at key points with the LEAP team members to ensure lived experience insights were central to the interpretation of the data.

Participants

Questionnaire participants

There were 82 people who participated in the online questionnaire. This included 50 mental health workers, 20 Peer-STOC peer workers and 12 Peer-STOC consumers. Self-reported demographic details are provided below.

Table 2.1 Demographic summary of Peer-STOC consumers completing the questionnaire (n = 12)

Category	Options	Number	Percentage
Area where received Peer-STOC	Greater Sydney†	6	50.0%
	Other NSW‡	6	50.0%
Gender	Female	4	33.3%
	Male	4	33.3%
	Non-binary / other	0	0.0%
	Not stated	4	33.3%
Age	18 to 29 years	1	8.3%
	30 to 44 years	4	33.3%
	45 to 64 years	7	58.3%
Years using mental health services	Under 5 years	10	83.3%
	Between 5 and 10 years	1	8.3%
	More than 10 years	1	8.3%
Most recent diagnosis§	Schizophrenia	3	25.0%
	Depression	6	50.0%
	Psychosis	1	8.3%
	Bipolar disorder	3	25.0%
	Anxiety	3	25.0%
	Borderline personality disorder	2	16.7%
	Post-Traumatic Stress Disorder	1	8.3%
	Other (Adjustment disorder)	1	8.3%
Place of birth	Australia	8	66.7%
	Asia	2	16.7%
	Europe	1	8.3%
	I'd rather not say	1	8.3%
Current or previous Peer-STOC service user	I am still using Peer-STOC	7	58.3%
	I used Peer-STOC in the past but am not using it now	5	41.7%

Notes: † Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney Local Health Districts; ‡ Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW Local Health Districts. Participants from Specialty Health Networks responded based on their geographic location. § Could select more than one diagnosis, so total is >100%

Table 2.2 Demographic summary of Peer-STOC peer workers completing the questionnaire (n = 20)

Category	Options	Number	Percentage
Area where worked in Peer-STOC	Greater Sydney[†]	13	65.0%)
	Other NSW[‡]	7	35.0%
Gender	Female	9	45.0%
	Male	8	40.0%
	Non-binary / other	3	15.0%
Age	18 to 29 years	3	15.0%
	30 to 44 years	7	35.0%
	45 to 64 years	10	50.0%
Duration as a peer worker?	Under 1 year	3	15.0%
	Between 1 to 5 years	12	60.0%
	More than 5 years	5	25.0%
Duration working within Peer-STOC?	Less than 1 year	15	75.0%
	Greater than 1 year	5	25.0%

Notes: [†] Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney Local Health Districts; [‡] Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW Local Health Districts. Participants from Specialty Health Networks responded based on their geographic location.

Table 2.3 Demographic summary of other mental health workers completing the questionnaire (n = 50)

Category	Options	Number	Percentage
Area where worked with Peer-STOC	Greater Sydney[†]	24	(48.0%)
	Other NSW[‡]	26	(52.0%)
Profession[§]	Social Worker	4	(8.0%)
	Occupational Therapist	8	(16.0%)
	Nurse	12	(24.0%)
	Psychologist	8	(16.0%)
	Peer / Consumer worker	9	(18.0%)
	Psychiatrist	1	(2.0%)
	Other	9	(18.0%)
Worked with Peer Workers in the past	Yes	34	(68.0%)
	No	16	(32.0%)
Duration working in mental health	Less than 5 years	12	(24.0%)
	Between 5 and 10 years	11	(22.0%)
	More than 10 years	27	(54.0%)
Which area do you work in?	Public sector acute inpatient setting	15	(30.0%)
	Public sector community mental health setting	31	(62.0%)
	Community Managed Organisation	1	(2.0%)
	Other	3	(6.0%)

Notes: [†] Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney Local Health Districts; [‡] Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW Local Health Districts. Participants from Specialty Health Networks responded based on their geographic location. [§] One respondent indicated two professional qualifications, so totals is >100%.

Interview Participants

58 People participated in in-depth interviews. This included 17 consumers who were currently or had previously used Peer-STOC; 22 Peer-STOC peer-workers, and 19 other mental health workers who had engaged in some way with the Peer-STOC program. Self-reported demographic details are provided below. Note. We are aware that some questionnaire participants also participated in in-depth interviews.

Table 2.4 Demographic summary of Peer-STOC consumers completing interviews (n = 17)

Category	Options	Number	Percentage
Area where received Peer-STOC	Greater Sydney†	12	(70.6%)
	Other NSW‡	5	(29.4%)
Gender	Female	9	(52.9%)
	Male	7	(41.1%)
	Non-binary / other	1	(5.8%)
Age	18 to 29 years	2	(11.8%)
	30 to 44 years	4	(23.5%)
	45 to 64 years	11	(64.8%)

Notes: † Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney Local Health Districts; ‡ Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW Local Health Districts.

Table 2.5 Demographic summary of Peer-STOC peer workers completing interviews (n = 22)

Category	Options	Number	Percentage
Area where worked in Peer-STOC	Greater Sydney†	15	68.2%
	Other NSW‡	7	31.8%
Gender	Female	11	50.0%
	Male	7	31.8%
	Other	4	18.2%
Age	23 to 39 years	9	40.9%
	40 to 49 years	4	18.2%
	50 to 65 years	9	40.9%
Currently/Previously working in Peer-STOC	Currently	17	77.3%
	Previously	5	22.7%
Years of experience in peer worker role (Peer-STOC or other)	< one year	2	9.1%
	1 to 2 years	4	18.2%
	2 to 4 year	9	40.9%
	> 4 years	7	31.8%

Notes: † Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney Local Health Districts; ‡ Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW Local Health Districts.

Table 2.6 Demographic summary of other mental health workers completing interviews (n = 19)

Category	Options	Number	Percentage
Area where worked with Peer-STOC	Greater Sydney†	11	57.9%
	Other NSW‡	8	42.1%
Gender	Male	3	15.8%
	Female	16	84.2%
Age	27 to 39 years	5	26.3%
	40 to 49 years	7	36.8%
	50 to 65 years	7	36.8%
Job Title	Clinical nurse specialist/consultant/NUM	6	31.6%
	Consumer engagement/partnership coordinator/manager	3	15.8%
	Peer support worker/manager/senior	3	15.8%
	Psychologist	2	10.5%
	Rehabilitation/recovery manager/coordinator	2	10.5%
	Social worker	1	5.3%
	Occupational Therapist	1	5.3%
	Health Education Officer	1	5.3%
Inpatient or Community role	Inpatient setting	6	31.6%
	Community mental health setting	13	68.4%

Notes: † Central Coast, Illawarra Shoalhaven, Nepean Blue Mountains, Northern Sydney, South Eastern Sydney, South Western Sydney, Sydney and Western Sydney Local Health Districts; ‡ Far West, Hunter New England, Mid North Coast, Murrumbidgee, Northern NSW, Southern NSW and Western NSW Local Health Districts.

Findings

Across interviews and questionnaires, consumers themselves, peer workers and other workers repeatedly and consistently described positive outcomes and impacts of the Peer-STOC program on consumers.

These outcomes included: a) a better, less traumatic inpatient experience; b) felt understood, cared about and less alone; c) easier to leave hospital; d) easier to back into life and daily routines; e) built and re-established community connections; f) gained new strategies, knowledge, understanding and skills; g) felt more hopeful about my recovery. The nine themes are provided in the table below with a couple of example quotes to illuminate each. This is followed by a detailed presentation of each theme.

Table 2.7 Synthesis of consumer outcomes from all stakeholder perspectives

CONSUMER OUTCOMES	
Themes	**Example Quotes**
A better, less traumatic inpatient experience	*"you've got clients that come into the ward that … don't want to be there either so it can create an atmosphere that can be traumatic for people you know… Having like a peer support worker is like someone that can kind of remove them from the situation … and help them like unpack what's going on"* (OW29) *"We did a lot of activities together... I was fully allowed to be sad or get angry or you know get a bit nostalgic in a safe environment where I wasn't being judged on how much better I was getting… Loved my Peer-STOC worker"* (C19)
Felt understood, cared about and less alone	"[the Peer-STOC program] *gave me … someone to talk to that really understood where I was coming from"* (C15) *"it's just pure understanding and pure empathy"* (C6) *"it helped me just to have a person that was interested in me that I could talk to because I was very alone and isolated and fairly scared"* (C9)
Easier to leave hospital	*"I felt supported. It took the edge off the change, bringing a bit of the hospital into the outside world"* (Cq91) "[Made] *me get*[ting] *out of the hospital or going to the community very easy"* (C1)
Easier to get back into life & daily routines	*"it really helped me to get back on my feet and in a routine once I got home… if I didn't have that support, I think I probably wouldn't have bounced back as quickly as I have"* (C10) *"It's just peace of mind. Like my head was a mess and it sort of helped me come back to reality and get more, start to get organised"* (C17) *"He helped me go back to work easily"* (Cq31)

Built and re-established community connections	"[My Peer-STOC] *peer worker helped me in getting involved with the psychiatrist... also helped me for him to be in between me and the psychiatrist"* (C1) *"we helped her connect with a psychologist"* (PW16) *"I've helped consumers enrol in educational programs… get involved in volunteer work, I've linked consumers in with clothing outlets ... Even things like taking people to Oz Harvest"* (PW6)
Gained new strategies knowledge, understandings, skills	*"she helped me a lot with lifestyle techniques"* (C14) *"he'd tell me about the resources available in the community. That was helpful"* (C16) *"she told me about … some good apps to use for mindfulness"* (C3) *"I think I'm more organised now… I've got these big plastic envelopes that we went and got at Officeworks and I put my bills and documents and medical documents in, and so … that actually helps, if I'm more organised I'm not as anxious"* (C13)
Felt more hopeful about my recovery	*"She probably gave me hope when I was pretty down in the hospital"* (C24) *"they make me feel very, very reassured and they make me feel well. They make me feel confident and clear and you know in tune with my thoughts"* (C6) *"I see them* [consumers] *walking away with more strength, more resilience, more positive about what they could achieve in their own lives"* (PW21)

Note. C = consumer who did an interview; Cq = consumer who completed a questionnaire; PW = a Peer-STOC peer worker who did an interview; PWq = a Peer-STOC peer worker who completed a questionnaire; OW = any other member of the mental health workforce who interacted with the Peer-STOC program who did an interview, and OWq = any other member of the mental health workforce who completed a questionnaire

A better, less traumatic inpatient experience

Repeatedly consumers emphasised the positive impact of caring interactions and conversations with Peer-STOC peer workers on their overall experience of being in hospital. The described **feeling comfortable, building a connection** with and **trusting** the peer worker. They also talked about the **empathy and shared understanding** they experienced from their Peer-STOC peer worker at times when they were feeling distressed or hopeless on the ward: *"they would sit with me and I'd cry and tell her 'this is hopeless' like super early on in my admission, 'this is hopeless, I've lost everything. I've nothing to go home to, like get kicked out of uni, don't have a job', blah blah blah, all those things that are a massive deal when you are hospital… She was never patronising, never holier than thou or complex like 'I'm recovering and you're not'… The way she uses her language is just so unique… I haven't seen it a lot in other mental health professionals"* (C19). C10 said: *"it was easy to talk to someone that had a lived experience. You know, rather than doctors and medical staff"*. Echoing a number of consumers comments about trust, C6 explained that *"there's a level of trust that goes beyond anything that I've experienced"*.

> *"having that experience, touching base with a peer worker… it made me feel at ease. It made me feel comfortable… they are really good assets for the hospital because… which gets back to this trust thing again"* (C6)

Other workers who were based within in-patient wards, also repeatedly described the impact that the Peer-STOC workers had on consumers' or patients' in-patient or hospital experience. They described the **availability** of the peer workers, their **individualised, caring interactions** with consumers, and the **value of their shared experiences.** Other workers said these, and the **lack of a medical agenda** during conversations, collectively **reduced distress and moved consumers focus away from illness management**. OW28, reflecting many comments from other workers based within a hospital or in-patient context, explained that: *"the whole environment* [on the ward] *has got the potential for a lot of tension. Whereas I know that* [the Peer-STOC worker]*, he goes over there, and he even does things like make people cups of tea. So, it's the least threatening or safest… I think he just works out what… can be of value with them. And sometimes, without telling anyone, it's going to the shop and getting them* [daily supplies]. *Sometimes it's taking them for a walk down the river. It's not to do with 'you have to come to this hearing', or 'you have to take these pills', or you have to do anything. His approach is, 'What would you like me to do?', or 'What can I do to help you?'".*

> *"When I was unwell, I was very angry and very aggressive and that led to a lot of issues between staff and me. … I remember the Peer-STOC worker sitting me down at one of the tables one day and just having a chat with me just about her experience… getting on my level. It was less of a clinical interest and more of an empathic interest… a more genuine connection … a safe environment where I wasn't being judged on how much better I was getting"* (C19)

Similarly, OW29 said that: "*Once they've been put in there involuntary and especially, you know, you've got clients that come into the ward that don't want to be there either, so it can create an atmosphere that can be traumatic for people you know… Having like a peer support worker is like someone that can kind of remove them from the situation and take them out for a walk or take them outside and help them like unpack what's going on or whatever".*

OW5 said: "*it kind of meant that they got to know some of those folk but also in terms of if someone was new and had no experience of an inpatient ward, that they were very available to be there, and… took it away from all that talking about how sick you are".*

Peer workers also recognized the value of their shared understandings and shared experiences with consumers on the ward. PW15 said: *"when I have the conversations in the inpatient unit, one of the things they often say to me is that 'this has been the most honest conversation I've had with anybody'".*

Some consumers specifically described the **advocacy and support roles** peer workers played on the ward: *"the other positive thing was when I was going in to see the doctors and the psychiatrists and all that like I was getting just so bamboozled… just feeling really stressed and uncomfortable, I think even the fact that they offered to come in and sit in with the psychiatrist and the doctors I think was helpful like just as a support person. So, I think the role they play in the hospital system is brilliant"* (C10). C6 explained: *"I was scheduled into the psychiatric ward against my will and I was treated involuntary for my condition which was a drug induced psychosis… peer workers help you… be go-betweens – between you and the doctor or you and any member of the hospital"*

Other consumers explained that the Peer-STOC peer worker **activities and groups on the ward,** as well as occasional outings with the peer worker away from the ward, were highlights during their time in hospital. C4 for example said: *"he* [the Peer-STOC peer worker] *used to*

do … a music class. Just a music relaxation class during the day" and C21said: *"They* [the Peer-STOC peer worker] *did a couple of groups in there which was great"*. C6 explained: *"quite often they would run therapy groups and some workshops on certain topics that… the peer workers thought we would benefit from… the memorable moments were when I was on the ward for 3 months – I used to see the peer workers every day and the other memorable moment was when we went into the city and we went out for lunch… and we also managed to catch a movie at the cinema which was nice as well".*

Peer-STOC peer workers also talked about the value of their group program in enhancing consumers experience of hospital. PW7 said that there were consumers: *"who are currently in the in-patient unit requesting my peer groups. They are always asking the nurses and the OTs and staff 'oh when is* [the peer worker] *running his groups?' That's really good because it means I'm actually engaging positively with the group*". A number of consumers said that they valued the activities and groups run by the Peer-STOC peer worker on the ward and some described the value of the groups as a way to open up and connect with others: *"he does group activities… what he does is he picks topics for people to talk about so we'll all sit in a circle and, yeah, he would get us to open up and talk"* (C16). Peer workers also recognised the connection to other peers that groups afforded. One Peer-STOC peer worker remarked: *"suddenly you can see it in their face that they've got something off their chest and recognize other people feel it too."* (PW5). Cq31, describing the activities provided said: "*Please continue to give Peer-STOC services to consumers in the hospital up to the time of them going back into home/community*".

Felt understood, cared about and less alone

Consumers repeated emphasised that working with their Peer-STOC workers made them feel understood, cared about and less alone.

> *"it's just pure understanding and pure empathy between the peer workers themselves and myself"* (C6)

Because of their **shared experience of mental ill-health and service use,** consumers consistently talked about feeling like **their peer worker understood them** *"and I have things in common with them"* (C3). C13 said: "*they can understand, they don't judge, you know what I mean … they're very understanding and that was, that was really good.*" Similarly, C19 said that their peer worker was *"super, super helpful. Like out of 10, 10… my Peer-STOC worker was the one person I could really connect with you know".*

C10 described how their Peer-STOC worker was **'in tune'** with them: *"I felt like they were in tune, like I wasn't just another person on the end of the phone. They actually had got to know me, and they knew when I was saying I was ok they knew I really wasn't which I thought showed like a real genuine concern and understanding"* Another put it this way: *"it* [the Peer-STOC program] *gave me … someone to talk to that really understood where I was coming from."* (C15) C17 explained: *"he understands my situation…. He's had his own experiences with mental health, so it's just an* [opportunity] *to talk to someone with the ability to empathise with the situation"*.

"From the feedback that we get from patients – how much it means to them to have someone that they can speak to that's not seen as a professional, and kind of understand some of what they are going through, I think it's really positive for the patient" (OW6)

Consumers contrasted this experience of being understood with less 'connected' interactions with other workers who did not have a shared lived experience*: "it … helped in knowing that because they were a peer – someone who has been through something … you knew that they understood what you were going through. They just had that better understanding of what was happening rather than sometimes when you talk to someone who's a clinician or you know even a nurse or a social worker … you know this time that that person's been through something similar … you know that they understand where you are coming from"* (C21).

The consistency of consumer comments about feeling understood by their Peer-STOC workers is further evidenced by the few quotes listed below:

- *"I found* [my Peer-STOC worker] *very helpful and understanding. He gave lots of good advice"* (Cq87)
- *"It was helpful to have somebody to talk to about my issues who understood and could relate, was like a friend but a part of 'the system' and was connected to the hospital experience, like a bridge" (Cq91)*
- *"we could talk about things more openly whereas when I compare it to my clinical service, it was like there was a barrier between myself and the medical service, whereas with the Peer-STOC service there wasn't really a barrier between myself and the peer*[STOC] *worker. It's like we had broken down those barriers"* (C15)
- *"Ah, someone to talk to, someone to listen to me" (C16)*
- *"It was good because that connection really helped… it sort of clicked and I found he picked up pretty quickly if I was having a bad day or if things weren't going really well and he would talk me through stuff"* (C21)
- *"very gentle. They were very sincere and understanding. I think they came from experience, so I liked that"* (C20)

One consumer expressed how feeling understood culturally was really important for her: "*The fact that we had that similar thing* [cultural background] *in common and then we had a sibling … that is always causing trouble within the family and I just think that because we had that connection I honestly felt that, ok, this person gets what's happening … that person understood and I thought, 'ok, well I'm being heard', you know … it's actually someone who understands the dynamics of the family and can relate to that problem that I've got"* (C10).

Beyond a shared understanding, consumers also talked about **feeling cared about** by their peer worker. Consumers provided a plethora of examples of things that peer workers did or said that lead them to realise that the peer worker cared about them. These examples range from sending friendly text messages when they knew the consumer was having a difficult day to advocating for them or sending them a Christmas card.

> *"People* [consumers] *were like 'wow!, you actually care about what I'm thinking, what I'm feeling and who I am as a person, and not just me as an illness or 'Come on, just move on'"* (PW19)

Again, just a few examples of many consumer comments are provided below:

- *when someone does something for you it brings about feeling cared for, and it kind of really helps you have a place in the community so that's what I felt. Like it makes those feelings of belonging rather than being excluded"* (C15)
- *"He* [my Peer-STOC peer worker] *rang again the other day to say that he had some spare time so he's just ringing to see how I was doing"* (C21)
- *"even when I was having a really rotten day,* [Peer-STOC peer worker] *made the effort to send me a text message, you know… to check that I was okay and then again the following day and I thought oh well, they didn't have to do that but just showing that little bit of empathy I think and kindness made a real lot of difference"* (C10)
- *"He actually took the time to send a Christmas card wishing me well and telling me how far I'd come and all that sort of stuff so that was nice" (C21)*

Advocacy or *"rooting for me"* (C6) was a particular 'action' that consumers described when talking about their Peer-STOC worker caring about them. C6 explained that: *"when you get scheduled… where you have to be treated involuntary for your schizophrenia under the Mental Health Act, sometimes it feels as though you are a victim and that you are being targeted. When you see someone like [Peer-STOC peer worker], then immediately you get a sense of belonging and a sense of worth and the bond is quite strong and [they] truly go out of their way to show that… they are rooting for me… They are always on my side*". C15 said: *""I think they were really able to advocate for me too which is something I haven't had before so really appreciated that*".

Feeling understood and cared about lead consumers to **feel less alone**. Consumers discussed in varying ways how their interactions with Peer-STOC workers led to them feeling less alone. Many described how important it was to have **someone to talk to that they trusted and who understood when they were feeling lonely and isolated**. Others described **feeling less alone in terms of their experience of mental illness or hospital use.** Talking to their peer worker, helped them to **recognise that others had similar experiences to themselves**. Again, examples abound within the interviews and questionnaires, but a few are provided below:

> *"I can ask questions and they tell you what they know or what they experienced, or they tell you a bit of their personal life when they were young and that, and I feel happy because I'm not alone in that sort of scenario or case"* (C3)

- *"It was nice to have someone who was at my level and could be trusted you know – someone I could actually go to if things were wrong or if I just needed to talk or if I just needed to sit there in silence"* (C19)

- *"For me it was just somebody on the other end of the line letting me know that I was okay... I didn't like hanging up the phone because I was very alone"* (C20)
- *"Ah, having someone to talk to, someone to listen to me. Being able to open up and get things off my chest, yeah"* (C16)
- *"It* [having a Peer-STOC peer worker] *helps me not feel, like I'm not alone with my problem because sometimes when I'm sick or suffering in pain it feels like I'm the only one in the world or the universe with it, but it kind of eases me off that I'm not the only one with the problem* (C3)
- *"it helped me just to have a person that was interested in me, that I could talk to because I was very alone and isolated and fairly scared" (C9)*
- *"It's very comforting. I'm not sort of stuck out on my own… but I've actually got someone who I could chat with who understands the situation. I find it very, very, very helpful"* (C17)
- "*just having someone to come over and take me out has been helpful because, you know, lately I've been worried so just having someone to come and take me out has helped me to take my mind off of things… It's been a positive distraction for me*" (C16)

Some consumers emphasised how critically important their connection with their peer worker was at times when they were **alone and feeling hopeless or suicidal**. One consumer described how his Peer-STOC worker made him feel very much at ease and helped him move through and beyond suicidal ideation. C25 described how his Peer-STOC worker: *"just more or less let me know that I was being heard and gave me numbers and things like that if I really needed to talk to someone. I mean by the end of it I felt very, I felt a lot better. I didn't want to go ahead with things that I was thinking of doing"* (C25). Similarly, PW21 said: *"so you sit and talk to them* [a consumer] *for an hour, but that might have stopped them from picking up a blade and cutting themselves or, you know, taking too much medication or walking out in the street and trying to get hit by a truck or whatever it is that, you know, just that one conversation has made a difference to them".*

Reflecting comments by others, Cq85 said: *"He* [my Peer-STOC peer worker] *has allowed me to talk through problems which may have escalated without his help"*, and C23 explained: *"one time I was feeling really… hopeless I guess, and my Peer-STOC worker came out and saw me and we had a conversation and afterwards it made such a difference to how I had felt".*

Other consumers described **not feeling as alone in dealing with interactions that they feared** when their Peer-STOC worker either went with then or debriefed with them afterwards. One consumer (C15) needed to attend a Mental Health Review Tribunal for a community treatment order hearing and her Peer-STOC peer worker attended. She also said that Peer-STOC was: *"the only service that actually checked in with me after the hearing to see how I went and to help me debrief. So, without the Peer-STOC program there would have been that gap in service delivery where I didn't have anyone to debrief with around"* (C15). Similarly, C10 said: *"when I was going in to see the doctors and the psychiatrists… I was getting just so bamboozled and just feeling really stressed and uncomfortable… the fact that they* [Peer-STOC peer worker] *offered to come in and sit in with the psychiatrist and the doctors I think was helpful like just as a support person".*
Central to consumers feeling understood, cared about and less alone was the consumer feeling that their peer worker was **on the same level, and trusting them**. *"I felt comfortable … I could talk to her and tell her all my, you know, different things that were happening"* (C13). Similarly, C6 said: *"I see the peer workers as someone I can trust,* [more than] *a doctor or a nurse, simply because they have been through it"* and C17 explained the process of building trust and connection: "*at first, I was very closed off and stressed out and anxious whereas now I can*

actually just say, we are really, really chummy and friendly with each other now. We can pretty much talk about anything".

Accessibility and flexibility were also highlighted by a number of consumers: *"I could communicate by email, by text, by phone whereas with community mental health or with other programs in the LHD… it's just communication by phone – you can't SMS or email. So if you're in a place where you can't really verbally communicate you kind of lose that ability to communicate with your clinician whereas with the Peer-STOC worker there is like the ability to send a text or to send an email to say whatever you need to say".*

Easier to leave hospital

"I felt supported. It took the edge off the change, bringing a bit of the hospital into the outside world. Helped me with anxiety" (Cq91)

Unsurprisingly, given this was one of the core objectives of the program, almost all consumers talked about how the Peer-STOC program support **made facing and managing discharge and the early or initial transition out of hospital and back into living at home easier.**

"In the past once I've left hospital there's been no support at all. And I found just knowing that … there was someone who was going to touch base with me just made it… the whole process made it a lot easier and comfortable to go home" (C10)

A number of consumers talked about the fear they had about leaving the supports within the inpatient unit when discharged. C13, explaining well the fragility that others also described about leaving hospital, said: *"I used to think when I was in the hospital many years ago it's like I was a little bird… that's been looked after and then they let it out of the cage… you've been nurtured in the hospital environment, then you go right, gotta go back to, like releasing your back into the wild"*. Consumers said that having Peer-STOC peer worker involvement "[Made] *get*[ting] *out of the hospital or going to the community very easy"* (C1). C16 explained that: "*It just would have been difficult to just go back to real life* [without Peer-STOC]" and similarly C17 said: *It's just peace of mind. Like my head was a mess and it sort of helped me come back to reality and… start to get organised.*

A number of consumers also **compared their current experience favourably to previous discharge experiences.** Consumers compared their positive experiences of Peer-STOC peer worker supported transition to previous experiences and consequences of leaving hospital without follow-up support. C17 credited Peer-STOC support with helping him to stay out of jail this time: *"If I didn't have that* [Pee-STOC] *I probably wouldn't be in this situation I'm in* now [safe accommodation]. *I was at the* [hospital] *for 4 weeks… that was in 2013 but there was no sort of peer follow-up when I left there. It was just pretty much; I went straight from there to jail".*

"when I was in last time… when I left there was no contact from anyone to check on me or see how I was doing or whatever … it was a bit of a struggle, whereas this time at least I felt that you were valued because someone was checking to see that you were ok, not just 'ok – kick you out and see you later'" (C21)

C10 said: *"I've had stints where I've had to be in there [hospital] for 3 and a half months at a time and then had to go home to an empty house by myself and manage and there's been no support. That's been really scary… I definitely think it has made a hell of a difference in the recovery and getting back to what's normal. Like it's made the journey and the process a lot easier"*.

"[Peer-STOC] *steers you in a really good way to help you to assimilate back*" (C13)

Peer-STOC peer workers and other workers from both inpatient and community settings reflected the comments of consumers, also repeatedly talking about the program providing consumers "*a softer landing and a softer transition* [back to community]" (OW13).

Some people talked about the particular value of Peer-STOC in **easing some consumers' fear about, and resistance to leaving the sense of safety and or the sense of connection they had experienced while in hospital**. OW13 explained that Peer-STOC was particularly useful for "*some people* [who] *feel supported in that inpatient unit environment and* [didn't] *necessarily want to get away from there*". Similarly, OW4, working with younger clients said: "*most patients are a bit scared about* that [leaving hospital]. *Like 'what happens if I have suicidal thoughts or what happens if my Mum or Dad don't really understand what I'm going through or what if going back to school is overwhelming'. Like I said, he's like a connection back to the ward where they feel like there's a little bit of support*."

A number of consumers, particularly those who had built connections whilst on the ward, said that the **transition was eased by the continuity of a connection** they had already established with the Peer-STOC peer worker while on the ward, C1 explained: "*it's good he* [peer worker] *went to the hospital because when I went out of the hospital, I think I was looking forward to seeing him again*". *Similarly, C4 said: "I was there for a little while … I grew fond of the daily walks … I found myself talking to the staff members a lot and just sort of getting involved in their lives a bit. So, when I left, I was happy to leave because … I still had a connection there and it was good to see my peer worker after I left"*.

C10 also valued having the same peer worker after they left hospital and not having to re-tell their story to someone new: *"It was just easier when you left hospital because you already had a rapport with that person… in hospital and you've* [already] *like spilled your guts* [so] *you don't have to re-spill your guts. I suppose that's what I'm saying."*

The value of continuity, having the same peer worker following them from inpatient to community setting was also highlighted by other workers*: "they're the only staff members who work across the in-patient and the community, so being able* to [say/know]*… ' I'm getting the support and engagement from somebody while I'm in the unit, and then I know that when I go home I can, I'm going to see that same person, and that familiar face, and I walk out knowing I've got an appointment with that person who I know, and I know their face and they know me' sort of thing."* OW3

Easier to get back to life and daily routines

Consumers talked about the impact that Peer-STOC had on their ability to get back into life after the initial period of transition out of hospital. They talked about the help their peer workers provided to support them to **get their home organised, to get out of the house and to start or return to previous, personally valued routines and activities.**

Consumers described **going back to homes that felt disorganised or overwhelming to manage**. Many of them talked about practical supports, suggestions and connections that the Peer-STOC worker provided to help them to manage and become more organised.

- "*I was very stressed and disorganised and sort of everything was sort of falling apart whereas now I feel pretty comfortable. Ah, I've got the ability to organise myself more… So, everything's not a mess anymore. He* [Peer-STOC worker] *has helped me organise everything and take small steps but to accomplish big things*" (C17)
- "*Looking from how I was when I got home which really wasn't very good… I was a lot better for having had my Peer-STOC worker. I would have been pretty bad*" (C9)
- "*also getting suggestions from him about what to do and how to help with some of the things. That sort of stuff was really good*" (C21)

While Peer-STOC workers connected consumers with other services to support them, some stepped in and provided practical help when other needed supports were not accessible: *I was going to get a service* from [a Community Managed Organisation] *… but I lost contact with them and then the peer worker tried to get in touch with them but couldn't so they tried to help me with services that would help me with the transition - so things like doing my shopping and doing some cleaning to facilitate that process*" (C15).

> *"It gave me the support that someone was there, and I had someone to ask questions to and bounce my feelings off as I was very confused. It was also great to have a friend, and someone to get me out of the house and to do things with*" (Cq64)

Another barrier to resuming a meaningful and satisfying life for some consumers was the fear and worry about leaving their house. Consumers explained that **having someone to encourage them, and to physically be with, made getting out of the house easier** during the early days after being in hospital. C9 said: "*then he started to meet me at the shopping centre. That's a very good thing because it got me out of the house. That's what I needed, and it gave me a person to be with, so we started to do that". C15 said: "When I left* [hospital] *he would do home visits which was really good because I had trouble leaving the house. He would take me to the community, and we'd have a coffee" and C16 said that "just having someone to come over and take me out… it's better than going out somewhere alone.*

Peer workers also repeatedly talked about the value of being with consumers and supporting them to venture out into the community – **sometimes for practical necessities like shopping, but often for pleasure or fun**:

- "*And she now goes and does her shopping, she'll meet me for coffee. And that's amazing. It took us about eight months to get her into the supermarket, but after that it was like you put a kid on a ski slope, she was off*" (PW21)
- "*the amount of people that were thrilled that I could meet them at a beach, or I could meet them at a café, that we could go for a walk. I went whale watching from a headland… She'd never seen whales. That made her day*" (PW23)

When geography or COVID restrictions prevented peer workers doing physical home visits, they often provided encouragement over the phone and supported consumers to set tasks and make plans that they would discuss at the next phone call. C21 for example said: "*there were little set tasks he'd give so that the next time he'd ring to see if I'd done something…it's a weird thing but making you answerable to someone else sometimes actually just helps … you actually go 'oh yeah, I will do this' whereas when you are not feeling the best sometimes, you just don't do*

it. Some of them were just little things like going for a walk, that sort of stuff… so that made me go 'okay I'm going out… so I can talk to him about it'. That was helpful".

Help to re-establishing a meaningful daily routine was something that consumers said their peer workers did. The routines that mattered, differed from consumer to consumer. For many it was about **managing home and looking after themselves,** for others it was about **re-engaging in employment or study again**. C10 said that Peer-STOC "*really helped me to get back on my feet and in a routine once I got home. So, I think if I didn't have that support, I think I probably wouldn't have bounced back as quickly as I have*", and similarly, C4 said that after a few meetings with their peer worker: *"I sort of started to feel like I was looking after myself a bit better and… then I was ready to sort of start getting back to my old self and looking after myself again".*

Peer workers also talked about supporting people to re-engage in routines as an important part of their role: "*a big part of* [what] *I see, like an integral part of that transition is helping people plan a routine when they're in the community"* (PW8).

Employment was a part of re-establishing meaningful routine for a number of consumers, and they described various ways that their peer worker facilitated this:

- *"when I left the hospital, he* [peer worker] *made an email to my boss, my employer at work… telling the employer that I want to go back to the company… I was surprised that he had done it very quick and very well. And I was accepted again.* (C1)
- *He helped me go back to work easily.* (Cq31)
- [M]*y Peer-STOC worker was able to email me my letter so I could get back to work on time. So, he'd been bridging those little things that really impact communication.* (C15)

Built and re-established community connections

> *"It kind of struck me that she* [Peer-STOC peer worker] *would… really work actively with them as they were leaving the inpatient unit and start to connect them with the relevant supports that they identified and provide them with options and opportunities and really practical support to then anchor and connect with those supports and become grounded in those supports"* (OW15)

Every Peer-STOC consumer we spoke to described having **greater community connections** because of their engagement with Peer-STOC. This was also consistently reflected by Peer-STOC peer workers and other workers when their role was community-based.

Creating new connections or re-establishing previous connections wasn't easy, and consumers repeatedly described the value of their peer worker **going with them** rather than just providing recommendations or referrals, because "*it helps with building confidence and getting there, because it's an icebreaker… they know what's going on"* (C3). C3 also explained the value of the peer worker being present: "*someone to double hear things in case the person goes by themselves and miscommunication or mishear something didn't get down, you've got a second pair of ears to listen".* The value of peer workers actually going with consumers to assist in forging connections was also repeatedly noted by other workers: "*I think with the peer support worker who accompanies them, there's … a bit more companionship about going to something*

that you might feel nervous about going to on your own." (OW28). PW5 explained: *"I may even go to school meetings with them as an advocate if they don't feel comfortable to… speak up for themselves fully without someone else there supporting them as a back-up in school meetings with deputies for example".*

Other consumers talked about peer workers exploring options to assist in connecting with services: *He said he will ask them* [how to get support services] *and then he will tell it to me* (C1).

Community connections were diverse and dependent upon individual needs.

(a) Community mental health services and supports:

Consumers described their Peer-STOC peer worker helping them to overcome barriers to engagement with community mental health services. Consumers, peer workers and other workers all described this as **bridging the gap between consumers and mental health services**: C15 said that they valued their peer-worker "*help*[ing] *out with the relationship with community mental health… I really needed someone to really bridge the gap between where community health was coming from and where I was coming from".* Similarly, OW28 described Peer-STOC peer workers as *"a bridge or an adjunct between perhaps clinical directives and clinical treatment".* OW16 said: *"It's improved the engagement of clients with the other side of mental health services – their case manager, psychiatrist".*

> *"I feel like he* [Peer-STOC peer worker] *engages with people well because they can relate to him. So, then he can support them in the community after they leave. Otherwise, they just, they don't, they might not engage with the case managers and staff or the hospital and it kind of becomes a revolving door"* (OW29)

C9's peer worker made the difference in them connecting with psychology services that they had previously avoided: "[Peer worker] *said 'I don't think you're 100% and I think you still need someone' … and he was 100% right ok… I don't like psychologists. I was never going to see one again.* [but] *I've now connected to a* [mental health community centre psychologist] *and I have been for 4 months. I'll see her every week and that was my Peer-STOC worker's doing… I could see that the whole thing was different to what I had expected and believed it to be".*

> *"they definitely helped me to connect with other services including community mental health. So, I had services that had the potential to help me to recover parts of my life rather than losing it because I didn't have any support" (C15)*

A number of peer-workers described helping consumers find psychologists or other mental health services that aligned with the qualities or approaches they were looking for. PW2 for example described how she helped find a *"rainbow friendly psychologist"* for a consumer from the LGTBQI+ community: *"I showed them some examples of emails that I'd sent when I was looking for psychologists – trying to do that purposeful self-disclosure thing ... I want to know that they are going to be a good fit for me. Like I'm a person who is queer, I want to make sure that they're not going to be disrespectful to kind of my values or my lifestyle. So, I'd written an email years ago when I was looking for a psychologist and I printed it out and showed it to a person to give them an example".*

Consumers also talked about the support of Peer-STOC peer workers in improving their interactions, and appointment experiences with psychiatrists and other clinicians. C6 called

their Peer-STOC worker advocating and being the *"go-betweens – between you and the doctor"* and similarly C1 said "[Peer-STOC] *peer worker helped me in getting involved with the psychiatrist... also help me for him to be in between me and the psychiatrist*". A number of consumers described their peer worker helping them to ask for what they needed from their psychiatrist: *"He came with me to my appointment with the psychiatrist which was about me going back to work. So, he advocated for me for that"* (C15).

It is worth noting that some consumers spoke about their Peer-STOC worker advocating for and enhancing the connections that consumers had with staff on the ward, before they moved from hospital to community. C10 for example said: "*she'd advocate for you which I think was a really good quality that she had. She… got them* [nurses] *to come and sit down and explain what had happened.*" C14's Peer-STOC peer worker *"help*[ed] *me access the consumer advocate at* [hospital]*"*.

(b) Services and supports beyond the mental health system

Consumers also said that their Peer-STOC peer worker helped them to establish better connections with a diverse range of other community-based services, systems or supports outside of mental health specific services including **applying for the NDIS, navigating Centrelink, getting on the list for Public Housing** and for one consumer, enhancing their connection with their **parole officer**. OW28 for example described witnessing Peer-STOC peer workers: "*help the client and the people involved in the client's life look at, or look toward, their recovery and their supports in the community that might not just be based around mental health services"*.

Peer-STOC peer workers' help to **navigate the complexity of the NDIS system** was something that consumers, peer workers and other workers all raised. C13 was fearful about engaging with the NDIS and explained "*I have a mobile phone, but I don't own a personal computer and, and with things like NDIS,* [Peer-STOC peer worker] *gave me the confidence to ring them and chat to them and know that there was someone there that you can* [get help from], *if you have any concerns or anything"*. Other workers also talked about the NDIS complexity and witnessing Peer-STOC workers *"help*[ing] *them* [consumers] *navigate the system"* (OW29). PW18 explained how they had assisted a consumer who had been struggling to manage her NDIS package and that with her assistance: *"after a lot of work, she's almost to the point where she can organise her own plan. She now has an occupational therapist that she didn't have before"*. Another Peer-STOC peer worker described how consumers: "*might be unhappy with their NDIS provider so instead of calling particular people within their NDIS support system to assist them with something, they'll call me. It's up to me to assist with building that bridge and trust with their NDIS provider"* (PW7).

C17 who had previously had difficulties with staying out of prison after leaving hospital said *"Uhm, I've had a few discussions with the lady, my parole officer, about the situation and she said he* [Peer-STOC worker] *has been a really good influence in helping me with stuff."* OW25 talked about the Peer-STOC worker assisting consumers with attending a *"court case" and using "transport"*.

Consumer also commented on their peer worker assisting them to connect with services and supports that helped them to **access other life essentials such as accommodation, food and clothing**. *C17 said: "he put me in touch with people like St Benedict's where I can get a warm meal and hotels and places that are available. Housing wasn't particularly helpful, but he did quite a bit of research for me to help me try and find places"*. At the time of the interview, C17,

through their peer worker assistance, was no longer homeless and staying in medium term, relatively stable accommodation. Similarly, C3 said that their peer worker: "*took me… just me and her, looking around op shops and looking around Vinnies… and talking about places where I can get cheap books… she took me to Salvation Army, and we inquired about when they [were] giving away food.*"

(c) Personal connections and relationships

For a number of consumers, one of the hardest aspects of leaving hospital was the isolation they faced. They talked about various ways that their peer worker had helped them to **reconnect with old relationships and to reach out and establish new ones**. C13 explained that their peer worker had encouraged them to reach out to caring friends and neighbours: *Like I have friends, like I've got a network of friends and people … and she encouraged me … if* [I] *needed certain things done around the… to ask different people, like luckily I've got very good neighbours.*

PW13 talked about facilitating two Peer-STOC consumers, who met in an inpatient support group, to maintain a relationship due to their shared love of cats: *"one guy was telling the other guy about how he could learn to love other humans again by loving his cat … And then he shared about how his cat was having kittens and these blokes decided that they were going to meet up the next week so that this one guy could adopt one of the kittens that was going to be born… 'You'll have to come over and we'll have a weekly time to have a cup of tea and learn about how to be a good kitten friend' and that just* [was] *really was a beautiful experience".*

Consumers described the difficulty they had with relationships with family, friends and neighbours, and the help their peer worker gave them in working to **manage or repair these difficult relationships**. C15 explained that "*it's easy for like relationships to break down before you go into hospital because you're unwell and your perception of things is a bit different. So, trying to rebuild that and with Peer-STOC to be a stepping-stone to doing that*". C1 who was struggling with neighbours said, *"he goes in between…I* [had] *a problem with my strata, and he said he will make an email to the address to the strata manager to help me with my neighbours".*

a) **Community organisations, activities and programs**

Peer workers also supported consumers to **establish personally meaningful connections and to engage in personally meaningful activities beyond health or community services**. These diverse connections and activities included educational, volunteer and employment, sport and recreation communities, programs, and activities. PW6 for example, described how she had helped consumers establish a range of community connections after discharge from hospital: *"I've helped consumers enrol in educational programs, I've helped consumers get involved in volunteer work, I've linked consumers in with clothing outlets and things like that so they can get some confidence with that kind of thing. Even things like taking people to Oz Harvest on occasions, for the Oz Harvest hub".* C23 said: *"my Peer-STOC worker… she spoke to me while I was in hospital – 'is there anything I might like to do that I haven't been able to do on my own or for whatever reason?'. … and one thing I really, really miss is going to the beach coz I can't walk on sand or anything anymore and then she told me… that she could take me down there to the surf club and we can find out about the information for the beach access wheelchair, you know to get from the sand to the water".*

Another Peer-STOC peer worker described helping a consumer to connect with a local community yoga group: *"I walked alongside with her and did that together … Also, that … there was someone who had the time and could do that, you know, come to the first yoga class, and that's one of the things I did do with her, to get her, you know help her feel comfortable doing that … she found that really … beneficial to be able to do that, to work on those sort of goals a bit more in-depth once you've been discharged"* (PW20).

> *"we played squash a couple of times together and then he just started going on his own and he joined a club… and he was also engaging in other community based supports that Mission Australia was running"* (PW 6).

As the quote above evidences, again, as with 'getting out of the house', consumers repeatedly talked about the value of the peer worker actually going with them, because *"it helps with building confidence and getting there, because it's an icebreaker…. they know what's going on"* (C3).

Gained new strategies, knowledge, understanding and skills

Consumers in various ways, repeatedly described how they had, with Peer-STOC assistance, **gained new strategies, knowledge, understandings and skills.** One consumer described how he felt: *"more knowledgeable on mental health and also more knowledgeable on getting a job"* (C24) after having discussions with his Peer-STOC worker. Another explained that her Peer-STOC peer worker introduced the idea of developing a 'to do' list and the consumer found this helpful because she had difficulties with her memory following ECT treatment in hospital: *"she encouraged me to write a list … if you needed certain things done around the house or you needed to ask different people"* (C13).

Consumers explained how they had **gained new strategies and skills** to enhance their health and wellbeing from their Peer-STOC peer worker. Most consumers and peer workers described a **flexible, 'organic' and individual focused process** of sharing strategies, when and if it was something that the consumer wanted. As PW6 explained, peer workers needed to be: *"quite malleable with their approach to each consumer because you have to be like recovery is a very individual process… [so]… while you can suggest certain coping strategies, it's up to the individual so just being there as like an educator and as a resource if they want to tap into that variety of coping strategies and things like that. So, like with one consumer, we go to the beach and do like grounding exercises and meditation but then I work with other consumers that wouldn't even consider doing meditation and that's ok too".*

Consumers described a range of strategies and skills they had developed from engaging with their Peer-STOC worker. Some examples include:

- *"He gave me a couple of helpful hints about going off to bed and I remember we discussed some fitness stuff as well…* [and]*… she helped me a lot with lifestyle techniques"* (C14)
- "*We spoke about ways of managing the anxiety, how I could have handled the situation, what I can do next time to alleviate the anxiety, like thinking about my feelings before it got to the point that it did, like how could I next time tune into those feelings*" (C10)
- *"like a wellness kind of [plan]… we jotted down different points about, like the strategies… sort of making a plan like as far as what makes you feel calm or what makes you feel uneasy"* (C13)
- "*somebody to learn from…she told me about … some good apps to use for mindfulness... learning off them I'd say*" (C3)

Peer workers also described supporting consumers to develop new strategies and skills, often by sharing their own, as well as encouraging consumers to **recognise the skills and strategies they already had**. PW5 described: "*reminding them* [consumers] *that they have the tools, or building the tools with them, on how to create boundaries with other people and take charge of these conversations that they are worried about*". PW9 had: "*connected with one consumer who never had anyone to talk to about his voices at all… I was able to talk about strategies I have for managing voices that could hopefully help him*". PWq62 in the questionnaire said that the best thing about their role was "*Having the opportunity to… help [people] understand what they can do for themselves to help make their lives better for themselves*".

A few consumers and peer workers also described using the Wellness Recovery Action Plan (WRAP) tool together to build personalised strategies to manage and plan their well-being and recovery. PW9 said: "*I developed … a wellness recovery action plan with her and she was so proud of it…It's a self-help plan and the consumers have something to take away from the Peer-STOC intervention rather than just words.*"

Several other consumers described how they had **gained new knowledge** because of their involvement with their Peer-STOC peer worker. They mostly talked about knowledge of services and resources available within the community. C16 explained: "*he'd tell me about the resources available in the community. That was helpful for me*" and C17 said: "*the advice on different housing options and stuff were very invaluable*". C3 who was interested in finding out more about applying for a peer worker role said: "*she* [Peer-STOC peer worker] *showed me her … old application when she applied years back* [to be a peer worker] *and gave me an idea of who to go to if I want to become a peer-support worker, like get a Cert IV or go to Flourish*".

Consumers also **gained new understandings or perspectives** due to their interactions with their Peer-STOC peer workers. C9 said that "*After a while of spending some time with me he* [peer worker] *had a very serious day and he told me all the things he thought I needed to do... and I think he was spot on with what he said*" and C17 explained: "*they are adjusting my medication at the moment and it's good to meet up with somebody who can generally have an outsider's perspective to see whether things are going okay with the medication or not because if I start having problems with my head, I'm usually the last person to realise that there's a problem. So, it's nice to have someone there that's… monitoring my state of mind when we catch up*".

PW13 talked about "*kind of helping them think more about themselves in terms of their strengths*" and consumers saying to them "'*oh wow yeah right I have really been thinking about myself in terms of deficits… that does make me feel really like I've been having a big pity party' and 'yeah, it is confronting to talk about my strengths but okay, that helps me have an idea about where to start in terms of working out what I want more of in my life, or working out what to move towards", so I guess people just reflecting on the framing or the worldview generally*". PW23, talking about her involvement in a consumer's changed perspective on life said: "*this woman stopped drinking … and then she went and signed up for uhm courses… and she said that she didn't realise that her life could actually have meaning and that she could positively impact people through the messed-up stuff that she'd been through and that meeting me had given her pain a purpose and that was amazing*".

Felt more hopeful about my recovery

Extending on from new understanding s and perspectives, consumers frequently explained that interactions with their Peer-STOC worker made them feel inspired and **more hopeful about themselves and their own recovery,** although 'recovery' was not a word they often used. Some examples of what consumers said include:

- *"having a connection with someone with a lived experience – seeing someone out there and recovered and doing her thing and wearing her bright funky tights and just bubbly and happy... I think it was just like a subconscious thing of like 'I want to get there!'".* (C19)
- "She [Peer-STOC peer worker] *probably gave me hope when I was pretty down in the hospital" (C24)*
- "[engaging with their peer worker helped me see] *"there's light at the end of the dark tunnel" (C3)*
- *"it did help me with my wellbeing and progress"* (Cq91)
- *"she's very good… and I'm looking forward to going back to do some computer work or more voluntary work or what have you, because it's been doing me the world of good"* (C14)

Some consumers felt more **hopeful about their employment futures** seeing their Peer-STOC peer worker, another with lived experience, working. C23 explained: "*well* if [the Peer-STOC worker] *can get a job, you know, get well and get a job and it doesn't matter how long it may have taken, that's a possibility for us'*." A few people explained that seeing what their peer worker did in their role made her start thinking about pursuing peer work as a career for themselves: *"I think it's opened up some important possibilities for me because I've seen how awesome the peer work service was and I think it might have kind of opened that door to me to become a peer worker."* (C15)

> *"I think it's a brilliant program. I think if anything it just needs to be increased you know. I think it definitely has… like I'm comparing it to my previous hospital stays where I didn't have that, and I definitely think it has made a hell of a difference in the recovery and getting back to what's normal like it's made the journey and the process a lot easier."* (C10)

Peer-STOC peer workers' recovery-oriented and strengths-based approach use helped consumers **reframe and feel more positive about themselves.** One consumer said that working with their Peer-STOC peer worker: "[made] *me re-look at myself and things that I've done and achieved and how good they were - so it made me sort of stop and turn around and focus on the good in my life, not the bad."* (C21) Another celebrated: *"Ah, having someone that comes over that thinks about you and gives you positive things to focus on"* (C16). C4 is another example of a consumer who was inspired and motivated by their Peer-STOC peer worker: *"Just the proactiveness and the positive attitude* [of my Peer-STOC peer worker]. *Just having someone there that's proactive and positive. I respected his approach. It reminded me of how I liked to live, you know".* (C4)

Consumers also described feeling more **self-confident** because of their engagement with the program and the Peer-STOC peer worker. C6 said: *"they make me feel very, very reassured and they make me feel well. They make me feel confident and clear and you know in tune with my thoughts".* Another remarked how the process of being unwell and in hospital had really played havoc with her confidence but having a Peer-STOC peer worker to work with once discharged: *"was of great assistance for me. It gave me some confidence that there was someone*

there. I think it was very good for my mental health" (C9). C17 similarly remarked: *"Ah, my state of mind has improved tremendously* [with the assistance of my Peer-STOC peer worker]. *Uhm, if I'm having any problems it's someone that I can talk to… together we can find solutions to problems"*

One consumer said her belief that she was recovering was validated after her Peer-STOC worker shared her pre and post RAS-DS results with her after she had completed the Peer-STOC program: *"there was a definite improvement, so I thought it was really, yeah, beneficial when he sent them, and I was like 'Yes!' It gave me that validation of 'yep, I am feeling better which is good. I am on the right track'. So, you know I'm not being silly thinking I'm improving"* (C21).

Reflecting consumer testimonies, Peer-STOC peer workers also described noticing the consumers they were working with being more **hopeful, optimistic and self-confident** after contact with the program: *"I see them walking away with more strength, more resilience, more positive about what they could achieve in their own lives"* (PW21). PW10 said: *"With that extra support we have been able to provide, you know,* [help] *people's recovery a little and just help them to stay afloat and a be a bit more resilient and hopefully prevent them from going back to hospital"*.

Repeatedly, in response to a questionnaire question asking them what the most satisfying part of the job was, Peer-STOC workers described watching and witnessing consumers' recovery progress. This is detailed further in the Peer-STOC peer worker outcomes in the following chapter, but a few examples are provided here:

- *"Helping consumers on their recovery journey and watching them re-assimilate into community living. And learning things about my own recovery along the way" (PWq17)*
- *"The positive feedback from Consumers that I have made a difference in their recovery journey" (Pwq97)*
- *"Being able to provide meaningful peer intervention with people when they are rock bottom and… [see them become] more inclined to attempt to make changes towards recovery"* (PWq25)
- *"I really enjoyed the direct service work with people who accessed the Peer STOC Service and seeing progress on their recovery journey"* (PWq2)

A final note. While all participants we spoke to highlighted positive consumer outcomes resulting from the program, many also described current program limitations or implementation related barriers. They believed that addressing these implementation aspects of the program would result in even greater consumer outcomes. Implementation challenges are discussed within the implementation section (Chapter 4) of this report.

WHAT WAS MEASURED – results from routine outcome measure data

Methods

In this part of the evaluation, we sought to explore outcomes achieved by Peer-STOC participants as captured by routine outcome measures. We accessed data from two sources: (1) information on clinician- and consumer completed outcomes measures (Mental Health Outcomes and Assessment Tools Data Collection); and (2) Recovery Assessment Scale – Domains and Stages (RAS-DS) data collected by Peer-STOC teams.

State-wide routine outcome measures included: (1) Kessler Psychological Distress Scale (K10) – a self-rated measure of psychological distress, including questions about depressed mood, anxiety, suicidal ideation and other symptoms; (2) the Health of a Nation Outcomes Scale (HoNOS) – a clinician-rated measure of psychiatric symptoms and their impact; and (3) Living Skills Profile – a measure of independent living skills. Similar to the approach used to gather service utilisation data (described in Chapter 1), these data were extracted from the Health Information Exchange data warehouse by Senior Data Analysts from InforMH and then provided to the research team. Participants in this part of the project are the same as described in Chapter 1. In summary, there were 987 Peer-STOC participants and 4,122 comparison individuals who did not receive Peer-STOC.

For each of the measures described above, "baseline" measures were calculated by calculating a mean score for each outcome measure completed for the 12 months prior to the index date. Scores for each of the follow-up periods were calculated by averaging all "ambulatory review" completions for each measure within each time period (e.g., 1 to 91 days was the "first 3 months"; 92 to 183 days was "3 to 6 months"; and 184 to 365 days was "6 to 12 months"). Measures with 75% missing data (i.e., more than 75% of the items in the measure were recorded as "missing" or "unable to rate"), were excluded. When there were no ambulatory review measures completed within the time period, then this was treated as missing in the analysis.

The initial analysis plan was to compare change from baseline to follow up between the Peer-STOC group and comparison group using ANCOVA (with baseline measure as the covariate) at each of the follow up periods. However, due to limitations in the data, a simpler approach was adopted, using paired *t*-tests to examine change over time for each group.

RAS-DS is a self-report measure of mental health recovery that includes four domains of recovery. These domains include: doing thinks I value (tapping into functional aspects of recovery); looking forward (psychological aspects of recovery); mastering my illness (symptom management and coping-related aspects of recovery) and connecting and belonging (social aspects of recovery). RAS-DS had been adopted as an additional outcome measure for Peer-STOC in a number of LHDs / SHNs. As RAS-DS data were not available from the Health Information Exchange, these records were provided directly to the evaluation team by Peer-STOC managers from the relevant LHDs / SHNs. As these records were required to be de-identified prior to being provided to the research team, it is not possible to describe the demographics of the sample of participants or to link RAS-DS outcomes with other outcomes.

Different LHDs / SHNs took different approaches to their use of the RAS-DS. Some offered RAS-DS as a tool to identify consumer priorities at the commencement of Peer-STOC and did not offer the RAS-DS at the conclusion of Peer-STOC. For these LHDs / SHNs, analyses of change over time were not possible. Other LHDs / SHNs offered consumers the opportunity to complete the RAS-DS at commencement and completion of Peer-STOC. These pre and post Peer-STOC RAS-DS completions were able to be used to evaluate change over time. For these measures, "percentage" scores were calculated for each domain and a total RAS-DS score for both timepoints (i.e., pre and post). Pre and post RAS-DS scores were then compared using paired *t*-tests. Cohen's *d* was calculated to quantify the "effect size", with scores of 0.2 being interpreted as "small effect", 0.5 as "medium effect" and 0.8 and over being "large effect."

Results

State-wide Routine Outcome Measures

In many ways, the key finding from this analysis was the very low number of recorded completions of these outcome measures. Table 2.8 lists the proportion of individuals who had outcome measures recorded at baseline and during the various follow up periods. Completion rates for the K10 were especially low (less than 10%). For the HoNOS, completion rates for some groups at some time points was up to 30%, however, this was sporadic and different individuals had measures available for different timepoints. As analyses would be most accurate if the same individuals were included in each of the follow up periods, the dataset was reviewed to determine how many individuals had measured completed at all timepoints (i.e., at baseline and during each of the 3-month, 6-month and 12-month follow up periods). These figures are also presented in Table 2.8 and were consistently low (generally under 5%).

KEY RESULT: **Completion rates for state-wide routine outcome measures (K10, HoNOS and LSP) were very low. This means that analyses of change over time will be difficult to interpret and may be misleading or not representative of change experienced by the broader participant group.**

Notwithstanding the limitations of this dataset described above, some analyses were completed. Figure 2.1 provides an overview of the results for analyses completed to explore for change over time: firstly, for individuals for whom "complete" sets of measures were available and secondly, for all individuals who had baseline and follow up measures for each of the periods. The markedly different results obtained from these two different approaches to analysis further highlights the limitations in this dataset. Detailed results from these analyses are available in Appendix 3.

Table 2.8 Proportions of participants with baseline measure and follow-up measure available at each time point.

	K10	HoNOS	LSP
Transition Support Peer-STOC participants (N = 611)			
3 months	27 (4.4%)	69 (11.3%)	39 (6.4%)
6 months	30 (4.9%)	114 (18.7%)	52 (8.5%)
12 months	28 (4.6%)	101 (16.5%)	41 (6.7%)
Individuals with "complete" sets of data (i.e., at baseline and at 3, 6 and 12 months)	6 (1.0%)	20 (3.3%)	10 (1.6%)
Other Support Peer-STOC participants (N = 376)			
3 months	31 (8.2%)	103 (27.4%)	61 (16.2%)
6 months	27 (7.2%)	110 (29.3%)	68 (18.1%)
12 months	27 (7.2%)	118 (31.4%)	70 (18.6%)
Individuals with "complete" sets of data (i.e., at baseline and at 3, 6 and 12 months)	5 (1.3%)	32 (8.5%)	27 (7.2%)
All Peer-STOC participants (N = 987)			
3 months	58 (5.9%)	172 (17.4%)	100 (10.1%)
6 months	57 (5.8%)	224 (22.7%)	120 (12.2%)
12 months	55 (5.6%)	219 (22.2%)	111 (11.2%)
Individuals with "complete" sets of data (i.e., at baseline and at 3, 6 and 12 months)	11 (1.1%)	52 (5.3%)	37 (3.7%)
Comparison group (N = 4122)			
3 months	119 (2.9%)	342 (8.3%)	219 (5.3%)
6 months	163 (4.0%)	409 (9.9%)	287 (7.0%)
12 months	230(5.6%)	543 (13.2%)	348 (8.4%)
Individuals with "complete" sets of data (i.e., at baseline and at 3, 6 and 12 months)	21 (0.5%)	77 (1.9%)	66 (1.6%)

Figure 2.1 Summary of results from paired *t*-tests between baseline scores and scores at each of the follow up periods.

	Transition Support Peer-STOC Participants			Other Support Peer-STOC Participants			All Peer-STOC Participants			Comparison group		
	3 Months	6 Months	12 Months	3 Months	6 Months	12 Months	3 Months	6 Months	12 Months	3 Months	6 Months	12 Months
Based on people with full data (i.e., measures available for baseline and for each of the 3 month, 6 month and 12 month follow up periods)												
K10	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
HoNOS	⇔	⇔	⇔	⇧	⇔	⇔	⇧	⇧	⇔	⇧	⇔	⇔
LSP	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
Based on people with any data (i.e., any individuals with measures available for baseline and for the relevant follow up period)												
K10	⇩	⇩	⇩	⇔	⇔	⇔	⇩	⇩	⇔	⇩	⇩	⇩
HoNOS	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔
LSP	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇔	⇧	⇧	⇧

Notes: ⇩ = significant reduction in score from baseline (note that lower scores represent better health / functioning, so reductions suggest positive change); ⇔ = no significant difference in score from baseline; ⇧ = significant increase in score from baseline (note that higher scores represent poorer health / functioning, so increases suggest negative change).

RAS-DS

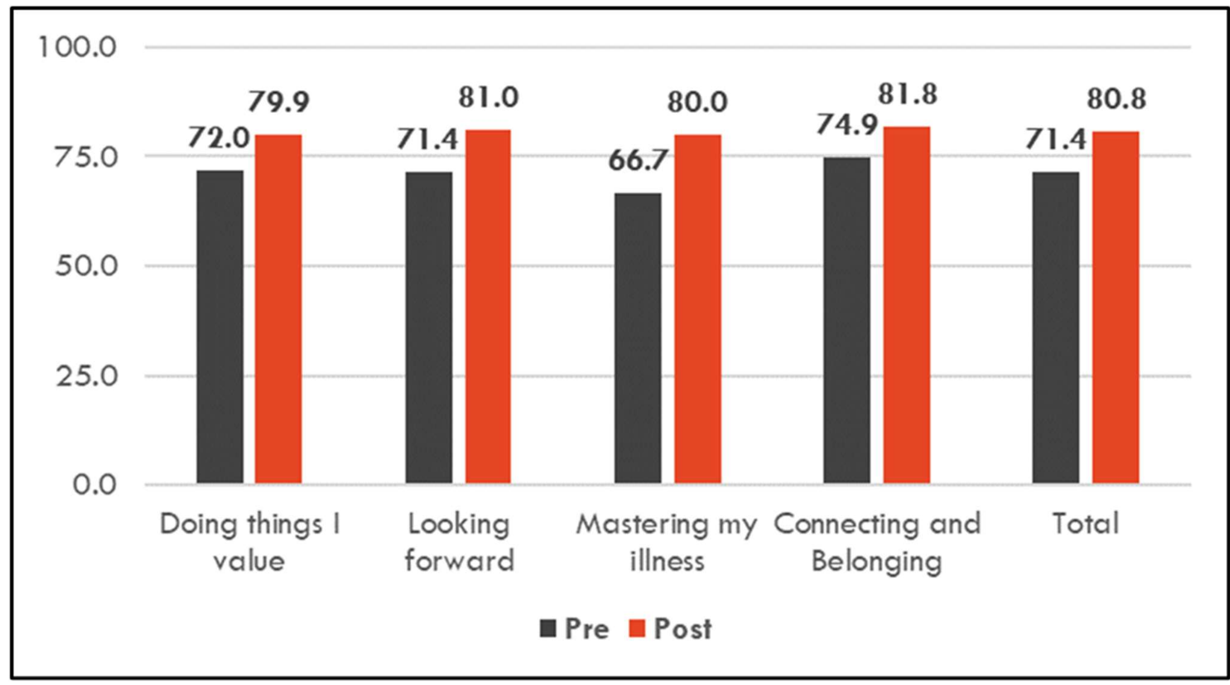
Data were available for a total of 41 Peer-STOC participants who completed the RAS-DS at commencement and completion of their engagement with the program. Table 2.9 and Figure 2.2 show the change over time. All changes were highly significant. Effect sizes ranged from 0.48 to 0.90, suggesting a medium to large effect.

> ***KEY RESULT:*** **RAS-DS results indicate that self-reported recovery was substantially more advanced following engagement with Peer-STOC.**

Table 2.9 Change in self-reported recovery from beginning to end of Peer-STOC contact (n = 41)

RAS-DS Domain	**Pre**	**Post**	**Paired t-test result**	**Effect size**
Doing things I value	72.0 (19.1)	79.7 (15.0)	$t = 4.2$, $p < .001$	0.68
Looking forward	71.4 (17.7)	81.0 (14.7)	$t = 4.8$, $p < .001$	0.77
Mastering my illness	66.7 (17.4)	80.0 (16.4)	$t = 5.2$, $p < .001$	0.84
Connecting and Belonging	74.9 (17.0)	81.8 (14.5)	$t = 3.0$, $p = .005$	0.48
Total	71.4 (15.2)	80.8 (13.8)	$t = 5.7$, $p < .001$	0.90

Figure 2.2 Change over time in self-reported mental health recovery from the RAS-DS



CHAPTER 3: FLOW ON OUTCOMES – Systemic & peer worker

Beyond outcomes of the program on Peer-STOC service users or consumers, participants in this evaluation described flow on impacts of the program for both 1. The mental health system more broadly, and 2. The peer workers employed within and delivering the Peer-STOC program. These are detailed below.

1. Broader systemic outcomes & impacts

Both Peer-STOC peer workers and other mental health staff spoke about the outcomes that the Peer-STOC program had made on other staff and the broader mental health system. Repeatedly the program and Peer-STOC peer workers were described as creating **bridges across the system and bridges between consumers and services**. Consumer interviewees were less aware of these broader systemic impacts or were less vocal about them in interviews and questionnaire responses.

Positive system changes attributed to Peer-STOC included: **a) Better system integration; b) Better consumer engagement; c) Shifting culture and perspectives; d) More recovery-oriented and person-centred practices; and e) Increasing respect and value for the Peer-STOC program and peer workers over time.**

While positive system changes or impacts dominated, from the perspectives of both Other Workers and Peer-STOC peer works, they also described potential system changes or impacts being limited by barriers. These barriers or negative outcomes included **a) Resistance to change and b) Ongoing confusion and concern about the role of the Peer-STOC peer-worker and the program** (both detailed below). Other barriers to realising positive outcomes included exclusion of the peer worker in contrast to the increasing inclusion described here, the level of peer worker confidence to challenge current cultures, hierarchies and practices and the 'overstretched' role of the peer workers within the program. These are covered elsewhere in this report.

Table 3.1 Synthesis of outcomes or impacts on the broader mental health system and staff (2 stakeholder perspectives)

BROADER SYSTEM AND OTHER WORKER OUTCOMES/IMPACTS	
Themes	**Example Quotes**
Better system integration	OW15: *they've* [Peer-STOC peer workers] *got a bridging effect, not just for the actual person that they are supporting but for the organization as well* OW16: *They… help to build a bridge between the inpatient setting and the community setting*
Better consumer inclusion	PW8: *we're the honey of the service that glues the people… to the service* PW 23: *a few people … felt they needed more support and they needed to come back to hospital… people told me that they wouldn't have done that*

	or wouldn't have done that as soon as they did, if I wasn't a link for them to the service
Shifting cultures and perspectives	OW18: *It changes the language people use … it just makes people a bit more aware that we're talking about a person here … it's those subtle things that I think have made a significant difference to just the culture of the service* OW4*: we remember that it's a person not just a diagnosis* PW13: *I do think it* [Peer-STOC] *makes a difference. It brings support to allies who are already working in the system, keen to work in humanistic ways* PW16: *quite a senior staff member… She's been a lot more mindful of her language… there was this willingness for people to take on board the peer values*
More recovery-oriented and person-centred practices	OW16: *I think having the Peer-STOC workers helps us to be more person-centred in our approach to clients and I guess how we kind of work with the clients is enhanced by having Peer-STOC around* OW13*: she is so verbal and strong and such an advocate for people like herself with lived experience, it just always makes the discussions more holistic and not just one sided from a medical or a psychosocial* [side]*, it just brings in that other aspect which is so important* PW16: *I have seen a lot more nurses coming out and engaging with patients on the ward. They are coming outside of the goldfish bowl. I don't know if that is me or that's a general move… I might just be a small piece in a big puzzle that's coming together*
Increasing value and respect for Peer-STOC and peer workers over time	PW(s)37: *connections with clinicians and allied health workers who are supportive of me personally, value peer work and support opportunities for peer worker involvement* PW 16: *I think the big thing is the respect, a lot of respect… the longer it* [Peer-STOC] *goes on in the service, the more I see psychiatrists and people come up and say 'I think such and such would benefit from your service' and that's a lovely thing, those who acknowledge me* OW18: *it's taken some time for people to appreciate the value and the complementary role of the Peer-STOC worker can play as part of the treating team*
Resistance to change	PW13: *I'd never worked inpatient before and the inpatient has a lot more doctors, a lot more registrars, they do the rotation every 6 months so that kind of culture seemed even harder to tackle … sometimes we did have a voice and there were some people trying to make space for us but lots of times we wouldn't have a voice* OW23: *The other thing is a lot of the registrars and psychiatrists aren't very well informed about what the Peer-STOC is. So that needs to be improved here* OW27: *I think it's partly just a natural resistance to change. I also suspect that some of our clinicians felt that by introducing peer workers would*

	devalue the role of clinicians whereas that's not true at all, but I think that's how some of our clinicians felt OW4: *I do think that the registrars and residents do struggle with it a little bit... they are a little bit defensive*
Confusion & concern about Peer-STOC and role of peer worker	OW19: *how are you going to fit Peer-STOC workers successfully into your team if nobody actually knows what that role is?... I'd love to understand a little bit more about their role.* OW 23*: Maybe a bit more education* [is needed] *for… the staff on the unit to know what Peer-STOC is*

Note. C = consumer who did an interview; Cq = consumer who completed a questionnaire; PW = a Peer-STOC peer worker who did an interview; PWq = a Peer-STOC peer worker who completed a questionnaire; OW = any other member of the mental health workforce who interacted with the Peer-STOC program who did an interview, and OWq = any other member of the mental health workforce who completed a questionnaire

Better system integration – 'bridges'

Other workers, and Peer-STOC peer workers themselves, repeatedly used the term 'bridge' to talk about the role the Peer-STOC program and peer worker played in enhancing **integration between inpatient and community based teams or services** as well as **integration between different members of a multi-disciplinary team.**

> *"They… work in the inpatient settings … that can help to build a **bridge** between the inpatient setting and the community setting. I guess the lived experience can really help in terms of building rapport"* (OW16)

Repeatedly interview and questionnaire participants described the Peer-STOC peer worker as **a bridge between the in-patient and community contexts and clinical teams.** They talked about the program leading to enhanced communication and linkage between previously disconnected services and staff across the mental health system:

"*they've* [Peer-STOC peer workers] *got a bridging effect, not just for the actual person that they are supporting, but for the organization as well, because they are working outside of the silos of an inpatient unit and a community team… they kind of become this conduit between different teams and services that may not otherwise be there*" (OW15).

"[it is] *quite helpful to have that bridge from the hospital to the community but also from the nurses and the doctors and allied health staff at the hospital to the nurses and doctors and allied health staff here* [in the community] (OW16).

Peer-STOC peer workers also described this bridging impact of the program and celebrated when colleagues recognised this value: *"one of the clinicians… put it really nicely… they see us as the glue that keeps the service going*" (PW8).

Peer-STOC also provided **bridges between community mental health and other community-based services beyond the mental health system**: *"[they] seem to be able to offer support in a less threatening way, and be a bridge… between perhaps clinical directives and clinical treatment, and… their supports in the community that might not just be based around mental health services"* (OW28).

Allied health workers including OW4 described the value of Peer-STOC peer workers as **allies, helping to create bridges between themselves and medical colleagues**: *I do think that the registrars, residents and consultants have a lot less interaction with* [patients] *and they just become a bit more like a name or number … I think the peer support worker… allows that gap to be filled. I don't have to stick my head out all the time".*

Some other workers didn't necessarily speak about community services but valued the **continuity of support** that Peer-STOC peer workers provided patients after they were discharged from hospital: *"I think the program is excellent. I see huge value in it especially now that the COVID restrictions are I guess decreasing and she can start doing home visits again and arranging to follow up with patients on discharge because that's been a very important part of our discharge plan for patients …. there's still a little bit of continuity of care*" (OW13).

Note. While identifying enhanced system integration as an outcome of the program, Peer-STOC peer workers and other workers described **variable integration of the Peer-STOC peer worker into the mental health system.** Some Peer-STOC peer-workers did feel that their role was well integrated into the system and described: *"strong collaboration with case managers, doctors and other health professionals*" (PWq17), while others described: "*Nurse Unit Managers*

[and other clinicians, being] *either too busy to help develop and integrate role or* [being] *actively opposed to peer work integration*" (PWq50). This is detailed more in resistance to change below and in the peer worker outcomes and implementation sections of this report.

Better consumer inclusion – 'bridges'

All three stakeholder groups also described the program and particularly the Peer-STOC peer worker as **a bridge between consumers and services**. The peer worker provided a conduit and helped consumers feel more comfortable and positive about engaging with mental health services or clinicians – both within the in-patient units and within the community.

> *"One of the clinicians … put it really nicely … they see us as the glue that keeps the service going. So, like* ***we're the glue*** *in the team, we provide the glue…* ***we're the honey*** *of the service that glues the people that access it to the service and to the supports"* (PW8)

C15 said: "*I think one of the highlights* [of the Peer-STOC program] *was my Peer-STOC worker and* [another Peer-STOC worker] *came with me to see* [a mental health worker] *who is one of the workers at community mental health and then* [the mental health worker] *ended up being one of the, being a safe person for me so having facilitated that contact with a service that in the future was going to be a really helpful and safe, a safe space for me. That was a highlight.*"

- "*It was helpful to have somebody to talk to about my issues who understood and could relate, was like a friend but a part of 'the system' and was connected to the hospital experience, like a bridge*" (Cq91)
- "*He helped me by getting in between myself and doctor or hospital staff. He helped me with my problems with my neighbours" (Cq31)*
- "[benefits of Peer-STOC] *building bridges between clinician and the consumer*" (OWq47)

Community-based workers also described the value of being able to maintain connection to their clients while they were in hospital through links with the Peer-STOC worker: "*I* [a community-based peer worker not in Peer-STOC] *and the Peer-STOC worker can you know bounce off each other ideas and stuff if one of my clients ends up in the ward and then, like, I'm a familiar face that the client knows then I can introduce them to the Peer-STOC worker so they have support while they are in the ward as well*" (OW29).

> *"It was helpful to have somebody to talk to about my issues who understood and could relate, was like a friend but a part of 'the system' and was connected to the hospital experience, like a* ***bridge****"* (Cq91)

Peer workers also described playing a role in re-connecting consumers with services that they had disconnected from due to previous negative experiences or had not managed to connect with due to barriers such as confusion, lack of response or waiting lists: "*so lots of people… are keen for someone to work with in this harrowing system of being told conflicting things and referred to services that don't ring you back, won't take you on or have a waiting list for months etc.*" (PWq34).

"*she was there for that person and she would advocate within the service… connecting* [them] *with their psychiatrist, and the various different professionals and… connecting all that care together*" (OW15).

Bridges extended beyond the mental health or services context into the community. These bridges were helped when peer workers walked alongside consumers and went with them as they tried to connect with community-based activities and programs. "*connecting in the local community, doing yoga and things like that. But I also walked alongside with her and did that together, and that was maybe the difference. Also that, you know, there was someone who had the time and could do that, you know, come to the first yoga class, and that's one of the things I did do with her, to get her, you know help her feel comfortable doing that, … she found that really, you know, beneficial*" (PW20). This is further illuminated within the 'Built or re-established community connections' theme in the consumer outcomes chapter above.

Shifting cultures and perspectives

Other workers repeatedly told us in powerful ways that they and or their medical colleagues had developed **new ways of thinking and new perspectives about consumers and about lived experiences of mental illness** through their interactions with Peer-STOC peer workers, their advocacy for consumers and their role modelling. They described a breaking down of pre-set ideas and stigma and achieving an **expanded understanding or greater insights into consumer needs:**

- "*we remember that it's a person not just a diagnosis*" (OW4)
- "*they are very good role models and they show a very… they are really breaking down some of the barriers within the teams around perceptions of people with a lived experience*", and "*I think what happens within the mental health services is that they are constantly dealing with crisis type scenarios, so they get a distorted perception of people with a lived experience… So when you have a peer support worker, that[s]… in a different place with their lived experience and their recovery … they are really good at breaking down maybe some of the pre-set ideas that staff have in those settings*" (OW15)
- "*I think it's changed the stigma that mental health patients seem to attract in that with the education of our registrars and psychiatrists, they can realise that even people with a mental health condition can really be instrumental in assisting other people with a mental health condition*" (OW23)
- "*broader thinking around what's supportive of a person and kind of supporting the staff to maybe have a broader understanding of what might support a person coming out of an inpatient may not be what we think it is*" (OW15)

"*So I think the change in that culture is something really important and I think it just changes things - it changes the language people use in meetings now, it just makes people a bit more aware that we're talking about a person here not issues around symptoms and management, it's the person, it's those subtle things that I think have made a significant difference to just the culture of the service.*" (OW18)

Workers often explained that the **change in culture was reflected by changes in the language** they now use on the ward, in meetings and in offices.

- "*When I started working the in the inpatient unit I guess it has the stigma of other professionals talk about patients as bed numbers and being derogatory about how they are talking about them but that's not something that I've experienced working on this unit. I do believe that's partly because we have this presence of the peer support worker and*

everyone is very conscious and trying really hard to talk about patient in a patient-centred way" (OW6)
- "*I'd been there for a few months I guess, and a staff member, it was quite a senior staff member said something… very, very inappropriate. I pulled her up on it and … she apologized to me and said she was going to try and make a change - and she has. She's been a lot more mindful of her language… So… there was this willingness for people to take on board the peer values*" (PW16)
- "*she* [Peer-STOC peer worker] *is so charming and patient, that it creates a culture. I think it's her… Sometimes we sit in there and people go, 'oh my God, I can't… if* [consumer] *rings me up one more time about the bloody* [community activity], *I'm going to…', and that is part of our culture, that we would moan about the clients to each other. But somehow I think within our team, we have needed to be mindful and respectful about all our shared humanness and not just dismiss people as* '[consumer] *and the bloody* [community activity], *she's rung four times today, I'm going to kill her'*" (OW28)
- "*I find she advocates for patients, reminds us of the correct terminology to use because at times we might slip into using, not necessarily inappropriate, but she reminds us of more positive ways of framing things. That's good to be reminded of and also she provides a different perspective on situations - I guess from the patients' perspective*" (OW13)

While most people explained that it was what peer-workers said that helped change culture, some other workers **emphasised the value of what peer-workers wrote in the medical notes:** **"***the other significant contribution I think that peer workers are making to culture change is notes in the electronic medical record and the person-centred nature of those. That makes a bit more of a whole picture rather than 'the symptoms are under control' or the response to the medication or whatever. There's the peer worker notes around the person and their goals and what they want. To have that voice in the team meetings but also in the medical record I think has been a significant shift. And then the use of the RAS-DS is another way of saying there's another way to measure and look at how things are going*" (OW18).

Some workers also said that Peer-STOC peer workers had **improved 'morale' or hopefulness** of themselves and other colleagues. OW6 for example said: *"I do really feel that the Peer-STOC workers presence and their support really helps to continue… the morale of working in mental health and I feel that there's hope for the ward to continue to grow and improve. It feels really good knowing that we have that patient voice".*

Some more recovery oriented other workers talked about the Peer-STOC peer workers helping them to challenge the attitudes and practices of other colleagues. Peer workers also recognised this alliance: *"I do think it [Peer-STOC] makes a difference. It brings support to allies who are already working in the system, keen to work in humanistic ways" (PW13).*

Interestingly, while the cultural impacts or changes described above were consistently reported by the other workers who chose to participate in this evaluation, the Peer-STOC peer workers who participated described much greater diversity of experience in terms of capacity to enact real cultural change.

Some Peer-STOC peer workers did also describe the **powerful impact they had on cultural change**. For example, PW19 said: "*from a culture change perspective, even just having peer workers being around the workplace and the environment was very powerful, … it was definitely something that I noticed*". PW 23 , leaving the role got written feedback from the multi-disciplinary team: "*about not just me but about the effect I'd had on the team, about making*

them be reflexive and accountable and remembering that they were working with humans. So yeah, I think I was well embedded and well respected and accepted by my team".

However, many other peer workers described the **battles they faced trying to shift or change culture,** with less effect and with a toll on their own mental well-being. PWq34 said: *"I know that Peer-STOC peer workers are supposed to help with this culture change but the clinical colleagues who most need to change don't respect us and therefore don't listen to us, so training and culture setting needs to come from allies that are quite senior in my opinion".*

Having non-peer allies helped Peer-STOC peer workers have the confidence to challenge dominant cultures: *"there's a few clinicians and again one of the consulting psychiatrists that's just super respectful and really understands why it is I'm trying to ask those questions"* (PW 12).

A couple of Peer-STOC peer workers **lamented not being able to shift the workplace culture** in which they wished they could have. PW 13 for example said: *"it's partly just a lack of recovery orientation… people being referred to as deeply damaged, … say*[ing] *oh they'll never recover and … cruel things about the service user. … I'd hoped that maybe you know I'd be able to pluck up enough, I'd be able to build enough trusting working relationships and accumulate enough social capital that I could like spend it on trying to call them 'in' rather than call them 'out' or you know facilitating a recovery dialogue about this…. I never figured it out, so when it came time to move to another opportunity, I guess it brought up some sadness that I wasn't able to do that".*

These challenges are detailed more in the Peer-STOC peer worker outcomes and implementation sections of this report.

More recovery-oriented and person-centered practices

Beyond talking about changed perspectives and attitudes across inpatient and community contexts, some workers said that having a Peer-STOC peer worker embedded within their team and present in the daily operations of their team had **challenged and shifted their approaches and practices**. They explained that their own and their medical colleagues' practice was becoming **more person centred and more recovery oriented.**

- "[Peer-STOC] *is kind of helping to shift the inpatient unit to being kind of more recovery-focussed and more person-centred*" (OW4)
- *"But it prompts me* [working with Peer-STOC peer worker] *or encourages me. There we go, it encourages me to behave at my best and most respectful about people's life experience. So maybe it improves my practice. It lifts me over the mark"* (OW28)
- *"sometimes we might be focused on service delivery kind of thing as opposed to helping the client as they are. I guess maybe not as person-centred as we could be and I think having the Peer-STOC workers helps us to be more person-centred in our approach to clients and I guess how we kind of work with the clients is enhanced by having Peer-STOC around"* (OW 16)
- *"when you are in a full-on meeting and everyone can get very formal with their language and the usual treatment routine he* [Peer-STOC peer worker] *always brings it back to, like he'll say, 'well I spoke to a patient yesterday and their complaint was this.' So, he doesn't give his personal opinion, he's repeating back what he's heard about patients... I've seen consultants in particular check themselves and think okay well maybe. Like they kind of forget to ask the person what they are really thinking and just do the usual treatment"* (OW4)

- "*she is so verbal and strong and such an advocate for people like herself with lived experience, it just always makes the discussions more holistic and not just one sided from a medical or a psychosocial* [perspective]*, it just brings in that other aspect which is so important*" (OW13)
- "*I think just making us a bit more, perhaps making teams just a little bit more recovery-oriented, a little bit more person-centred. I think that shift – having the peer workers there helps to… shift to that approach*" (OW 18)

Some Peer-STOC peer-workers also recognised changes in broader systemic practices, although sometimes they were unsure how much of a part they had played in those changes. PW16 for example said: *"I have seen a lot more nurses coming out and engaging with patients on the ward. They are coming outside of the goldfish bowl. I don't know if that is me or that's a general move… I might just be a small piece in a big puzzle that's coming together"*.

Some workers said because of the Peer-STOC program, their teams were now **including consumers more in their own care planning** and **recognising consumer or patient abilities, knowledge and expertise.** OW23 for example said: *"I think it's changed the way the health system works in that it's beautiful to be able to… more include the patients in the development of their care plan because these are the people that best know themselves… so just acknowledging the fact that they have intelligence, they have abilities that we haven't been previously recognising"*

A number of other workers who partnered with Peer-STOC peer workers said **that their individual practice or service to consumers was enhanced through that partnership**. OW23 who ran groups in partnership with the peer-STOC peer worker said: *I've seen people coming through and I've seen the results of the positivity that they can instil with people. So, it helps me in the group, in the way of being able to instil hope for the future for people.* OW 16, based in a community-health centre said: *"we kind of work with the Peer-STOC workers to find out some insights that they may have about our clients and how we can work kind of in conjunction with them in terms of helping the client as they come out of the hospital setting to work on the road to recovery."*

Other workers also talked about the opportunity to have **greater insights into and thus ability to focus on the needs and experiences of individual consumers** because of the Peer-STOC peer worker connection with the consumer. OW19, speaking about a consumer who "*didn't kind of open up very much and speak to us*" said: *"the Peer-STOC worker went out with her and spent some time with her and was able to come back and say 'ok, this is what's happening' and I don't think we would have been privileged to that information because she would have seen us as professionals whereas the Peer-STOC worker found out really what was going on there and then was able to give some insight to the team as well."*

Increasing value and respect for Peer-STOC and workers over time

Around half of peer-workers interviewed or who completed the questionnaire described experiencing an immediate sense of inclusion and respect for the Peer-STOC program and their role. These peer workers described joining a team that was ready for the program, understood the purpose of the program, and embraced them from the start. PW6 said: *I definitely feel like I'm part of the teams I work with. I feel respected and I think that the input and the feedback I provide is valued.*

> *They [multi-disciplinary team] were ready, and I was ready… when I first arrived, they'd always invite me to the main table, so I never felt excluded. There was always respect* (PW16)

In interviews, and responding to a questionnaire item that asked: **'What has helped you to be the best Peer-STOC peer worker you can be?'**, most peer worker respondents described, in various ways, **colleagues who embraced what they and the program had to offer**:

- *"connections with clinicians and allied health workers who are supportive of me personally, value peer work and support opportunities for peer worker involvement"* (PWq37)
- *"Supportive work colleagues. Awesome clinical allies"* (PWq9)
- *"Being supported by senior staff. Being trusted"* (PWq62)
- *"having a team leader* [nurse unit manager] *who is supportive of the values of peer work and open to having business as usual disrupted"* (PWq34)

However, rather than immediate initial inclusion, many Peer-STOC peer workers, as well as other workers, described a **process of working towards increasing inclusion and respect from some or most of the team over time** and this was also reflected by other workers.

> *"They put me in the same office as the allied health team which has been hugely helpful… It's also allowed me ways to endear myself to these people so I can get them onboard… I can gather more allies on the team that way, get momentum with changing culture that way"*
>
> (PW5)

- *"it's taken some time for people to appreciate the value and the complementary role of the Peer-STOC worker can play as part of the treating team"* (OW18)
- "we had a nice connection. I felt like he could see where I was coming from and helped make space for me in the team even though I wasn't able to transform the culture to a recovery orientation" (PW13)
- PW 16: *"the big thing is the respect, a lot of respect of the peer workers. I see it, you know. And the longer it goes on in the service, the more I see psychiatrists and people come up and say, 'I think such and such would benefit from your service'… and that's a lovely thing, those who acknowledge me"* (PW16)
- *"I need to get* [referrals for] *consumers so I slowly worked myself into the unit there, created relationships with the social workers… I developed a relationship with the nursing unit manager… It's about putting yourself in there and making yourself a regular face, so I go in down there and now they are opening the door for me so to speak. They know who I am and, you know, I'm part of the system. They don't view me as some sort of 'who is this person coming in?' anymore"* (PW 22)

Other workers also described a process of striving to change the workplace culture to improve peer-STOC inclusion and respect. OW18 for example said: "*mental health teams can potentially be a bit intimidating – psychiatrists and big multi-disciplinary teams … you need some confidence for the peer worker to come in and have their say and feel equal to that team and I think what we have done over the last couple of years is hopefully change that culture a bit to be a bit more welcoming and open to the input from the peer worker and also build the confidence of the peer worker so that they can use voice in those meetings and have that respected*".

However, **allies sometimes left and a change of staffing, particularly senior or leadership allies sometimes led to a reduced respect and valuing of the role** of the Peer-STOC peer worker. PWq82 explained: *"Late into my role there was a management change which was rather hostile towards my often organic and consumer-led way of working - I was expected to swing back the other way and be extremely regimented with large amount of (duplicated, sometimes triplicated) assessments which were often far more clinical than peer".*

A few Peer-STOC peer workers **never felt included and respected** by the team/s they were working within and some other workers described incidents where Peer-STOC peer workers were intentionally excluded or included merely to "*tick a box*" (OW6).

- *"The multi-disciplinary team meetings that were supposed to be multi-disciplinary in theory, … there wasn't any making space for the peer perspectives in those…it's still very hierarchical… The psychiatrists are also deeply hierarchical, you know, the registrars deferring to the consultants and there's these very long-established custom and practice, I guess. Things are done the way they are done because they've always been done that way and so it's very challenging to work out how to imagine it being different"* (PW13)
- "*they* [other clinicians] *actually excluded the peer worker from that meeting and it would have been a really valuable thing for that client to have the peer worker there and it was a very disappointing, to say the least, because it's not like this is a new program… I was really disappointed… It didn't have to be that way and I think it would have been better for the client to have the peer worker there*" (OW5)
- *"I think it does vary in the team about how respectful people are to peer support workers... I think there are some people that don't value it as much as say someone else on the treating team… the Peer-STOC workers are used as kind of like a token thing … [they] won't be very clear about the purpose… It's more… like they have ticked that box"* (OW6)

> *"My experience has been that peer workers are not really integrated within any of the teams/service models. We make individual connections with consumers and follow these up as a peer team, but we are not part of… the 'clinical' processes" (PWS37)*

Resistance to change

While we heard a lot about cultural changes and increasing inclusion of Peer-STOC peer workers over time, both other workers and Peer-STOC workers also described witnessing or experiencing **resistance and barriers to the Peer-STOC program and peer workers**. Usually, but not always, these were within inpatient settings and the staff flagged as resistant to change were mostly medical team members.

Sometimes this resistance was attributed to colleagues' **discomfort or resistance to recognising other forms of expertise** to their own, or fear that by doing so might diminish their own. OW19, a nurse within an in-patient unit said that: "*the Peer-STOC worker… they've made suggestions, great suggestions, but the mental health service is this big, clumsy, slow turning service – we can't just go 'okay that didn't work, let's give this a try'… I felt really sorry for the Peer-STOC worker who* [gave] *a really insightful recommendation but I also thought it might be quite hard for the doctor as well because [of] how many years [he] has he been at university, and how much is he always treated as the expert… he maybe sees the expert as being slightly different to a Peer-STOC worker who sees the expert as the person*". OW27 shared the following insights: "*I think it's partly just a natural resistance to change. I also suspect that some of our clinicians felt that… introducing peer workers would devalue the role of clinicians, whereas that's not true at all. But I think that's how some of our clinicians felt…. Funnily enough it was the community team that was a little bit sus. The staff in the inpatient unit never really had a problem with the idea of the Peer-STOC program. They were really all for it, it was more the community guys that were a little bit sort of slow to warm up to the idea*".

Others explained that the **rotation of staff, particularly medical staff increased resistance to the program** – in part because new staff were not familiar with the role of the program or the Peer-STOC peer workers.

- *"I'd never worked inpatient before and the inpatient has a lot more doctors, a lot more registrars, they do the rotation every 6 months so that kind of culture seemed even harder to tackle … sometimes we did have a voice and there were some people trying to make space for us but lots of times we wouldn't have a voice" (PW13)*
- *"I think it's advocated well by upper management. It was basically that we needed to embrace it. The nurses have embraced it. I do think that the registrars and residents do struggle with it a little bit. They don't know really what the peer support worker does… when we have consultants come down on an ad hoc basis and they see someone who's not within our usual scope, they will come and say to the peer support worker 'What's your role here? What are you doing here?' So, they are a little bit defensive"* (OW4)

> *"a lot of the registrars and psychiatrists aren't very well informed about what the Peer-STOC is. So that needs to be improved here"* (OW23)

Confusion and concern about Peer-STOC and role of peer worker

While not always the case, we heard that within some settings, the role, purpose and parameters of the Peer-STOC peer worker role was unclear. Repeatedly Peer-STOC workers and other workers engaging with Peer-STOC said that there was **confusion about the role of the program and the Peer-STOC peer workers**. In part this had to do with changing staff, or staff who had not attended earlier introductions to the program. A few example quotes are provided below:

- "*how are you going to fit Peer-STOC workers successfully into your team if nobody actually knows what that role is?... I'd love to understand a little bit more about their role*" (OW19)
- *"Maybe a bit more education for the people on the unit, the staff on the unit to know what Peer-STOC is"* (OW23)

- *"I received very limited information. I got a draft copy of the Peer-STOC model and that was that… I've asked, I tried to get further information… but there was nothing… in terms of getting anything from the state, that was not supplied… to actually implement it best"* (OW24)

A number of **Peer-STOC peer workers themselves were also unclear about the limits of their role or how to be firm about what was in-scope or out of scope to other workers** who told them to do things not in their job description. PW5 for example said: "*I was at times* [In the early days] *being used as a bit of a babysitter or a nursing staff* [member]*, being asked to do roles that I'm happy to do to support the team but it wasn't the best use of my time and skills I think*" and PW20 lamented: ""*six months and not doing much except reading policy stuff or, that was a bit disheartening*".

Extending on from this confusion, both Peer-STOC workers and other workers also raised concerns about Peer-STOC worker safety, supervision, them being overloaded or overstretched and these collectively leading to risk of burnout and for some peer workers to leave the role. This is covered in more detail within the peer worker outcomes section below as well as within the implementation section (Chapter 4) of this report.

2. Outcomes for the Peer-STOC peer workers

The Peer-STOC program has also resulted in outcomes for, or had an impact upon, the Peer-STOC peer workers themselves. These impacts or changes were noticed and described both by peer workers themselves as well as by other health workers who engaged with them. Positive Peer-STOC peer worker outcomes included a) job satisfaction; b) increased skill and confidence in my role; c) increased connection with and appreciation from the multi-disciplinary team; d) my mental health has improved, and e) I feel better about myself as a person.

While outcomes for peer workers were predominantly positive, this was not the case for all. It was Peer-STOC peer workers who had a clearly understood and defined role, were valued and respected by colleagues and had support networks (both peer and other) who were more likely to describe positive outcomes for themselves. Where their experience was one of exclusion, unmanageable workloads and lack of support and supervision, peer workers were more likely to describe negative outcomes: f) isolation and exclusion from the team, and g) risk of burn-out and negative impacts on their own mental health. These positive and negative outcomes or impacts are detailed below.

Table 3.2. Synthesis of outcomes or impacts of Peer-STOC on the Peer-STOC peer workers (2 stakeholder perspectives)

PEER-STOC PEER WORKER OUTCOMES/IMPACTS	
Themes	**Example Quotes**
Job satisfaction	PW23: *Like this is the first job I've had that… I was proud of, and where I actually felt like I was making a difference* PWq72: *I so enjoy working with people with a mental ill health issue and watching them open up and slowly start to improve their life*
My mental health has improved	PW8: *So I found that there was a real reciprocity in that … being able to share in those support groups in general has been, you know, just sharing in a meaningful way has also led to improvements in my mental health* PW22: *It's been the best therapy I've ever had in my life. No honestly, I've gotten as much out of the work, some of my consumers give me as much as I give them. Yeah, and that's the truth. It helps me contextualise my own life and my own experience*
I feel better about myself as a person	PW15: *just feel better about myself as a person [because I'm a Peer-STOC worker]* PW23: *I left work most days feeling like just being present had made people's days better right. That's really, really amazing. It really changed how I think about myself and how I think about my place in the world*
Increased skill and confidence in my role	PWq62: *Initially it was difficult to find the confidence to promote the Peer STOC program, this was probably because it simply took a while to build confidence of myself in the role*

	PWq15: *The few times that I have doubted myself has made the job extremely stressful, but my ability improved, and my experience improved when I focussed on my strengths*
Being supported & welcomed into the team – or not	PW6: *We are really embedded into the teams we collaborate with and we are praised and respected… So, I definitely feel like I'm part of the teams I work with* V PW13: *The multi-disciplinary team meetings that were supposed to be multi-disciplinary in theory… there wasn't any making space for the peer perspectives*
Risk of burn-out	*PW21: [you] can I guess take on vicariously the trauma and the distress of the person you're dealing with* *PW23: the inherent challenges of working with highly distressed, vulnerable people on a daily basis in a system that doesn't always meet their needs in a way that would actually help them*

Note. C = consumer who did an interview; Cq = consumer who completed a questionnaire; PW = a Peer-STOC peer worker who did an interview; PWq = a Peer-STOC peer worker who completed a questionnaire; OW = any other member of the mental health workforce who interacted with the Peer-STOC program who did an interview, and OWq = any other member of the mental health workforce who completed a questionnaire

Job Satisfaction

Most Peer-STOC peer workers said that their role was "*really rewarding*" (PW23) and described the job satisfaction they experienced. PW21 said *"[I] walk out of the room at the end of the day and go 'wow' and leave with a smile on my face and* [know] *I've achieved something"*. PW21 continued to say that working in Peer-STOC "*it's one of the best decisions I ever made in my life*".

The most frequent experiences that peer workers associated with job satisfaction were **witnessing positive consumer outcomes and knowing that they had had an impact on this.** Peer workers also repeatedly celebrated **being able to build connections with consumers**. Job satisfaction stemmed from **knowing they had a positive impact upon consumers mental health and recovery** including **knowing that they had supported people to better understand and manage their own mental health and well-being**. PW15 explained "*that is probably the most rewarding thing… you know, being able to continue that support and watching them grow*". PW16 said: *"I was on the phone to her and she started having an anxiety attack and I breathed with her and she came down and she was fine. She phoned me up the next day and said 'oh my god I just went to the supermarket and I started to have a panic attack and I did what you said and I was fine and I could go into the shop and everything'. You know, it's stuff like that, just giving people skills and they trust the information is going to/could be useful because someone who has been through it has given you the information"*.

Of many examples, here are a few more comments from peer workers:

- *I so enjoy working with people with a mental ill health issue and watching them open up and slowly start to improve their life* (PWq72)
- *The use of my personal experience to affect positive change in people* (PWq80)
- *positive feedback from consumers that I have made a difference in their recovery journey* (PWq97)

- *being able to provide meaningful peer intervention with people when they are rock bottom and are more inclined to attempt to make changes towards recovery. This can be a socially rewarding role at the best of times* (PWq25)
- *I really enjoyed the direct service work with people who accessed the Peer STOC Service and seeing progress on their recovery journey* (PWq2)
- *[the best thing about my role is] The consumer contact and the ability to see changes in the ratings in the RAS-DS as administered before and at the conclusion of the Peer STOC intervention* (PWq38)

Peer-STOC peer workers also talked about the **job satisfaction experienced by watching and supporting clients engaging or re-engaging in personally meaningful daily lives after a stay in hospital.** PW5 commented: *"The impact it has is really beautiful and, you know, seeing the kids go back to normal life and experience the things that are important for themselves - experience things like they have their own agency - they are not being told to do* [something] *by a clinician".* PW21 described supporting a consumer to self-advocate to her mother and psychiatrist for the right to have a go at studying: "So *for me, those are the ones that really make an impact because she's now studying, she's doing a nursing degree, which her mum said she would never be able to do, she's holding down a full-time course load, she's doing really, really well".*

Several Peer-STOC peer workers said the ability to **continue support from the inpatient unit to back in the community was a highlight and source of satisfaction**. PW10 explained: *"I think it has been really good when I've been able to meet a few consumers in hospital and then continue to support them after the they're discharged. Especially when they might find it difficult to navigate the health service after hospital. Often they are not given that much information about what to expect".*

Job satisfaction was also derived from **knowing that they had been able to make a real connection with consumers** they were working with and **when other in the team also recognised the value of these connections.** PW8 said: *"We're kind of seen as like a bit of a darling of the service at the moment because of our ability to foster connections with consumers and also foster their trust in the service".* Similarly, PW12 explained: *"I get… little highlights every now and again… a week or two later, the clinician will come and say, 'Oh, that client was asking about you… he's sad that you weren't there at the last meeting.' … So those are really nice interactions, and it kind of minimises my doubts as well. You know what I mean? Oh OK, maybe I am making a difference! … especially when he* [Chief Medical Officer] *comes and says… 'Thank you for talking to the client. They really found that helpful', I'm like yeah, that's great, cool".* Connections sometimes took time, and PW21 described the delight in finally connecting with a consumer: *it took me about five weeks to actually get her to sit down and talk to me other than 'yes', 'no', 'yes', 'no',* '[go away]'*… excuse the language… they're little wins, but boy are they big wins".*

> *I've had some of the most rewarding experiences ever in this job, particularly when talking one on one with the consumers (PWq15)*

While job satisfaction was the dominant experience of Peer-STOC peer workers, it was not experienced by all. For some, the **lack of career path for Peer-STOC workers had a negative impact on job satisfaction.** It is worth noting though that a couple of Peer-STOC peer workers experienced a degree of job dissatisfaction with peer work more generally because **they**

could not see a career path for themselves with limited opportunities for progression. PW10 for example said: *"there's not that much of a career pathway for peer support workers. It would be good to have more senior roles if there was going to be expansion in the future"*. Another explained that: *"there isn't one [a career path] … in my LHD… you are a peer worker in the inpatient unit or in community and the only other place you can go from there is into the coordinator … and it's a huge jump from being a peer worker to what her* [the coordinator's] *role… there's nothing else in between"* (PW17). The barriers to job satisfaction are covered in more depth within Chapter 4 of this report.

My mental health has improved

Notwithstanding the important conversations about risk of burnout that are detailed below, many Peer-STOC workers also described a flow-on impact of their role was their own improved mental health. They described **reciprocity** where at the same time they were supporting others with their mental health recovery, they too were gaining new perspectives and strategies and *"learn[t] things about my own recovery along the way"* (PWq17).

One Peer-STOC worker talked about the personal benefits gleaned from facilitating support groups on the ward : *"I found that I benefitted greatly from* [leading support groups], *my own mental health and my own physical health, … as well as having consumers benefit from it as well. So, I found that there was a real reciprocity in that … being able to share in those support groups in general has been, you know, just sharing in a meaningful way has also led to improvements in my mental health*" (PW8). Similarly, PW22 said: "*It's been the best therapy I've ever had in my life. No honestly, I've gotten as much out of the work, some of my consumers give me as much as I give them. Yeah, and that's the truth. It helps me contextualise my own life and my own experience"*.

> *"I learnt a lot about how to manage my own mental health both through having to manage my mental health in my role but through all the people that I met and the wonderful and inventive, creative ways of dealing with themselves. People have beautiful self-help strategies"* (PW23)

A few peer workers also spoke positively about the encouragement that colleagues provided to focus on their own mental health: *"My supervisor told me …'if you're focusing on just the young people and not yourself, you are actually not going to give as good a care'… That* [helped me realise that] *I have to really be focusing on myself and making sure I'm doing the right things in my own life and looking after myself and it actually helped and motivated me to kind of do more of the right things in my free time and that has been a huge help to be honest"* (PW5).

I feel better about myself as a person

Extending on the job satisfaction that most peer workers described, several Peer-STOC workers said that the work they were doing as Peer-STOC workers had **increased their own sense of self-worth and value**. They talked about the sense of pride and social value they had gained from working in the Peer-STOC program.

- *"I just feel better about myself as a person* [because I'm a Peer-STOC worker]" (PW15)
- *"I left work most days feeling like just being present had made people's days better right. That's really, really amazing. It really changed how I think about myself and how I think about my place in the world" (PW23)*
- "I feel like I'm valued in society and… you know, I have a valuable position" (PW8)

> *"I've learnt that people are amazing... I think sitting with people who are experiencing profound deep suffering and just being able to give them that space, that's incredible. I think that's changed me as a human."*
>
> (PW16)

Increased skill and confidence in my role

Most Peer-STOC peer workers talked about **building their skills and confidence** through their time working in the Peer-STOC role. This was usually a consequence of their **direct work with consumers,** witnessing the impact of their role and *"on the job experience"* (PWq41). A number of peer workers flagged that they initially didn't feel confident in the role. Reflecting others' comments, PWq62 told us: *"Initially it was difficult to find the confidence to promote the Peer STOC program, this was probably because it simply took a while to build confidence of myself in the role. I would have valued being supported more in a1-1 setting when I first started the role".*

> *"once a month we get together for a reflective group kind of co-learning session. We get to have a person who is sharing about their peer practice, someone who is interviewing them and the rest of us form a reflective team so we hear about them reflecting on their peer practice and then we talk about how that might, uhm, what reflections that brings up for us in terms of our own lived experience, in terms of our own peer practice, in terms of what stories are untold or what kinds of potential for … generative recovery conversations there might be there and so that's often the highlight of my month".*
>
> (PW13)

However, peer workers also repeatedly told us that they developed skills and confidence **through discussions, interactions, and reflexive processes with other peer workers** as well as with **others within the multi-disciplinary teams** they worked within. PWq62 valued *"being given freedom to develop my own strengths and also the opportunities to learn from others".* PW11 said*: "meeting other peer workers in the hospital … we might have… conversations about what their thoughts are and, and you know things that I'm doing, or you know, that I'm on the right path. Or that if they've got any other sort of ideas that I haven't sort of thought about. Reflective practice really".* PW12, reflecting the comments of many, described building their confidence in the role through more **formally organised peer workforce meetings and supervision**: "*we do have … meetings with the whole peer workforce of our local health district. And that is actually really helpful to get that validation. You know, like sometimes I'm here and I'm like 'What am I doing?' I just feel like totally out of my depth, but then I… go to these meetings and like 'Yeah, same here'. You know, or like 'That's natural to feel that way".*

Other Peer-STOC peer works described developing their skills through **opportunities to co-deliver groups or engage in other activities with colleagues** within the team. PW13 for example said she developed her skills through having the opportunity to work with a colleague to design and deliver a workshop about reasonable workplace adjustments: "[It] *was a chance for me to skill up myself and figure out for myself what things do I need to ask for to be different at work in order to not quit or get fired*" PW13.

Access to formal training opportunities also built Peer-STOC peer workers' confidence and skills. PW15 for example said: *"due to a team leader … I have had amazing access to training. Every single thing that clinicians have had access to training, my team leader put me forward as well"*. Similarly, PW16 and a number of other peer workers explained how Certificate IV in Peer Work training opportunities had built their skill and confidence: *"I'm a happy bunny you know. The role is really, really good. Yeah, great training, great training which has helped me with every interaction I have with someone I work with… I think it really did inform the way I work – incredible – especially trauma informed, recovery oriented"*.

Being supported & welcomed into the team – or not

Many Peer-STOC peer workers we spoke to reported having **supportive and positive professional relationships with their** multi-disciplinary colleagues. They described the value of having **allies on the team** to help buffer against less welcoming team members. As described in more detail above in the systems outcomes and impacts section, for some peer workers, this outcome (being supported and welcomed) was immediate. For others, it took time and effort to forge these positive relationships and connections, and others never experienced a sense of inclusion and connection or welcome.

> *"I think the connections we've got here in the teams on the mental health unit with the psychiatrists, psychologists, social workers, the nursing staff and here in where I am at the moment in a community health care centre, and that team there is really supportive - also of peer work generally. So, I'm a happy bunny you know. The role is really, really good."* (PW16)

Some example quotes from Peer-STOC peer workers describing the experience of team support and inclusion:

- *"I get great support within my team like the team I work for, they've got a range of support. If … I'm having difficulty with a person, I'm always able to approach my team and, you know, we can look at solutions or stuff like that. So yeah, so I feel like I'm really supported, which is good"* (PW4)
- *"We are really embedded into the teams we collaborate with and we are praised and respected… So, I definitely feel like I'm part of the teams I work with. I feel respected and I think that the input and the feedback I provide is valued. Like, I'm invited to join these meetings and I have a voice"* (PW6)
- *"There's a good team around me that I can always go to for advice and support"* (PW7)
- *"I was able to form a really trusting working relationship with the team leader. … So, if people were saying pejorative or saneist stuff … he'd say 'Do you want to come have a cup of tea with me?', and we'd go and sit in the sunshine and talk a little bit about what was problematic about that… I think he really got that justice was important to me"* (PW13)

Several Peer-STOC peer workers reported that they had been physically located in offices with other team members and this helped connection with and support from the broader team. PW5 explained how this helped reduce isolation and helped him build allies on the team: *"They put me in the same office as the allied health team which has been hugely helpful... I would have been a lot more isolated being on my own, more confused about everything to be honest. It's been helpful to be able to bounce ideas off people. It's also allowed me ways to endear myself to these people so I can get them onboard with my ideas. I can gather more allies on the team that way, get momentum with changing culture that way".*

On the other hand, however, **some Peer-STOC peer workers described feeling isolated and excluded from the multi-disciplinary teams** they worked within. In some cases, this was due to the newness of the Peer-STOC program. PW10 explained: *"I guess it took a while for us to really get some more support from hospital staff."* Similarly, PW7 said initially it was: *"a lot of… just breaking down some of the personal barriers as well some of the workplace barriers in particular in the* [in-patient unit]. *It's like 'Who are you? What are you doing?'. Basically, almost like you don't belong there".*

However, a number of Peer-STOC peer worker experienced **continual difficulties, lack of team support, and ongoing isolation and exclusion.** PW13, for example, described this in depth: *"The multi-disciplinary team meetings that were supposed to be multi-disciplinary in theory, peer support is supposed to be a discipline that is part of that polyphony but there wasn't any making space for the peer perspectives in those rooms and it's still very hierarchical, you know, the doctors. All the other health professionals are the handmaidens to psychiatry … Things are done the way they are done because they've always been done that way and so it's very challenging to work out how to imagine it being different. But without making it different, it's a pretty inhospitable place for people who have been mental health service users ... Like I said, you can hear people who have your same experiences being talked about in really cruel and dehumanizing ways and that's really upsetting and disappointing".* Similarly, PW15 said: *"I'm trying not to be negative, but this cultural change that needs to happen within the teams … I found it, no matter how hard you try, that some people are just stuck. And they don't want to embrace change".*

"My experience has been that peer workers are not really integrated within any of the teams… We make individual connections with consumers and follow these up as a peer team, but we are not part of… the 'clinical' processes. It's difficult knowing the evidence base and value of this program but not seeing it enacted in practice" (PWq37)

A few further examples from questionnaire responses to the question 'What are the worst things about your experience of working within Peer-STOC?' include:

- *"Poor structure and integration. Nurse Unit Managers either too busy to help develop and integrate role or actively opposed to peer work integration"* (PWq50)
- *"Lack of knowledge of our role by other professionals. Lack of cohesion between different parts of the health system"* (PWq7)
- *"zero support or supervision"* (PWS 82)

Lack of co-location created barriers to peer workers feeling supported and included: *"Even though I do work within a small team, I am based separately and find this can be an isolating experience at times, particularly working across sites in a regional area"* (PWq 67).

The contextual and procedural aspects that facilitated or hindered peer worker experience of team inclusion and support are covered in further depth within Chapter 4 of this report.

Risk of Burnout

A negative outcome for some peer workers was risk of burn-out. "*The stress peer workers can be under is also significant and not recognised enough*" (PWq41). This was something that both Peer-STOC peer workers and other workers frequently commented on and were concerned about. *"It's actually quite exhausting and is taking its toll"*. (PWq25)

Stress and risk of burn-out was a consequence of different challenges faced by different peer workers. For some it was about **unmanageable workloads,** for others it stemmed from a **lack of support and supervision** to manage with the **vicarious trauma related to distress facing consumers they were working with.** Others described isolation and exclusion from colleagues and **being re-triggered by and battling against non-recovery-oriented practices around them.** The experience or negative outcome of burn-out is briefly reported on here and detailed further within the implementation section of the report – Chapter 4.

Some Peer-STOC peer workers talked about "*the stress involved in* [looking out for] *their* [consumers'] *safety at times **without enough support***" (PWq15), and "*the stressors of people being discharged when they were homeless and myself being the only person supporting them*" (PWq2). Some peer workers reported struggling to create the "*personal boundary that I need to keep myself well*" (PW7) and to look after their own mental health in order to avert burnout. PW7 also described how mentally and emotionally stressful the Peer-STOC role was sometimes, and how he was: *"not adequately trained to handle some of the disclosures that people make… as patients so it can be very mentally demanding. Some people actually disclose quite deep personal histories, and they do it in confidence. It's not easy to process"*.

Sometimes there were situations where Peer-STOC **peer worker's own lived experience of mental distress resonated with clients' stories and experiences**. PW16 explained how the story of a client she was working with impacted on her own mental health and *"I had to have a month off"*. PW16 went on to explain: *"you can, working with people, experience trauma. Most peer workers experience trauma and how are we going to be supported when we put ourselves on the line like that?"*.

> *"I found it very stressful to be a one-person service essentially, especially as a person with lived experience. This is also involved liaising with 5 different teams across the service, as well as engaging with non-government community services. One aspect of this also involved being the first peer worker to work within the MH Inpatient services" (PWq2)*

It was not just peer workers who talked about their risk of burnout. Other workers also repeatedly expressed concern about the limited support provided considering the complexity of the Peer-STOC role.

- *"So, I feel like they are a little bit unsupported like it's sort of like such a unique role… they are very difficult peer roles… and the peer workers who step into those roles need to be quite experienced and resilient in some ways. They are not easy roles; you are working on that acute end" (OW15)*
- *"I think that very much does take an emotional toll on some of the Peer-STOC workers being, living through vicarious experience, and having that experience… can cause re-traumatisation and I think there is the need for increased support in relation to emotional debriefing and clinical direction. (OW25)*

- *"patients might share things with him that are triggering him personally. So, I guess I worry about his welfare like anyone else who works on a mental health ward"* (OW4)
- *"I think that can be quite challenging because I know they've been put in that position before where they've had to kind of manage the risk of a* [consumer]*… you know it's difficult if they are suicidal and that's been through a telehealth conversation outside of work hours. Yeah, I think that is quite a challenge to manage" (OW6)*

Peer-STOC workers specifically discussed the issue of **high workloads** that were difficult to manage and the stress this caused. For example, PW8 explained: *"you can be quite overloaded from clinicians with people to work with, and you know,… it can be a bit forgotten that we're someone with a lived experience and we do have our kind of thresholds, and I found that a couple of times I've gotten to the point where I've been so kind of overloaded with work and really stressed out that I've kind of become unwell and I've needed to, to pull back from work."*

Similarly, PWq25 said: There is just not enough of us. The expectation to work across community as well as inpatient is not sustainable long-term workload wise.

> *"My supervisor told me to make sure I'm well because even if you're focusing on just the young people* [clients] *and not yourself, you are actually not going to give as good a care if you are struggling. … I have to really be focusing on myself and making sure I'm doing the right things in my own life and looking after myself and it actually helped and motivated me to kind of do more of the right things in my free time and that has been a huge help to be honest. If someone hadn't told me that I might have been at risk of burning out or trying too hard, staying too late for the young people etcetera out of guilt. So, that's been hugely helpful"* (PW5)

Again, other workers also repeatedly expressed concern about unmanageable workload expectations of Peer-STOC peer workers. *"it's a directive that Peer-STOC is going to be offered to everyone, very quickly the* [peer] *workers become overburdened and just burnt-out. I don't know, I feel like it should be standard practice, but you need many more peer workers to do that"* (OW10). Similarly, OW3 said: "*there's just a challenge for them to be covering all the roles that's expected of them on the in-patient and the community... they're all pulled in other directions as well, like people always want them involved in quality improvement, and doing education for staff. So, it's just sort of that juggling all the roles… there's lots of demands, they're in demand basically.*"

Others linked the risk of burnout to **working in isolation**. PW22 for example, who worked within a supportive team, said: "*Peer workers working by themselves are in huge danger of burnout or of being overwhelmed, and I certainly personally despair for the peer workers I've seen, I've met, who are just … the only person in the service. ... I think that's, it's not right. … I can't imagine any other professions, critical professions, where you just put one person there. … Even the police go out, you know, in pairs, or even ambulance services go out with another person".*

Again, other workers were in unison with peer worker comments about the need for more peer support. They also repeatedly emphasised the need for peer workers to not work in isolation, but to be working within a peer worker team. OW6 for example suggested that "*just having*

someone else on the ward, or on the team, would support them as well. Like I said, more of them but maybe, yeah, if they were in pairs, perhaps another person as well for support".

Finally, some Peer-STOC peer workers described the distress of witnessing staff-to-staff conversations and staff-consumer interactions that they felt were disrespectful or not recovery-oriented. P13, as an example, said: "*you can hear people who have your same experiences being talked about in really cruel and dehumanizing ways and that's really upsetting and disappointing*".

CHAPTER 4:
The IMPLEMENTATION OF PEER-STOC

FINDINGS AT A GLANCE

✓ Peer-directed ideology, focused on hope and recovery, is core to the program and its delivery

✓ Flexibility in implementation timeframe, tools and approaches is both a strength and a challenge across LHDs

? Many experienced peer workers value the opportunity to create models of care and procedures. However, documentation and templates for key procedures are needed to support implementation in new settings and for new peer workers

✗ There are exemplary models of supervision, but in many areas, investment is still needed in supervisory models and leadership pathways to support peer supervision, career pathways and recognition

✗ The low award rate and lack of recognised qualifications discourages experienced peer workers from applying for Peer-STOC roles, limiting support for new peer workers

✓ Many peer workers feel included and valued in multidisciplinary teams. Practical supports such as integration into eMR for referral and outcome measures are needed to support this

✓ Positive organisational culture including clinical/manager "champions" promotes acceptance of peer work into teams, but attitudes vary across LHDs

Introduction and Approach

The research team at The Australian National University (ANU, A/Prof Michelle Banfield and Dr Georgia Pike-Rowney) focussed on the implementation analyses using qualitative data collected in semi-structured interviews with consumers, peer workers and other mental health workers. Data for this section are drawn from the same set of interviews as described in the previous chapters, Chapter 2: Consumer health, recovery and wellbeing outcomes and Chapter 3: Flow on outcomes.

The evaluation of the implementation aspects of Peer-STOC encompassed the contexts, personnel, planning and logistics that influenced the roll-out of the program across NSW. To ensure a comprehensive analysis, the ANU team used an established implementation evaluation

framework, the Consolidated Framework for Implementation Research (CFIR) [15]. The CFIR details a comprehensive list of implementation constructs, organised under five key domains, that were then adapted for use in the Peer-STOC evaluation:

- **I. Intervention Characteristics:** characteristics of the **Peer-STOC model** itself
- **II. Outer Setting:** the **broad external context** (i.e., NSW system) and understanding of peer work and consumer needs
- **III. Inner Setting:** **internal context of LHDs**, such governance, supervision, resources and culture
- **IV. Characteristics of Individuals:** attitudes, identity, self-efficacy, understanding and beliefs
- **V. Process:** implementation planning, stakeholder engagement, leadership, and evaluation

The CFIR was used at multiple stages of the research process: in the early stages to inform the design of the interview guide; as a comparative tool when interviewing participants to ensure themes were relevant as information was being gathered; and as a tool for detailed analysis and development of themes. The framework proved to be particularly helpful when looking at implementation in the wide variety of local contexts, environments and locations in which Peer-STOC was rolled out.

This section of the evaluation is structured according to the five CFIR domains, under which are grouped relevant themes that emerged through the interview process. The themes were guided by the published CFIR constructs, [15] and labelled a), b) etc., with specific subsections underneath. A summary of the domains, themes and subsections is provided below in Table 4.1 as an overview of the Implementation findings, followed by the in-depth analysis for each section. As noted by Damschroder et al, [15] the boundaries between domains were not always clear, and there was overlap between individual constructs as described by participants. However, the framework provides useful signposting on the level at which improvements may be targeted.

Table 4.1 Summary of key implementation themes

I. INTERVENTION CHARACTERISTICS: THE PEER-STOC MODEL
a) The Peer-STOC model i. General characteristics ○ In-reach into inpatient settings pre-discharge ○ Prompt contact with consumers post-discharge ○ 6 weeks of Peer-STOC peer worker support ○ Work with consumers in the community to support transfer of care ○ Tools and approaches ii. Flexibility of the Peer-STOC model
b) How the model was developed and implemented, and by whom i. Strong peer work foundation of the Peer-STOC model ii. Models of care iii. Lack of clarity over the details of Peer-STOC
c) Belief in the Peer-STOC model i. Perceptions of the usefulness and viability of peer work and/or Peer-STOC model ii. Important aspects that relate to belief and viability of the model: ○ Lived experience ○ Non-clinical ○ Voluntary ○ Responsive to needs
d) Comparison of Peer-STOC model to other peer models
e) Complexity of implementing Peer-STOC i. Newness of the peer workforce ii. Scale of state-wide implementation iii. Flexibility adding to complexity
f) Design of the program and accompanying materials i. How Peer-STOC is presented to consumers ii. How Peer-STOC is presented to other mental health workers iii. Design of supporting documentation
g) Cost i. Allocation of funds ii. Resources for direct work with consumers iii. Allocation of Peer-STOC workers iv. Peer-STOC staff access to basic resources
II. OUTER SETTING: THE NSW-WIDE MENTAL HEALTH SYSTEM
a) Understanding of consumer needs i. The extent to which consumer needs are accurately understood and prioritised ii. Alignment of consumer needs and the Peer-STOC model
b) Peer-STOC and LHD/SHN relationships with external organisations i. Peer-STOC key role of engaging with and referring consumers to other organisations ii. Living Well Strategic Plan 2014-2024
III. INNER SETTING: LHD/SHN CHARACTERISTICS, CULTURE AND CLIMATE
a) Characteristics of LHDs and specific units, communities i. Impact of LHD characteristics on Peer-STOC implementation

ii. LHD/SHN level of experience with peer workforce

b) Support and Supervision for Peer-STOC peer workers

i. Supervisory models:
- Level 1: Basic
- Level 2: Moderate
- Level 3: Sophisticated

ii. Peer supervision (external and internal)
iii. Clinical supervision
iv. Workload management
v. Support for the mental health and well-being of Peer-STOC peer workers

c) Networking opportunities

i. Opportunities for Peer-STOC peer workers networking
- Peer network within LHD
- Wider peer network

ii. Impact of COVID-19 on networking opportunities

d) Organisational culture

i. Level of understanding and acceptance of peer workers by other mental health workers
- Positive understanding and engagement
- Passivity, lack of knowledge, lack of interest
- Active hostility to Peer-STOC

ii. Potential philosophical clash of peer workers embedded in clinical settings
iii. Cultural change

e) Implementation climate

i. Understanding of strong need for Peer-STOC after successful implementation
ii. Working relationship with clinical teams
iii. Degree to which Peer-STOC alleviates burden on clinical roles and hospital system
iv. Impact of COVID-19 lock downs on Peer-STOC activities

f) Recognition and remuneration of peer workers

i. Salaries
ii. Career pathways
iii. FTE issues
iv. Recognition (informal and formal)

g) Documentation of consumer progress

i. eMR and progress notes
ii. Complexities of communicating information about consumers to clinicians

h) Learning climate, education and training for Peer-STOC implementation

i. Provision of staff training about Peer-STOC and peer work
ii. Cert IV Mental Health Peer Work
iii. Peer worker access to further training

IV. CHARACTERISTICS OF INDIVIDUALS: PERSONAL ATTITUDES AND BELIEFS INFLUENCING PEER-STOC IMPLEMENTATION

a) Knowledge beliefs about Peer-STOC and peer work in general

i. Consumers
ii. Peer-STOC peer workers
iii. Other lived experience mental health workers
iv. Clinicians

b) Peer workers' sense of self-efficacy

i. Importance of supervision and support

ii. Responsiveness of LHD to peer worker initiatives, needs and requests **iii. Professional development and career pathways**
c) Professional stage of peer workers
d) Peer-STOC peer worker identity
V. PROCESS: PLANNING, ENGAGEMENT, LEADERSHIP AND EVALUATION
a) Planning and readiness for Peer-STOC implementation
b) Engagement with key stakeholders (consumers, peer workforce, clinical teams) i. **Recruitment of peer workers** ii. **Referral processes for consumers into Peer-STOC:** o **How consumers learn of the program** o **Referral and discharge processes** o **Referral criteria** iii. **Exiting processes**
c) Leadership and Peer-STOC 'champions' i. **Buy-in from higher levels crucial in acceptance by clinical teams** ii. **Responsibility for implementation at the local level** iii. **Senior peer workers**
d) Evaluation of Peer-STOC **i. Challenges to data collection, due to voluntary nature and lack of uniformity across LHDs** **ii. Tools and processes for evaluation**

Findings

I. Peer-STOC model (INTERVENTION CHARACTERISTICS)

a) The Peer-STOC model

i General Characteristics

The basic Peer-STOC model, as specified in the guidelines developed and disseminated by the Ministry, was designed to provide prompt 7-day post-discharge follow up with consumers after an inpatient stay, with the aim of reducing 28-day re-admission rates. The model was implemented and adapted in a number of ways by each LHD / SHN. Key characteristics of the Peer-STOC model, and associated variations and challenges in implementation, are summarised below, including: in-reach into inpatient setting pre-discharge; prompt contact with consumers post-discharge; 6 weeks of Peer-STOC peer worker support; voluntary nature of Peer-STOC; Peer-STOC tools and approaches.

In-reach into inpatient setting pre-discharge: Many peer workers, clinicians and managers cited the contact within the inpatient unit as being valuable and critical, as well as being difficult to achieve in all cases. This was primarily due to many peer workers working part-time, and only available to attend inpatient wards on specific days. Consumers were sometimes hospitalised for a short time, which again made the inpatient Peer-STOC meeting more difficult to ensure. There were also examples where referrals to Peer-STOC failed to come through to the Peer-STOC worker before a consumer was discharged.

In some LHDs, Peer-STOC workers reported running group sessions, providing an avenue for connection with a wide range of consumers as a useful first step into the inpatient unit:

> *So first we'd kind of just do little incursions onto the ward and facilitate the peer support group and definitely the connection was with the service users and immediately that's what is most energising about this work for me...* (PW13)

Other peer workers described a more relaxed approach to engaging with consumers on the wards, through casual contact and conversations:

> *The value of Peer-STOC is, again, and then it comes down to being a peer worker in the inpatient unit, not just a Peer-STOC, but, depending on the personality of the person… I make a chance of anyone whose eyes contact mine I smile and say hello. I don't necessarily ask them, you know, do they want to chat? Because quite often you can read people OK? You can read someone who looks at you and says hello and then just, you know, looks down, looks away, doesn't wanna talk and you're like OK, but you've seen me, you know I'm here, next time you might decide you know to have a chat.* (PW15)

COVID-19 had a particular impact on the in-reach element of Peer-STOC, particularly group work, as peer workers were not allowed into the inpatient units at all during periods of lock down. This was overcome in a range of ways by peer workers, including providing over-the-phone peer support and video conference meetings with case managers:

> *…COVID was challenging, but we got through it and was able, me and my team were able to introduce some new things, especially in the virtual world…I was very proud that we were able to establish virtual meetings so meeting the people in the units with the case manager here in community.* (PW4)

Prompt contact with consumers post-discharge: As with the in-reach to the inpatient units above, many peer workers, clinicians and managers cited prompt post-discharge follow up as valuable and critical. Peer workers spoke of their ability to provide support when it is most needed, through providing links into the community:

> *…the peer workforce can add significant value to people's experiences, knowing that there's a specific need for people to have active follow up in the days following discharge, and the links into the community, and being that pivotal link.* (PW19)

This sometimes proved difficult to achieve in all cases due to many peer workers working part time:

> *...it makes it really hard particularly with the new program, to get it up and running when you're working 2 days a week...say someone gets discharged this Tuesday I might not get to see them for 3 weeks if I'm a community peer worker, or two weeks because by the time the rosters role round and their day doesn't fall on my day.* (PW17)

COVID also impacted upon this element of Peer-STOC, where initial contact with consumers post-discharge relied upon phone calls and texting. Little video or web-based meetings were reported with consumers post-discharge, instead peer workers relied on phone calls and text messaging:

> *I also offer phone, phone contact, certainly while COVID's been happening. I've been having a lot of … phone contact with people. So generally, I might even call them or text them in that time, in between times, if I haven't seen them.* (PW1)

Later interviews suggested that engagement with consumers within the community had generally been able to return to face-to-face contact.

6 weeks of Peer-STOC peer worker support: On-the-ground support for consumers within the community post-discharge was designed to ensure individuals were set up with all the supports and ongoing services they might need, ensuring that processes begun within the inpatient unit were carried out and supported:

> *…often it will be that the inpatient unit has started the process on a lot of things but it's around the Peer-STOC then making sure and almost driving that once they leave the unit to ensure that it all happens and to keep the consumer informed to what's going on.* (PW17)

The 6-week timeframe was one of the elements of Peer-STOC that varied widely across the state. In one LHD, the 6-week transfer-of-care model was seen as so successful that they adopted the Peer-STOC model across all peer worker positions:

> *…the funding came through for the Peer-STOC in our district, so why don't we do a whole restructure, all our peer workforce and change their job descriptions to be very much that Peer-STOC model of working across in-patient and community.* (OW3)

But even in this district, while they began with a 6-week model, this could be negotiated with the consumer at the end of the first 6 weeks if they would like to extend the support:

> *… we'll review it. So, we might, and that's negotiating then after the six sessions, well do you want to continue with working on particular goals that we've sort of got some traction around, and we can keep working for another six sessions.* (OW3)

Another LHD adapted the 6-week provision by offering 6 sessions over a longer time period, rather than once a week for 6 weeks:

> *…the six sessions to six weeks was a bit more interchangeable to look into ideally having six sessions with the person, ideally in that range of time, but without it being a strict or hard-and-fast rule of six weeks itself.* (PW19)

Peer workers in other LHDs described a much more ad hoc and flexible model. While it was understood that Peer-STOC was not to be an ongoing service, flexibility was required to ensure consumers were appropriately supported to access community services and resources, however much time that might take:

> *…it needs to not be a six-week transfer of care. It needs to be flexible, because like I said some people are done in a week, some people two weeks, other people, you know, either that or there needs to be another service of community peer workers, or if we can get people better connected into private services, but that's not always possible.* (PW15)

Work with consumers in the community to support transfer of care: The 'STOC' element of Peer-STOC, namely the Supported Transfer of Care, was the key element of the in-community support provided by peer workers:

> *By the time I was done with people in six weeks, they were already connected to the permanent services that would take over…That is the role of it, that is your role as well. Your role is not to be there, I said this, the role is not to be there to, right to the end of their life, your role is to just a smooth transition, and that smooth transition is connecting to other services.* (PW14)

To enable this transition, Peer-STOC workers reported developing individualised plans with consumers that involved supporting them to engage with community programs, resources and activities in a wide range of areas. These could include groups, social services and ongoing mental health supports that would help the consumer to seek help when needed. The exact nature of the support provided by Peer-STOC workers within the community thus varied greatly, in response to consumers' needs. One peer worker emphasised the importance of making that discussion an ongoing one, which could be difficult give the pressures on their time and number of people they were supporting:

> *…we should keep on checking is this what you want at this particular moment in time? Are we meeting what your needs are at that time? And we can always get better at asking that question. I think Peer-STOC or anybody can get better at asking, because you get so busy caught up in what you're doing with a number of different people and other bits of your job that we don't often, you know, stop to say is it meeting your need right now or not?* (PW20)

Some peer workers described a structured approach to such consultation:

…oftentimes I would take my laptop and I'd say to them look, this will help me to just be aware of what we're discussing. I can type pretty quickly so I was pretty fast in moving, and it will keep that conversation going and not making it an impediment to the flow of the conversation…with the plan that you create afterwards, whether the plan is provide source information on a Flourish program, or locate and print off a workbook for them, or book time with an area with the exact date and time (PW19)

Social engagement was mentioned by many Peer-STOC workers and consumers as a key element of their in-community work with consumers, including meeting for coffee, going for walks, and supporting them to attend social groups. Consumers reported a wide range of practical, creative and health related areas that the Peer-STOC workers had supported them with, very much tailored to their individual interests and needs:

...she helps me with my poetry, my new lifestyle skills, and the fact that I like working in the gardens, I'm very interested in Chinese and Japanese designs of flowers and other things. (C14)

Support within the home was mentioned by many consumers and peer workers, such as support with developing plans for managing tasks and general life skills. Both peer workers and clinicians raised some issues, however, about conducting home visits. In some cases, clinicians expressed concern for the safety of the peer workers, requiring peer workers to conduct risk assessments before conducting a home visit:

There was also safety issues because they were going off on their own all the time and they were not conducting home visit risk assessments, and I really put my foot down on that and said you will not go out on the first visit with, until you're with an ACS [acute care service] member and then you can start your work with them because you just don't know what you're going to walk into, because we try to get them into the mindset of completing the home visit risk assessment or starting it before they even left the, left the inpatient unit. (OW24)

One peer worker related their LHD's reticence about home visits, due to the death of a clinician on a home visit previously. This attitude was seen as stigmatising of consumers in some cases, and potentially problematic due to peer workers' perception of the value of home visits:

[Health] was just in this massive freak out about home visits and was very risk averse so even though I feel my background as an open dialogue facilitator and I'm really comfortable meeting people in their homes, as a service user I would prefer to do my therapy, to have health professionals come to my home and do my therapy there, uhm, that matches with my values, but a combination of [the health worker's] death plus COVID meant that I was mostly meeting people at cafes or at parks or at libraries or meeting them at their house but not going into their house, going somewhere else with them, but that was not about my worry about safety, that was about this massive organizational anxiety. (PW13)

Some peer workers felt concern for themselves and other peer workers on solo home visits:

I think because we had to visit people individually as peer workers, that was a significant area of concern for some for quite a while, thinking that if in the community people in the acute care team visit two at a time, and in the community, most community case managers visit two at a time, but you have peer workers for people who haven't been case managed,

who are just straight out of hospital, visit individually themselves, then where's the safety in regards to that? (PW9)

The COVID-19 pandemic also impacted upon this element of Peer-STOC, with peer workers relying on phone calls and text messaging for communication. Contact with consumers did continue in most instances as much as possible, in a modified manner:

> *...if I'm transporting, they'll be in the back seat. If we're walking, we're walking 1.5 metres apart from each other. You know, doing all the precautions that, that you know that you need to do.* (PW11)

It was generally acknowledged by interviewees that most activities were back to some form of normalcy, though some group work is run with reduced numbers in order to maintain social distancing.

Tools and approaches: Because Peer-STOC is a service, not a specific approach, Peer-STOC peer workers were able to utilise a wide range of approaches, ideas and tools in their engagement with consumers. Ministry guidelines provided to LHDs / SHNs mention the use of the RAS-DS (Recovery Assessment Scale – Domains and Stages). Peer-STOC workers in some LHDs were encouraged to offer the use of this tool to consumers at the beginning and end of the Peer-STOC program. Other tools that were mentioned by peer workers includes WRAP (Wellness Recovery Action Plan), YES surveys (Your Experience of Service) and peer groups. However, it should be noted that across the board all use of tools was voluntary for consumers within the Peer-STOC program.

Interviewees were asked about their use of specialised tools, such as the RAS-DS. The table below provides a summary of tools mentioned in the interviews, and examples of their use.

Table 4.2 Tools and Approaches Used by Peer-STOC Peer Workers

Tool	Details	Mentions and usage
RAS-DS	**Recovery Assessment Scale – Domains and Stages**: a mental health recovery measure designed to 'help consumers to take a leading role in understanding their own recovery progress, and from that, make recovery plans and track their recovery over time; To help mental health workers to work more collaboratively with consumers, enabling recovery planning to be based on consumers own reporting through the RAS-DS and from conversations that follow around what matters to the individual person; To assist	1 consumer, 9 other health workers and 14 Peer-STOC peer workers mentioned the RAS-DS during interviews. *Consumer:* The consumer who mentioned it remembered completing it with their peer worker. *Other mental health workers:* 6 said that RAS-DS was being used by Peer-STOC workers in their location, 3 were discussing the possibility of using it and its usefulness (these were individuals in management positions). *Peer-STOC peer workers:* 11 specifically mentioned that they use, or have used RAS-DS, 2 said specifically that they do not use it, and 1 expressed interest in learning more about it.

	services to track recovery outcomes. [17]'[1]	
Wellness planning, WRAP	This type of planning was described in many ways, including wellbeing planning, wellness planning, recovery planning, and the use of the WRAP tool: **Wellness Recovery Action Plan**: 'a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be.'[2]	2 consumers, 5 other mental health workers and 1 peer workers specifically discussed the use of planning tools of some description. *Consumers:* The two consumers who mentioned planning of this type both described developing 'wellness plans' with their Peer-STOC peer workers. *Other mental health workers:* 2 mentioned the use of WRAP specifically, 3 referred to wellness planning. *Peer-STOC peer workers:* 2 peer workers mentioned WRAP specifically, and 9 mentioned some form of wellness, wellbeing and / or recovery planning.
YES	**Your Experience of Service**: survey instrument designed to capture 'mental health consumers' experiences of health care'[3]	4 other mental health workers and 3 Peer-STOC peer workers mentioned the use of YES surveys.
HoNOS, K10	**Health of The Nation Outcome Scale:** 'a clinician rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms and social functioning for those in the 18 - 64 years'[4] and **Kessler Psychological Distress Scale:** 'a 10-item questionnaire intended to yield a global measure of distress.'[5]	One peer worker interviewee mentioned their use of these clinical tools in a previous LHD they had worked in as a Peer-STOC worker. One clinician also stated that when they first came to a unit and saw peer workers being asked to complete K10s, they ensured that it stopped as they were clinical tools, not peer worker tools.

A number of peer workers cited the usefulness of RAS-DS and WRAP when supporting consumers to develop a plan for their recovery:

> *…focus on the RAS-DS a lot more as a really effective, useful tool for where the person was at, and the modules as well were really good. So, I really actively liked those particular parts of the program, the recovery focus.* (PW19)

However, some peer workers expressed a general dislike of formalised tools or approaches, feeling that it conflicted with the role of peer work, or expressed some concern that such tools

[1] https://ras-ds.net.au/about
[2] https://mentalhealthrecovery.com/wrap-is/
[3] https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/national-mental-health-committees/mental-health-information-strategy-standing-committee/your-experience-of-service-survey-instrument
[4] https://www.amhocn.org/publications/health-nation-outcome-scales-honos
[5] https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0015/212901/Kessler_10_and_scoring.pdf

should not necessarily always be used, citing the potential of overwhelming consumers when they were vulnerable:

> *I know I'm supposed to [use tools], because it seems to be the norm. But um, I don't, for me, it detracts from the peer role, OK, it makes me more like a clinician, you know, there just to answer my questions and, whereas, no, I just don't feel that that's a peer role to be, you know, doing that sort of thing.* (PW15)

> *Not everyone wants to sit and do more paperwork and I was really conscious of the fact that these people had just been discharged from a hospital where they have done a lot of paperwork on discharge and then they've done a lot of paperwork on intake to community, right, whereas people didn't want more paperwork…I know it's not another K10, but it feels [laughs], people are kind of sick of being asked how they feel – do a Likert Scale for me! It's not on the people's recovery list when they get out of hospital which I get.* (PW23)

ii Flexibility of the Peer-STOC model

The flexibility of the Peer-STOC model, particularly in terms of the nature of peer workers' direct contact with consumers, was one of its great strengths. Peer-STOC is a service of individuals, rather than a specific method, approach or tool. Therefore, the variety of services, activities and contexts that Peer-STOC workers support consumers with is expansive and shaped to each consumer's needs. For one consumer, this included making use of her love of music as a tool for wellbeing:

> *…we jotted down different points about, like the strategies to, I guess it's like sometimes if I don't really feel like watching television, I put my radio on, have music, because I find I've, ever since I was a very young child, music's been, like I've been very, love music from a very young age and that. But yeah, she was great with, yeah, having that sort of making a plan like as far as what makes you feel calm or what makes you feel uneasy and like different things and that.* (C13)

In other cases, consumers reported practical support to find specific services and resources in the community, and make first approaches to those services:

> *[peer worker] took me to an excursion, just me and her looking around op shop and looking around Vinnies at [location] and talking about places where I can get cheap books and taken, she took me to [location] Salvation Army and we inquired about when they [were] giving away food and having a bit of services at Salvation Army.* (C3)

This in-built flexibility was evidenced across the state.

In terms of organisational management, some peer workers noted that their roles were very flexible and autonomous, and their relationship with clinical supervisors and line management was one of trust that they knew where best to spend their time:

> *…we get a lot of autonomy and support in whatever we want, like so we're sort of, people believe in us and let us run our own show basically.* (PW3)

This very flexibility, however, seemed to be a cause for concern for many across the state who felt that the role was unclear, and too unstructured.

b) How the model was developed and implemented, and by whom

i Strong peer work foundation of the Peer-STOC model

Among peer worker interviewees, there was a strong belief in foundational aspects of peer work that formed the basis of the Peer-STOC model, described by one participant as philosophical 'genes' through which the program had emerged:

> *...there's a lot of philosophy or ideology or peer-directed ideology or philosophy that's instilled in that, so it's got good genes, there's good genes. There's good chromosomes at work there as well, so I'm very acutely aware of that. Because I've been involved in the industry and peer work industry for years, but I've been involved in think tanks, I've been involved in research as well in this whole area as well as on the ground. So, there's definitely good genes there.* (PW2)

The program was also designed, and the implementation led by individuals with lived experience, both inside the Ministry and within committees designed to support the role-out of the new program. Though it was a peer-led development, it was not defined as a co-design or co-production process but did involve consultation and a broad-scale study of existing peer work roles within the state.

ii Models of Care

Each LHD and SHN was required to complete a model of care for Peer-STOC, to suit the specific needs of the populations and contexts they served. Models of care varied widely in their length and level of detail. The department set out a number of foundational aspects that were a required inclusion in the model, with suggestions for those aspects of the model that were to be determined by each LHD/SHN. A summary of aspects of Peer-STOC, and how they have been treated by some LHDs/SHNs in their model of care is provided below.

N.B: The evaluation research team was given access to seven models of care from both metropolitan and regional LHDs/SHNs. This is not an exhaustive collection as more LHDs/SHNs may have completed models of care. Responses and adaptations have been summarised below to reduce individual LHD identification. The below analysis refers to Models of Care only. An analysis of Peer-STOC characteristics emerging from interview data is discussed above.

Table 4.3 Models of Care Summary

Peer-STOC element	Models of Care Summary
Lived experience	All seven models of care described Peer-STOC peer workers as having a personal lived experience. Descriptions of lived experience included: o lived experience of recovery and firsthand experience in managing their own wellbeing o lived experience of a mental health issue o lived experience and personal recovery o lived experience of using mental health services o lived experience with mental health

	Lived experience as a carer was not included in any of the models of care, in line with Ministry policy for the Peer-STOC program.
Cert IV Mental Health Peer Work	Four of the seven models of care mentioned the Certificate IV Mental Health Peer work. Two specify it as a requirement either to already have completed it or to enrol and complete it through the Peer-STOC role, and two refer to it in other ways, either as a recommended minimum training or as a part of the role description.
Integration healthcare team	According to Ministry guidelines, Peer-STOC workers are required to be embedded into health care teams. The terms describing how Peer-STOC peer workers relate to health care teams was described in a variety of ways in the 7 models of care: ○ 'located' ○ 'based in' ○ 'alongside' ○ 'in partnership' ○ 'work collaboratively' ○ 'embedded' ○ 'fully integrated' Terms such as 'located' or 'based in' suggest a less active process of implementation and integration than terms such as 'embedded' and 'fully integrated'.
Initial contact with consumers through in-reach to the inpatient wards	The models of care detailed the process of in-reach into inpatient units in various ways, most commonly described as 'in-reach', but also described as 'making contact' and 'supporting' consumers when an inpatient.
First contact made with consumer post-discharge	The time within which a Peer-STOC peer worker was expected to make contact with a consumer post-discharge varied in the models of care, and included: ○ Contact made within 7 days ○ Face-to-face contact within 7 days ○ Preferably within 24 hours but no longer than 72 hours ○ Preferably within 24 hours but no longer than 2 days
Timeframe of support to consumers in the community post-discharge	The timeframe of post-discharge transfer of care support provided by the Peer-STOC worker differed in length and specificity in the models of care: ○ 6 weeks ○ Up to 6 weeks ○ Up to 6 weeks with one face-to-face session per week ○ Up to 8 weeks ○ Up to 12 weeks 6 weeks was the most common time frame.
Client-related contact hours	Not all models of care specified minimum client-related allocation of hours. Those that did specified: ○ 20 hrs/week consumer related time (1FTE) ○ 65% of their time

Positions recruited at a minimum of 0.6 FTE.	Only one model of care specified the recruitment of Peer-STOC workers at a minimum of 0.6 FTE.
Caseload	Caseloads were not described in all models of care. Those that did specified: o 15 consumers at all times (or FTE equivalent) o 15-20 consumers (1FTE)
Referral criteria	Models of care key referral criteria varied. Criteria included: o An inpatient stay o Consumer agreement/consent o Assessed as at a high risk of readmission o Consumers who would benefit from the post-discharge support to implement recovery goals o Consumer has limited or no support in the community o Consumer does not have a care coordinator o Consumer is at low risk of suicide and self-harm o Within geographical catchment Some models of care described the criteria as priority areas rather than criteria for inclusion in the program, including: o limited support networks o complex needs o experienced difficulty engaging with mental health services o high risk of re-admission

Most LHDs reported that they had completed a model of care, or were in the process of formulating one. Peer workers reported varying levels of consultation in the model of care drafting process. Some peer workers reported being heavily involved in the process:

> *We all designed the Model of Care. That was very much a co-design thing. You know, we looked at little things like how are we going to write notes in the EMR. We were the ones who went in and well, to a degree, shared the responsibility for informing people about the program and the staff on the mental health unit and the access teams you know. So, we were part of that education as well that went around educating other people about what we were going to do.* (PW16)

Other peer workers were less clear about who might in charge of the process:

> *From what I'm aware of we don't have a model of care in in our district, it's something that's being worked on at the moment for peer workers. Whether that's something that, I know quite a few districts are probably still developing those peer worker models of care.* (PW8)

One peer worker who found herself in the position of developing a model of care for her district, found the process daunting but rewarding:

> *Probably having a Model of Care up beforehand would have been more helpful but having said that, it was pretty fulfilling, and it helped me work in a way that I felt was best*

for me – setting up my own Model of Care – so I don't know if I actually would change that. It was just something that was difficult. (PW5)

iii Lack of clarity over the details of Peer-STOC

Some interviewees, both peer workers and clinicians, expressed deep concern at the lack of preparedness of some locations within their LHDs, which they felt was necessary before recruiting a peer worker for the role. Preparations they felt should include processes, documentation and information sheets, in one case described by a peer worker who had arrived to start the role to find that nothing had been developed:

> *…they didn't even have a referral form…the first thing they needed was a pamphlet to actually say… what it was… they didn't even have a referral pathway…staff information sheet, for, for health staff…how referrals were made, who would make the referrals, and what we needed on those referrals, like risk assessments from the treating team… I then had to do things like a returning home checklist, I did safe work practices form…Work checklist, welcome pack, safe work practices, returning home plan…* (PW14)

> *…essentially, we don't have any guidelines, official guidelines…Peer-STOC is a new role that really needs to be developed and fleshed out. Which is all well and good, but if there was some more direction on how to do that, especially since I'm green.* (PW12)

A clinician involved in clinical management of some Peer-STOC workers was similarly concerned:

> *I found an immense amount of gaps. I put an extensive amount of work into the Peer-STOC program because when I came on, they were unsupervised, not doing the, doing their own thing. There wasn't appropriate planning from the inpatient unit. They were basically, patients were coming out and they were just following up whoever they wanted to follow up, there was lack of governance over the, the documentation processes and actually very [un]clear about the role.* (OW24)

While a level of autonomy and flexibility was described as a positive element of the Peer-STOC role for some peer workers, the need for good supervision and support was seen as vital and often lacking.

c) Belief in the Peer-STOC model

i Perceptions of the usefulness and viability of peer work and/or Peer-STOC model

Across consumer, peer worker and other mental health worker interviews, there was a strong belief in peer work as a vital consumer-focussed service that supported transfer-of-care, promoted recovery-oriented language and approaches, and effectively made meaningful human connections with consumers. As mentioned in the sections above, there was a strong sense that the peer work underpinnings of the program were strong and very beneficial for the service.

In terms of the Peer-STOC model itself, interviewees expressed a general sense of transfer-of-care and connecting consumers with community supports as very beneficial, as was the engagement with consumers in inpatient units prior to discharge.

Though interview participants expressed their own belief in the benefits of peer work and the Peer-STOC model, there was some discussion of those within the system who did not see the benefit or seem to acknowledge the role of peer workers and peer work in the system and the medical context. This was characterised in some cases as a lack of knowledge about peer work and a somewhat passive attitude or lack of action in terms of implementing it appropriately:

> *I guess there's not a lot of faith, again this is totally my opinion, not a lot of faith in peer work from the system. That's just my impression. Because I guess a lot of people I speak to and even my peer work manager expressed that basically every time I try to say 'oh you know what should I be doing today? What should I be working on?'…* (PW12)

In some cases, the lack of understanding or acceptance of peer work was characterised as more actively hostile, attributed to clinician's 'burn out' and lack of interest in new ideas:

> *… we started out at a different acute care service…the team had a lot of cultural problems, which meant that it wasn't really safe for peer workers to be on the team, so we had to think of a different way, a different team to be on. So, we've moved it to a different team where the attitude's, there's not as much burnout among the staff, because if there was a higher level of burnout … that's too difficult for us to be there. Very triggering and overwhelming to listen to some of the things people would say…*(PW3)

The attitude referred to above did not seem to be common, though many did feel that the system in general could be better educated and prepared to receive peer workers and make the most of their unique perspectives and approaches.

ii Important aspects that relate to belief and viability of the model

Key elements of the Peer-STOC model described by participants as expressing its strong peer roots are summarised below, including: lived experience, non-clinical, voluntary and responsive to individual needs. These elements were seen as not only important philosophically but also key to Peer-STOC's success in attractive consumer engagement in the program. The below characteristics are described by participants as being central to peer work generally, not just to the Peer-STOC model.

Lived experience: The lived experience of Peer-STOC workers was cited almost unanimously by interviewees as the key ingredient, enabling them to engage meaningfully with consumers and provide hope and guidance along the path to recovery:

> *…it's not just a Peer-STOC thing, it's a peer thing of people have hope. So anytime, when I have the conversations in the inpatient unit, one of the things they often say to me is that this has been the most honest conversation I've had with anybody.* (PW15)

For consumers, the practical knowledge that a Peer-STOC peer worker could pass on due to their lived experience was particularly valuable, as was the empathy they offered:

> *I can ask questions and they tell you what they know or what they experienced or they tell you a bit of their personal life when they were young and that, and I feel happy because I'm not alone in that sort of scenario or case*. (C3)

> *…the empathy, their empathy was just really good. Uhm, he was also really good at explaining things kind of like being able to make things simple but also be able to have*

appropriate anecdotes, you know, stories about things. I found that, yeah, and I found him really easy to talk to and he was a great listener. (C21)

For peer workers, having a lived experience formed a key part of their professional identity as well as a means of connecting with consumers:

> *As soon as people find out that I've got a lived experience of mental distress throughout my life and that I'm ok, as soon as I mention I've got lived experience you can see relief in people you know – 'oh thank god' you know [laughs]* (PW16)

Clinicians also spoke to the importance of lived experience in providing hope as well as a valuable resource when struggling to connect with a consumer:

> *…it's a good initiative to have a support person down in the ward other than the nurses because it's a different role and because the Peer-STOC worker has lived experience of mental health so clients can relate to him…he can support them in the community after they leave otherwise… they might not engage with the case managers and staff or the hospital and it kind of becomes a revolving door.* (OW29)

Non-clinical: The identity of Peer-STOC workers as non-clinical health workers was also cited as a key aspect of the success of the program. Consumers expressed their appreciation of the non-clinical nature of peer workers:

> *I think it was easy to talk to someone that had a lived experience. You know, rather than doctors and medical staff.* (C10)

Peer workers cited the non-clinical nature of their role as particularly important in instances where a consumer has had previous negative experiences with the clinical system:

> *…because you're not there to tell them about their medication or their diagnosis, or, you know, judge them about why they're in there in the first place, and that sort of thing, it really is just a thing that they actually feel there's someone to listen to them, someone's heard them and, you know, when you feel that you've been heard and validated and not judged because that's, as a peer worker you can't, judgment just, you know, you don't judge anyone.* (PW15)

A number of peer workers noted the tensions with clinical staff that needed to be managed due to the non-clinical nature of their role, coming from what some staff might see as the 'outside':

> *…where say a peer worker is in an inpatient unit and then the staff aren't really connecting or helping them out or something like that, how can you solve that sort of problem, how do you work through that helpfully. I think particularly when peer support workers, like I said, are on the outside a bit, how do you work from that position well.* (PW10)

Voluntary: The voluntary nature of Peer-STOC was in some examples seen by consumers, clinicians and peer workers as a key feature of the program and its success with attracting consumers. Engagement with Peer-STOC peer workers in the inpatient unit was voluntary, with some describing a flexible way of working on the ward and engaging with consumers in a range of ways:

…we run groups; we connect with people in the group unit. Of course, the uptake of Peer-STOC is entirely voluntary. They don't have to take advantage of that…clinicians sometimes refer and if the client is willing, we will then contact them off our own back…In terms of the inpatient unit, there's no formal incorporation of Peer-STOC into the structure. (PW9)

I make sure that I do, go and introduce myself, have a chat about the program and see if it's actually something they would like to be involved with. That's the big thing, they have to, because it's a voluntary program they don't have to. (PW11)

The voluntary character of Peer-STOC is not only part of the Peer-STOC model, but a foundational aspect of peer work, which is about supporting the needs and wishes of the consumer.

Responsive to needs: The flexibility of the Peer-STOC model described above is particularly relevant in terms of ensuring that the individual needs of consumers are met. One consumer noted that she felt she could raise something with a peer worker and the peer worker would help her with it, whatever that might be, and support her with writing it down in a notebook, her preferred way of keeping information organised:

…it was like having someone, it as a really good sounding board. I could speak to her and say something, something like if I, if I wasn't confident in a certain task, she'd say, like she said it was good because I've got like a notebook that I write things in, like as, like I've, I've got my mobile phone, but I sort of like to have things written down, so I'm organised. (C13)

The responsiveness and flexibility to meet consumers' needs in ways suited to them is a cornerstone of the model and was described as a feature of Peer-STOC programs across the state. Many interviewees discussed how the model and Peer-STOC peer worker services and consumer engagement were adapted to suit the needs of specific populations, such as young people, seniors, Aboriginal communities and other specific demographic populations.

Diversity amongst the peer workforce was a key aspect of the adaptability of the model, with one peer worker advocating for a greater diversity to suit a greater number of specific populations, such as the LGBTQIA+ community:

… to better reflect the cultures we live in, ideally we'd have, you know, sort of similar percentages of peer workers that reflect the similar percentages of people from that community there, ideally. Definitely there are indigenous, Aboriginal, Torres Strait Islanders there. We don't have peer workers that I know of who can, you know, connect to those communities and that's, sometimes that's part of the people we support. And definitely because I'm from the Rainbow community and I'm involved in the policy group looking at how rainbow communities are treated in the health system. Definitely a rainbow friendly or rainbow allies for that. (PW2)

Both peer workers and other mental health workers cited the need for a greater number of Peer-STOC peer workers more generally, to service the needs of a diverse community.

d) Comparison of Peer-STOC model to other peer models

The Peer-STOC model calls for the peer worker to work across both inpatient and community settings. Peer-STOC workers are also embedded in teams of mental health workers who are not peer workers, such as Acute Care Service or community mental health teams. This is a different model to those reported by some participants who were working as peer workers prior to the roll-out of Peer-STOC. One individual described an earlier program that involved working across clinical and community contexts, but where the peer worker was based within a peer unit with other peer workers:

> *When I first started as a peer worker that's how we were all set up. We were set up as a consumer unit or a consumer team, so that was our team, and we would go to different kinds of services rather than being based just in one service.* (OW33)

This was viewed as having both positive and negative consequences, for while the peer worker felt very supported by colleagues with lived experience, there was more of a divide between peer workers and other mental health workers. There was also more difficulty in embedding peer-led attitudes and approaches into everyday clinical practice.

Some peer workers reported having a breadth of experience from working as a peer worker with other teams and units that they could bring to the Peer-STOC role:

> *I was involved with the community doing a lot of what we're doing now, for four years, that was in community health, and then I've come into these guys in the last, gee I think it's just three or four months old, but I had all those years of understanding the health system and dealing with the health system, from a different point of view. And there's been a good cross-pollination of skills, approaches, I've been able to take with me.* (PW2)

Many peer workers interviewed for this evaluation, however, started their careers as peer workers through Peer-STOC.

e) Complexity of implementing Peer-STOC

i Newness of the peer workforce

There was a great deal of variation as to the readiness of LHDs to implement Peer-STOC. For those LHDs with a pre-existing peer workforce, implementation seemed to have been undertaken more efficiently and with appropriate supervision and leadership. Some LHDs with no pre-existing workforce took the time to prepare and educate the workforce, and develop their model of care, prior to the arrival of their peer worker, developing processes and procedures:

> *…so that was well developed before the employment of the Peer-STOC workers, so there was a model of care developed, an orientation and an implementation plan, and, and, that was, yeah, well thought out, coincided with their position descriptions and so by the time the employment process happened for the Peer-STOC workers, it was very clear from that strategic point of view what the peer work, you know the Peer-STOC workers would be doing.* (OW35)

For those LHDs who developed processes and procedures prior to recruitment, Peer-STOC functioned more smoothly.

For those who recruited a peer worker before sufficient planning, documentation and processes had been put in place, and/or where there had been long gaps between Peer-STOC workers recruited for positions with no hand-overs, the lack of clarity created complexity and confusion:

> *…on my teams there's been two people before me, but the first one only stayed for about a month and the second was only about 3 months I think. So, I'm the first one that is planning to actually stay for the long run I think, hopefully! So, it, I think they first had one about a year or two back. But again, they didn't really get a chance to integrate properly is what I've been hearing.* (OW12)

It was suggested by some interviewees that a senior peer worker or equivalent is required in the on-boarding and implementation process, made particularly evident by the problems that can ensue when appropriate set up has not taken place:

> *It wasn't very well thought out…they didn't have a program coordinator that was there first… they didn't introduce the program even, before the peer workers that started their work, … in-services to everybody before they even got referrals. Like it just wasn't implemented correctly, it wasn't supported correctly, and I think that's got, speaks to the bureaucracy and how it is overstretched in itself. It needs, I can't say this enough, it needs a … Peer-STOC coordinator with my type of background…it looks like you get peer workers that have no grounding in roles, or support role, similar, without the skill set.* (PW14)

While the nature of consumer engagement was somewhat clear once they were an official participant within Peer-STOC, referral processes and communication channels with inpatient units and clinicians was often problematic and complex:

> *There are Peer-STOC workers in the units, but unless I've got a relationship with that particular peer worker and they call me before the client comes out, I don't even know that they're being released back into the community. I only find out on the back, sort of back side of it, when a clinician is asked to go and do a seven-day follow-up and they'll say to me, oh they had a peer worker in the unit, do you want to come with me? So, I don't necessarily always see, and that's where the downfall is at the moment, that communication between the inpatient setting and the community setting, it just falls down all the time.* (PW21)

In this sense, overcoming systemic resistance was cited by many peer workers and clinicians as the primary issues of successfully implementing Peer-STOC, rather than complexity.

ii Scale of state-wide implementation

Some interviewees suggested that while they appreciated the level of investment in the peer workforce through Peer-STOC, the simultaneous implementation of the new program across the entire state led to some issues. Because there had been no pilot program within an LHD where processes, procedures and documentation templates could be developed, many LHDs potentially 'reinvented the wheel'. There was little sharing of documentation resources and processes across the state, with no central system for sharing resources between LHDs/SHNs. In some cases, the development of these basic implementation tools was left to individuals, often

peer workers themselves, in addition to the face-to-face work with consumers they were hired to undertake. This was a difficult ask when in one case the peer worker recruited to the role as just beginning in the peer workforce:

> *I'm brand new to healthcare and to peer work and so is everyone else in the team and the LHD. So, I think some more oversight or guidance or direction would be beneficial, in my opinion.* (PW12)

In this case, the lack of executive buy-in was key to the lack of clarity over how to implement the program appropriately.

iii Flexibility adding to complexity

While the flexibility of the Peer-STOC model was welcomed in terms of direct engagement with consumers, the lack of clarity in some LHDs concerning the nature of the Peer-STOC role was a cause for concern:

> *…my general kind of feeling about it is that it's, it's been interesting. Relatively rewarding but also quite challenging in that it's very murky, the role. And in my opinion, not integrated or implemented as well as it could be. That's my general feeling. So there's a lot of development that's going on that I didn't realise would have to be done.* (PW12)

Both experienced peer workers and clinicians also expressed concern about the lack of clarity, supervision, support and induction through the early stages of implementation if relying on inexperienced peer workers:

> *…anybody without my experience would struggle in that role. It would be an absolute nightmare and they would struggle. There was no, there's minimal supervision of, yeah, well supervision, minimal support, no support really…Like no, no 'come out with me and I'll show you the basics'. What do they call that? Induction.* (PW14)

f) Design of the program and accompanying materials

i How Peer-STOC is presented to consumers

A number of interview participants described specific materials developed for consumers to facilitate initial engagement and explain what Peer-STOC was and who it was designed for, such as fliers and pamphlets:

> *…we would then start working towards, you know, introducing and see who would be the right person for it and then, and then we say this is what we want to do, we're [?] understanding we're offering this service, would you be interested? And then, and then facilitate another meeting before they left to look at their goals and give them, say a pamphlet to say this is, this is Peer-STOC, this is what we do, have a read and we'll catch up with you in the next couple of days.* (OW24)

Others described direct engagement with consumers in the inpatient ward, both casually as well as in group settings, as the primary way that consumers were 'educated' about Peer-STOC:

> *I didn't know anything about the Peer-STOC program it was just that they had the groups running throughout the day and one of the groups each day was taken by the peer support*

workers and that's how we were introduced like that's who they are, that's what their role is, that's what they do. (C10)

ii How Peer-STOC is presented to other mental health workers

One interview participant described the fliers they developed in order to educate clinicians about Peer-STOC, explaining the importance of clinician-specific information in order to encourage referrals and engagement with peer workers:

> *I also then from there did a one page…staff information sheet, for, for health staff, so it said [?] what is peer supported transfer of care, so explained the program, you know, state-wide initiative, connecting with people before discharge and follow up, and then it explains who, who Peer-STOC workers were, again its aims, and how, and how, and how we will achieve our aims, who the target group would be, the evaluation process, how it was going to be, approaches, and what we needed from you.* (PW14)

In general, the education of other mental health workers about Peer-STOC was more ad hoc, and seen as a large part of many peer workers' role:

> *I think I'm spending, spent a lot of time like in the early days just educating the medical staff on what I do. And I spent a lot of times in meetings just putting my hand up and saying to, 'oh this person would be suitable for Peer-STOC because XYZ'. So that happens a lot so they get an idea of 'oh hold on a minute. That's what she does.* (PW11)

There was a general sense in the interviews that clinical staff knowledge and acceptance of peer work was improving over time.

iii Design of supporting documentation

A wide range of supporting materials was listed by interview participants as necessary for appropriate implementation of Peer-STOC. These included: information sheets for consumers and clinicians (mentioned above), referral forms for clinicians, roles and responsibilities documents, referral criteria and checklists, consumer consent agreements, peer worker handbooks, selections of peer tools such as WRAP and RAS-DS, development of YES surveys specific to the Peer-STOC service, and supervision frameworks. This type of documentation was seen by some participants as absolutely vital to successful implementation, as described above. Some peer workers described the use of tools and approaches as enabling their work without ever crossing the line of becoming diagnostic or clinical:

> *I think we've got a bespoke set of tools that have gone through all the different people to be approved of that we use… But nothing, no, nothing diagnostically. Under the models that clinicians use we just keep away from that sort of stuff.* (PW2)

There were examples where peer workers enjoyed the flexibility and autonomy of not feeling tied to formalised processes, tools and documentation:

> *I don't like being bogged down in process. I understand clinicians need to have that process. There are all sorts of legal red tape they've got to follow and that's the beauty of my job, obviously there's stuff I need to follow but it's not that rigorous.* (PW22)

The variety of attitudes concerning documentation and processes speaks to the in-built flexibility and adaptability of the model.

g) Cost

i Allocation of funds

Peer workers and other mental health workers and managers generally acknowledged that Peer-STOC is a significant investment for NSW Health, particularly as a state-wide program. Some individuals expressed some concern that LHDs that already had a well-developed peer workforce were disadvantaged in terms of the amount allocated to them, compared with LHDs with little or no peer workforce. But there was a general sense that the investment in peer work was worthwhile and closing some gaps in the health system, for example improving post-discharge follow up.

A number of workers in management roles noted that it would be helpful to have specific funds set aside in the early stages of on-boarding new peer worker staff members, for example paying a senior peer worker to set aside specific time for new staff supervision and development. A large number of both peer workers and managers recommended that money should be allocated for LHDs to develop a senior peer worker position in those LHDs without one, in order to support the implementation of Peer-STOC and develop its workforce.

There was also some concern about where the money should be targeted, in terms of specific populations or locations within an LHD, as well as how to get started in terms of recruitment, particularly if peer work was new to the LHD. Each LHD was responsible for developing the implementation to suit their unique environments and populations, but it seems that some LHDs were unclear as to where to target the funding, particularly in those areas that are geographically large.

ii Resources for direct work with consumers

In general peer workers and other mental health workers confirmed that there was sufficient access to petty cash or reimbursements for costs associated with working with consumers in the community, such as coffees. However, there were a small number of examples where Peer-STOC workers were paying for such things out of their own pocket.

Many peer workers reported running groups in the inpatient units, and a number mentioned the use of different materials and musical instruments. While resources were generally reported to be tight, peer workers could apply to purchase such materials, however in some instances priority was seen to be given to clinicians and other mental health workers. Peer workers noted that given more funding the breadth of the group work and activities they could offer could be expanded.

iii Allocation of Peer-STOC workers

The need for more peer workers was echoed across peer workers and other mental health workers and managers across the state, in terms of meeting consumer needs, improving the general understanding of what peer work is, and promoting recovery-focussed care.

Themes relating to pay scales, number of FTE and numbers of peer workers are detailed below in 'Inner Setting: Recognition and remuneration of peer workers'.

iv Peer-STOC staff access to basic resources

Peer-STOC peer workers across the state reported access to basic resources commensurate with other health staff, such as access to a fleet of cars, computers, desks and phones. There were some peer workers who noted that desk space was difficult to come by, particularly for those peer workers who had to travel between different locations and who had to therefore take their work with them from place to place:

> *I hot desk wherever I go. So that can, that can be a little bit challenging if there's not enough desks for me. So, then I sort of find a desk or find an area, find a little posi somewhere to work. I mean most of the time I'm obviously on the road anyway. I'm not, you know, ideally I shouldn't be in the office as much as when I am on the road. But you can have sometimes when you're, when you're in meetings and then you'll spend extended periods of time writing notes or whatever in the office.* (PW11)

Some peer workers suggested that given the mobility of the Peer-STOC role, support for better phones and laptops might be helpful, particularly in terms of ensuring access to information when in the community:

> *I think having internet access is definitely something that those phones should have. That's something that wasn't provided which would have been extremely useful. I mean oftentimes you were in a car travelling to someone's place, and if your work phone doesn't have internet access you're using your own data to find out where they're getting to, and making sure your own phone is charged and it's ready…I think in the Peer-STOC role especially, a mobile is extremely critical, and even the laptop to be able to do things, because you're often at different locations and areas, not just here's a desk that you have permanently. (PW19)*

II. NSW-wide mental health system (OUTER SETTING)

This second domain explores the broader context influencing the implementation of Peer-STOC. For this evaluation, reference is made specifically to NSW Mental Health Commission's Living Well Strategic Plan 2014-2024.

a) Understanding of consumer needs

i The extent to which consumer needs are accurately understood and prioritised

The Living Well Strategic Plan 2014-2024 was developed through consultation with both government agencies and the community:

> *…more than a year of intensive consultation by the NSW Mental Health Commission with the NSW community and government agencies. In an innovative co-design approach, more than 2100 people came together either online or in person to develop ideas and comment on working papers.* (p11)

The focus in the plan on consumer engagement, lived experience employment and recovery speaks to the level of community engagement in the consultation process.

In addition to the Living Well Strategic Plan, before the development of Peer-STOC it is understood that NSW Health employees undertook a scoping process to ascertain the status of

peer work across NSW. This served to clarify the contexts within which the peer workforce was to be built and expanded.

ii Alignment of consumer needs and the Peer-STOC model

The strategic model of mental health service delivery developed in the Living Well Strategic Plan outlines aspects of service delivery and their corresponding frequency of need, size of service and cost:

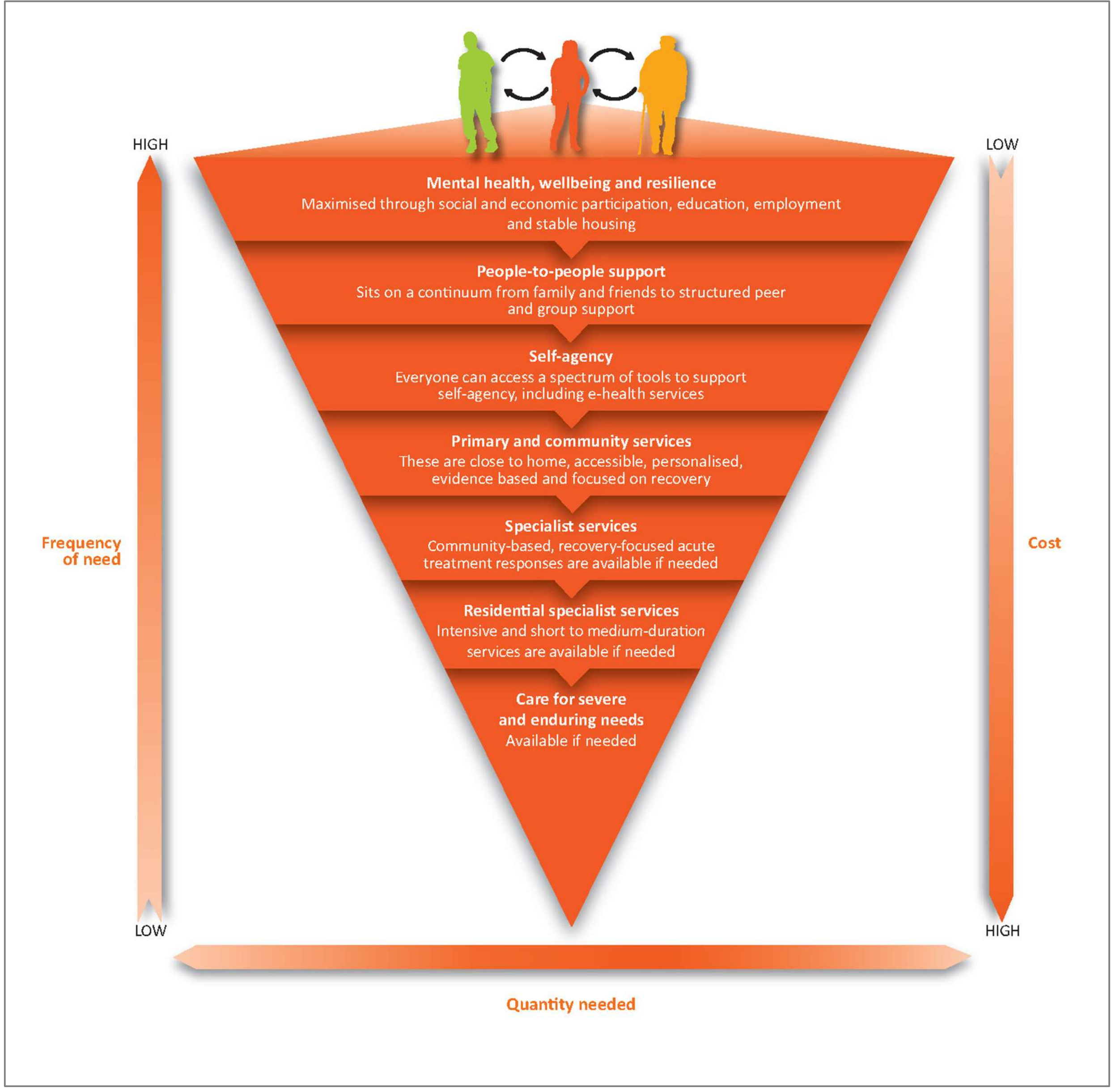


Figure 4.1 Extract from p 13 Living Well Strategic Plan 2014-2024: '1.8 Delivering mental health and wellbeing to NSW' [17]

The Peer-STOC model is uniquely and holistically designed to support all of the priority areas illustrated above, at multiple levels:

- Reducing reliance on hospitalisation and acute care services
- Providing links to specialist, community and residential services as required
- Supporting and advocating for consumer self-agency
- Providing direct people-to-people support in group and individual contexts, as well as connecting consumers to further people-to-people support as required
- Providing resources and approaches to consumers that holistically support mental health, wellbeing and resilience

The efficacy of the Peer-STOC model in these ways is supported by the evidence detailed above in the qualitative and quantitative outcomes sections of this report. **Growing the Peer-STOC workforce will further support NSW Health in meeting the recommendations of the Living Well Strategic Plan.**

b) Peer-STOC and LHD/SHN relationships with external organisations

i Peer-STOC key role of engaging with and referring consumers to other organisations

Peer-STOC workers' skill in bridging the divide between state-run hospitals and mental health services and community-based services, resources and organisations was a key strength of the Peer-STOC program. This 'bridge' is a practical, pragmatic bridge, developed through direct support to the consumer to connect with those resources and services appropriate for the individual.

Services and organisations may include support for the functions of daily life, building confidence to reach out to organisations such as banks or support networks, or to make use of community resources that support wellbeing:

> *I sort of had the tools now, like learning to sort of like say if I get a letter from some sort of the bank or whatever, and if it's anything I need help with…they say people can help, like if you need help reach out and get help. That, that's so important 'cause I think like when I was getting mentally unwell this last year I sort've, I isolated myself and I didn't reach out…I think I've got more confidence now...* (C13)

> *…it's somebody to learn from and it's someone who can tell you what's out there in the community and that, they can tell you what, like a contact, like [peer worker] the other day even though she's not my Peer-STOC anymore, she told me about what some good apps to use for mindfulness and other good apps.* (C3)

Importantly, Peer-STOC workers also provided resources and information that consumers can make use of when in need of additional support:

> *I changed my lifestyle, with [Peer-STOC Peer Worker, group facilitator, consumer advocate, case manager] have helped me with, I have a new medication, my doctor is very approachable and we get along well, and I've got a full file of recommendations which have been carried out, and I've got a, yes, I've got a full set of files about, which I look at all the time.* (C4)

The practical engagement of Peer-STOC peer workers with consumers was the great strength of Peer-STOC, described by a number of interviewees as 'walking' with or alongside the

consumer as they navigate the community post-discharge. Their lived experience of accessing such services themselves provided them with authentic knowledge of how services work, how to access them, and what kind of support they might offer:

> *…we're meeting on that level of the shared experience of our own wellbeing recovery. So we're, you know we can talk about what's worked well for me in the past and what, you know and problem solve what might work for that individual… I can sort of support people through the different ranges of what teams there are and like contact with that team, liaise work, you know, alongside that team. You've got more flexibility to move with the person along that journey…We as peer workers can walk along with the person while they're navigating that.* (PW20)

This does not limit the peer workers' ability to connect consumers to other types of services and tailor offerings to meet the individual needs. This is where having some experienced peer workers as well as a number of peer workers with a range of lived experience can add to the lived experience resources on offer through Peer-STOC.

c) External policies and incentives influencing implementation

This theme refers to those policies and incentives that influence the investment, development, and implementation of Peer-STOC.

i Living Well Strategic Plan 2014-2024

The Peer-STOC program was funded as a response to the 'Living Well Strategic Plan 2014-2024' [17]. In section '8.2 Peer Workforce', Living Well begins with describing the expertise of those with a lived experience (p100). It also highlights Australia's poor employment record of individuals with lived experience. Living Well calls for action:

> *Services and agencies need to consider how to attract a mix of peer leaders and new staff, create support structures, develop career pathways and support training and development specific to this workforce. This would include access to training such as the Certificate IV in Mental Health Peer Work within the first year of paid employment for all peer workers with government and community-managed organisations. Peer workers should also have access to formal supervision or mentoring by a person with lived experience.* (p100)

Peer-STOC has made great strides in terms of investing in the peer workforce and drastically increasing the number of peer workers embedded in the system. It has also supported many individuals to complete the Cert IV Mental Health Peer Work by providing scholarships to help peer workers already in Peer-STOC positions complete the training. Where more development may be needed is in the career pathways, support structures and supervision, which are discussed in depth below in 'III Inner Setting: b) Support and Supervision for Peer-STOC peer workers.

The other aspect of the lived experience workforce highlighted in Living Well is through leadership and research:

> *Peer worker roles are integral to the concept of lived experience at all levels – including peer support to consumers and carers, peer mentoring, peer leadership, policy development and research.* (p101)

Peer-STOC has drastically improved engagement with consumers and increased the number of peer workers to support a greater lived experience network. Peer leadership, however, is more ad hoc across LHDs, with interview participants reporting only a portion of LHDs/SHNs with a senior peer worker, and a small number of individuals with lived experience in higher leadership positions within the department. Leadership issues are discussed in more detail below in 'V Process: c) Leadership and Peer-STOC champions.

Recommendations made through this evaluation may help to overcome these issues to support a thriving peer workforce by 2024, as described in the Living Well Strategic Plan above.

III. LHD/SHN characteristics, culture and climate (INNER SETTING)

a) Characteristics of LHD/SHNs

i Impact of LHD/SHN characteristics on Peer-STOC implementation

The impact of certain aspects of LHD/SHN characteristics may include geographical size, population size, and contexts, such as metropolitan, regional and rural. This diversity speaks to the need for individual models of care to be created for the unique needs of each LHD/SHN. Within this study, according to definitions held by NSW Health, interviewees stemmed from:

- 8 Metropolitan LHDs
- 6 Regional / Rural LHDs
- 2 SHNs

Peer-STOC has necessarily undergone an adaptation process to those LHDs outside of the greater Sydney area. A number of challenges presented themselves in geographically large LHDs and/or encompassing rural and remote areas. One of the key challenges has been the limitation placed on the provision of Peer-STOC services with a small number of staff and a large geographical area that would require many hours of travel to service fully:

> *…you can't do the job. You can't effectively, you know, in three days a week you can't travel those distances to provide face to face support which peer work is, at its best, that's what it is. It's that sitting in front of somebody.* (PW22)

In some instances, this was managed by placing geographical limits on those areas serviced by Peer-STOC workers, and basing Peer-STOC within the larger towns to service as many people as possible. In some cases, this resulted in people who began to benefit from Peer-STOC as an inpatient, who were then later unable to continue to receive service as they were out of the geographical area. Described by one Peer-STOC peer worker as the 'tyranny of distance', this issue was frustrating when a peer worker had made a positive connection with a consumer when they were in the inpatient ward:

> *…there's one particular person…So we've built a good rapport, but the issue was she was out of region, so she lived basically in [remote location], but the issue was she would build good stuff while she's in the unit, but then once she was discharged she would fall, fall between the gaps if you know what I mean?...She's currently living in [a closer location] now and linking her into services where before it wouldn't be able to access because she would she would ideally say no, but every appointment that it's been a new appointment for her I've been able to go with her and transition her into those people.* (PW4)

Consumers also felt frustrated by the limitations set on accessing Peer-STOC post-discharge, in this instance a formal boundary had been set in order to provide limitations on the amount of travel required of the Peer-STOC worker:

> *I live in the middle of nowhere…it wasn't put to me as like 'you cannot join the Peer-STOC program'… It was an automatic like 'I'm from [location]' so that's [location] Regional Council so she's going to [location] Community Health Centre'… I had like catatonic depression, like I couldn't leave the house, so having somebody over that 6 week period coming home would have been quite nice, quite jealous, but it would be nice for somebody who's like me who's living in this like divide between the two council areas. It's 15 minutes difference [between one community health centre and the other]. I would totally get it if was like two hours away, that's fine but it's 15 minutes. It wasn't because I couldn't get there. It was more because I don't, you know, it's not where I live on the census sheet you know.* (C19)

The 'borders' of LHDs also presented challenges in greater Sydney LHDs, where some consumers may be in an inpatient unit in one LHD, but are living in a different LHD, causing a break in the transfer of care:

> *…the only negative about the Peer-STOC from an inpatient unit really[?] is when you find someone who you've been talking to is out of area. And then once they leave, you don't get to continue. That, that has on a couple of occasions actually, when your out of area, we're going to lose[?] custody and you lose that contact with them. And even though you really do want to keep that contact going because, you know, if, if you make a connection with that person then you really want to be able to support them, empower them, and grow them along the way.* (PW15)

It was suggested by some participants that a stronger network of Peer-STOC peer workers across LHDs would help with inter-LHD referrals for those consumers who cross LHD borders.

In other LHDs, Peer-STOC resources were focussed strongly in particular locations or with particular populations that were in particular need of support. The application of Peer-STOC to seniors was described by one other mental health worker:

> *I think the vital role I see with older people, probably not sustainable, is that. Is the extra warmth and friendliness of human contact…we live in a really high retirement area. And sometimes that means people have moved up to the [location] and away from families and away from supports that they've had through life, and then a spouse might die. The classic, a lot of New Zealanders move over here, [location], going to retire. But it may not have been a good move. They've got no one. I think the peer support worker, particularly in that gradual way that they can introduce some of, a retired person with a mental illness to community support, yeah man, that's vital. That's like establishing a new life.* (OW28)

ii LHD/SHN level of experience with peer workforce

Another characteristic of LHDs/SHNs that had a particular impact on the process of implementation of Peer-STOC was their previous history with the peer workforce. Some LHDs, mostly within greater Sydney, had been developing their peer workforce before the investment in the Peer-STOC model, and were thus already equipped with supervisory models and staff training related to peer work:

I think it was around ten years ago… And back then there wasn't a lot of training or structural guidance around peer work, apart from I think, New South Wales CAG might have put out a document, so we sort of worked hard to ensure that we set up sort of structures and a specific role for our peer workers. (OW3)

In this same LHD, their existing peer work roles were all changed to align with the Peer-STOC model, which was seen as an effective means of providing service across inpatient and community settings:

…all our peer workforce and change their job descriptions to be very much that Peer-STOC model of working across in-patient and community. And so, we could have that ability to sort of engage with people on the in-patient unit and follow them out. Or, vice versa, if someone's working with someone in the community, they can still keep seeing them in the in-patient unit. And then they also run groups in the community, and in the in-patient unit as part of their roles as well...we've just had everyone working in that model. (OW3)

In other LHDs, particularly those in more regional and remote areas, peer work had been either ad hoc, at a small scale, or non-existent prior to Peer-STOC:

…our Peer-STOC workers were our first peer workforce members, and came into the roles in 2018 and we did have some challenges, however, they commenced slightly before I did into my role, but yeah, the, the transition's been quite smooth, they've been able to build relationships with the clinical partners and people that are case managing consumers as well as building good relationships with consumers as well. (OW35)

Despite the 'newness' of Peer-STOC for some LHDs, some preparations were completed in order to implement the new role, with peer workers feeling supported to develop the role:

I was the first person for the Peer-STOC in [location]. So it was, when we first started there was a lot, it was still processes to go through, how it was gonna look and what we're gonna do with it. We did have a, we did have a model of care for the Peer-STOC out here. So I wasn't actually involved in designing it, but it was more, I started, we started doing stuff in the unit that was all similar to the model of care, and believed that you know that was working, get some feedback around it. But you know it was, it wasn't really a bumpy road, it was a slow process at the start because it was a brand new position, and what was it gonna look like and stuff like that. But I think we've at this point in time out this way in [location] and you know, it's been very successful… (PW4)

A clinician from a regional/rural LHD felt that while peer work had been new to the area, it was welcomed and supported by staff:

…we've been able to retain the same employees since 2018 so I think that's a good indicator that despite the challenges of implementing the very first peer workers into our LHD, there's obviously been motivators there and some drive for them to want to continue on in those roles, even when it's been quite challenging…I think the other key, keys of, or the key indicators of success have been really positive rapport and relationship with consumers, lots of positive feedback, really good relationship building with clinicians, a lot of respect amongst the clinicians for the peer workers and not in a tokenistic, you'll be the taxi driver, kind of approach either, but you know, they really want to partner with the consum-, with the peer workers as well. (OW35)

b) Support and Supervision for Peer-STOC peer workers

i Supervisory models

A range of models were identified across LHDs, from very basic to very sophisticated, incorporating a variety of peer supervision (both internal to the LHD and/or external), group and individual supervision, clinical supervision, and line management. Three levels of supervisory model are summarised in the table below, in order of level of sophistication.

Table 4.4 Supervisory models

Supervisory Models	Description	Approx. # of LHDs/SHNs (2 unknown)
Level 1: Basic	– Little to no supervisory model developed – Supervision *ad hoc* – Little or no access to regular peer supervision (group or one-on-one) – Clinical supervision and/or line management only	3
Level 2: Moderate	– Some form of supervisory model formally developed – Access to some peer supervision (internal or external, group or individual) – Access to clinical supervision – Access to some peer / group reflection with other Peer-STOC workers	8
Level 3: Sophisticated	– Sophisticated supervisory model formally developed by or in consultation with senior peer workers – Internal peer supervision available from a senior peer worker – External supervision available (group and / or individual) - some peer workers pay for their own external one-on-one supervision – Peer workers can choose their clinical supervisor	4

Level 1: Basic: The more developed models outlined above are in stark contrast to some LHDs with little or no supervision available for their Peer-STOC workers. One peer worker only had access to clinical supervision, and then only on an ad hoc basis: "*I don't have access to any supervision unless I ask for it...I mean I use my clinical leader here if I've got something that's clinical*" (PW21). In another LHD, a very new peer worker was unclear about clinical supervision, and only had access to peer group supervision once a month. The lack of clarity around supervision, and lack of access to appropriate peer supervision, was seen by peer workers as detrimental to their well-being as well as their efficacy as Peer-STOC workers. The importance of peer supervision, and the perceived effect on mental health and well-being, is detailed below in this section.

Level 2: Moderate: The majority of LHDs provided a moderate level of access to some form of peer supervision, and some clarity over line management and clinical supervision.

Some LHDs who don't have the capacity for a senior peer worker have arranged for external peer supervision for their peer workers. Others also provided regular and open access to clinical supervision:

> *I'm able to approach, approach my team leader or my peer coordinator [name]...I've got a good support around me as well.* (PW4)

Clinical supervision was not regarded as a replacement for peer supervision.

Some peer workers seem to be quite happy with a low level of supervision, enjoying the autonomy and flexibility that comes with their role:

> *My direct day to day supervision is actually quite low which is fine. I don't have a problem with that...[clinical staff] are always sending me check-up emails, whenever I'm in the hallway they'll catch me up and say 'how are you going, are things ok'... I'm pretty autonomous.* (PW7)

In these cases, it seemed to be the *choice* and *access* to the supervision they require was more important than a formalised or regularised supervisory model. Choice was a recurrent theme, particularly in models that were successfully being run in LHDs with less capacity for senior peer workers or large peer workforces:

> *...the great thing about this district is that we have a decision, and we have autonomy about where we get our external supervision from, or our supervision from in general. So, I mean if we want to have supervision with the boss, we can do that if we feel comfortable to have that. But if we want external supervision, we can go and get that ourselves.* (PW8)

Level 3: Sophisticated: Some LHDs with a longer history of peer workers had developed sophisticated models of supervision and support for Peer-STOC peer workers. One example involved a supervisory model developed and managed by a senior peer worker:

> *…anyone that's new to peer work that starts with us I work doing individual supervision with them once a week for 12 weeks, and then fortnightly for another 12 weeks and then monthly from then on, as well as there's the group supervision that's like a reflective circle that we do once a month, a co-reflection. So we do a lot of supervision, like much more than the rest of the mental health workforce by the looks of it."* (PW3)

Another LHD had also developed a management framework for peer work, seen as a particular draw for this peer worker:

> *…there is a management framework for our peer workforce here, which was, from my last experience it is kind of the main reason I moved over here...a peer worker manager who oversees probably like five or six peer workers. And then that peer worker manager would report to the rehab, rehab clinician... it is the involvement of that lived experience peer manager, to be more of a representative to the, to the rehab coordinator and be a bit of an advocate, you know, to support the peer workers in their role, I thought was really quite progressive.* (PW8)

The coordination of peer supervision within clinical teams was a theme that emerged as regards peer worker self-efficacy - a senior peer worker can advocate on behalf of the peer workers, address concerns and facilitate positive relationships with clinicians.

Other peer workers have noted the importance of access to regular group reflection with other peer workers across their LHD, not just Peer-STOC workers, in this case facilitated by a clinician:

> *…the monthly meetings are really helpful with the rest of the peer workers...we talk about, you know, some topics and things we bring up, certain things that we're unsure about, things like that. So that's really good.* (PW12)

The importance of peer networks is discussed in the next section below in 'Networking Opportunities'.

Some suggestions from peer workers and peer managers for improving the sophistication of peer supervision in NSW includes providing more choice for peer workers over their supervision:

> *…in Victoria they have a peer supervision database, and people can choose to register... you have a certain budget and you give it to the individual peer worker to choose who would you like to have peer supervision with.* (PW 19)

ii Peer supervision (external and internal)

Supervision should include at minimum: internal peer supervision with a senior peer worker (or an external senior peer worker if none are available in that LHD), clinical supervision for clinical issues and advice, and line management (which is sometimes also provided by a senior peer worker). At their most well-developed, the ideal supervisory arrangement includes group supervision and reflection, access to external peer supervision, and access to a range of clinicians that understand peer work for clinical supervision. Senior peer workers have also expressed their need for peer supervision from other peers in leadership roles, in addition to clinical supervision, and line management.

The importance of access to peer supervision in particular was of importance to many peer workers interviewed for the evaluation, seen as important for reflection, support and mental health and well-being, as well as a representative voice within clinical teams and across the system. One individual explained the importance of a lived experience supervisor in terms of having lived experience as a peer worker, of talking about your diagnosis and your story, something that clinicians cannot share:

*…no clinician has that, they don't have to come out and say it and they're actually actively discouraged at saying that they've got an ongoing diagnosis, actively discouraged to say anything to a consumer about that. So, they can't identify of what that feels like because they haven't really walked in that shoes…(*PW20)

External peer supervision was seen as particularly helpful in terms of being able to discuss internal issues with someone without a conflict of interest:

...external supervision I've found to be very beneficial. It's a pretty casual thing. It's just sort of like seeking support from someone in your world that you're not directly working with so that there isn't a conflict of interest. (PW6)

A number of peer workers expressed their concern that supervision and management from internal senior peer supervisors can become 'blurry' in nature, one noting that this issue is overcome with an external peer supervisor:

Because in my past experiences our supervision has always been with our senior peer worker or someone that's more senior to us, I really felt the lines were blurred and I felt it was more managerial supervision as opposed to peer supervision...We benefit a lot more from having external supervision, be it, there be like a, a peer supervision network that can be built in the future, or that's something that can be covered in the framework I think would be definitely more supportive. (PW8)

Another peer worker noted their concern over the lack of clarity around what supervision really was, and suggested some discussion might be necessary to determine the differences between supervision, reflection, and mentoring.

iii Clinical supervision

Many peer workers noted the importance of clinical supervision, with examples of clinicians who were very supportive and open to peer work: *"I use my clinical leader here if I've got something that's clinical, and he's very receptive to peer involvement, which is really good"* (PW21). Some peer workers noted that they were able to choose their clinical supervisor, as did clinical managers: *" if you want to have any supervisor from my program, here you go, pick a person and go for it"* (OW24).

Clinical supervision was generally regarded by peer workers as important towards recognition within clinical teams. Access to clinicians for clinical issues was also seen by peer workers and clinicians as important for peer workers' development as health workers, as was the importance of ongoing clinical training (discussed in more detail in 'Learning Climate, Education and Training').

iv Workload management

According to the Ministry guidelines, Peer-STOC workers were required to spend 65% of their time in direct consumer service. Case load as well as the number of meetings required of a peer worker, and appropriate supervision and support, seemed to all be variables when it came to a peer worker feeling overloaded or not. There was, however, a commonly held view that peer workers were 'burning out' from both their workload but also the nature of their work, contributing to attrition rates in the workforce:

I've never experienced like being spread so thin, so the fact that I, I guess we'd be more effective if there was actually more of us and peers that would cover units that, like a peer dedicated to each unit and a peer in community teams as well or more of us. So that way our workloads weren't as full on and as intense. That's something I've found. So I've like, I really feel like burnout could be a really, really big issue, and I know I've seen a lot of pretty high turnover in some of the workforces I've been with so far, and I know that this is a shared frustration. (PW8)

In terms of case load, most peer workers expressed frustration that they were not able to meet the needs of more consumers, but that they were already at (or over) capacity with the needs of the consumers they were committed to supporting:

I think workload is very much to be talked about and talked about...our peer orientation guide or whatever it was – I can't remember now – came out and it said we needed to do 15 clients a week and that's working 3 days a week. So when you put all that together, how much time are you going to spend with them? 10 minutes each?...like 10 [consumers] is the maximum at the moment and I pointed out that even that is not sustainable over 3 days because then you've got another couple of meetings or another that you've got to go to and that leaves you basically 2 days, well it's just not doable by the time you do you notes and everything. (PW18)

The requirement to attend a lot of meetings was met with frustration by other peer workers, one of whom quoted a KPI of 80% client-related time, much higher than the 65% outlined by the Ministry:

...it really is hard to be in two places at once. And it's, being in the health system there is, there is quite a bit of time spent like staff meetings, multidisciplinary team meetings, and for a while there I was doing clinical reviews and handovers each day until that was one of the things that I sat down with them and I said look, you know, I've got a KPI of 80% client related time. I said, I actually worked it out, there was eight hours each week that I was spending in meetings and I only work 24. (PW15)

This was dealt with to some extent, however, when the peer worker explained the difficulty to her supervisors, who have limited the meetings they are now required to attend*: "they have listened, they have really listened*" (PW15).

A senior peer worker described how close they were to quitting, before receiving additional support in terms of gaining an additional supervisor:

It's like, I'm gonna go talk to someone else who's inspiring because I don't want to quit, but I'm feeling a bit like quitting. Like 'cause I believe in this. I want it to happen. But I also feel really tired. (PW3)

This again is an example where appropriate and open supervision was central to the peer worker's sense of self-efficacy and well-being in the job.

COVID-19 was also cited by some peer workers as adding to their workload, to the point of exhaustion:

I know there was a report that came out the district about an increase in admission rates. So yeah, it's made it a lot harder on our role and yeah, so it's what I've heard from others.

But I'm also, I guess I'm kind of experiencing that, you know, I feel like I'm being quite pushed to the limit in the role and I feel you know I kind of get back into the, to the community work and I [?] like I'll just be absolutely knackered. I'll be absolutely, you know, it will take me, you know, I feel like I can't be effective in the afternoon 'cause I'm just so, across all the different wards you know, it's yeah, it's tiring. (PW8)

This same interviewee suggested that due to the levels of burn out likely to occur in such a new and overburdened role as Peer-STOC, exit questionnaires would be helpful to gauge the key reasons for people leaving the job:

…there's a lot of different things going on, and you know we kind of talked about churn and burn, and the fact that it's early days and you know there's going to be quite a high burnout rate until we have the proper supports and framework in place. But I, I think if there was a, a really concise and accurate exit survey…you know, like an anonymous exit survey that that peer workers could fill out and that information will be sent back to the committee and could be fed back to the Ministry and the, the actual workforce coordinator. That way they can get a really good tab on why, what's going on. And you know where are the gaps and, and how they can keep people in those roles and support them. (PW8)

v Support for the mental health and well-being of Peer-STOC peer workers

All Peer-STOC peer workers had access to the standard supports for health and well-being made available to all NSW Health employees, including the EAP (Employee Assistance Program) and access to supervision. One LHD in particular built upon these supports by providing their peer workers with time to undertake their own mental health maintenance during work hours:

...if there were any appointments and, or lifestyle things in, or wellness, wellness activities that peer workers needed to do, they would be permitted to do that within work hours. So for instance, if I needed to go to a medical appointment, or if I needed to, you know, go for a run or do something that would contribute towards my wellness in the job that was supported. (PW8)

The need for this type of support was expressed by a number of peer workers, who felt that supports for mental health in the job were insufficient:

I'd like to see peer support available, I'd like to see more psychological debriefs, more involvement of the clinical leader in what's happening, and the clinicians. I'd like the clinicians to be aware that, you know, the impacts on a peer person or a peer support can be different to what they are on them and to recognise that. I'd like to be able to see my psychologist for free but that doesn't happen. I still have to pay $160 a month to see my psychologist to make sure I'm well. (PW21)

Supervision seemed to be a key feature of mental health maintenance, and a number of peer workers noted that their supervisors want them to focus on ensuring their own health is supported in order to then support consumers effectively:

My supervisor told me to make sure I'm well because even if you're focusing on just the young people and not yourself, you are actually not going to give as good a care if you are struggling...making sure I'm doing the right things in my own life and looking after

myself and it actually helped and motivated me to kind of do more of the right things in my free time and that has been a huge help to be honest. (PW5)

The other key suggestion from peer workers in terms of improving well-being in the job was to simply have more peer workers to meet demand, as well as to provide support to each other in a demanding job:

> *I think it's really tough for peer workers to work in community health or hospitals by themselves. I think it's horribly unfair and unjust because certainly we're the safe people. We're like the safety embassy for people in most systems. And I really am concerned that these peer workers are really at the brunt of a lot of things, so they're having to negotiate some of the, you know, fixed views of doctors and psychiatrists and nurses and they're having to negotiate the huge amount of needs that are happening for the people that are there...There should be at least two, personally I think that there should be at least two, don't leave the peer worker by themselves, but they're limited by budgetary restraints. It's really sad actually. 'Cause it's a huge need*. (PW2)

The demanding nature of the Peer-STOC role was echoed by many peer workers and clinicians.

c) Networking opportunities

i Opportunities for Peer-STOC peer worker networking:

Through the interview process peer workers described varying levels of opportunities to network with other peer workers, as well various types of networking opportunities, and differing levels of engagement with those networks.

Peer network within LHD/SHN: Engaging regularly with peers within the same LHD was cited by many peer workers as very helpful in both sharing ideas and the process of reflection and problem solving. One peer worker described the different character and usefulness of formal or informal peer meetings:

> *…in the informal meeting we'd swap stories, we'd say where there's issues, have you got a solution to this, do you know where I can get this resource? The formal meetings were more what's happening in the LHD, any new policies that are coming down, any new things that are happening. So, from that perspective it was really good.* (PW21)

Because of the way Peer-STOC peer workers were allocated across an LHD, Peer-STOC workers may often be working alone. Opportunities to engage with other peer workers within the same LHD were limited in these cases, but seemed to at least include a monthly meeting, seen as extremely valuable:

> *We have monthly meetings with all the peer workers from our area [LHD]. At the moment there's 4 of us...It really helps build up your sense of solidarity and the belief in your role and the importance of this role when you with these incredible people and they tell you they've been doing and the challenges they've had, you know, and the belief they've got in there which is fantastic.* (PW6)

Others were more embedded within a team of peer workers, which provided some more opportunities for shared reflection as well as the discussion and development of new tools and ideas:

> *…we'll do that as a big group anyway, we'll look at different modalities and see how we can add them to our bag of tricks to what we do.* (PW2)

A senior peer worker in one LHD described their community of practice that brings together all peer workers, not just Peer-STOC, as a valuable place for learning, sharing and mutual support:

> *…in our district we have a community of practice which is for all of the peer workers coming together and that's Peer-STOC and non-Peer-STOC and there's opportunities in that space to I guess to support each other and sort of learn from one another and I guess like identify areas that are difficult and kind of learn from one another around how to improve things in those areas.* (OW10)

It was generally felt by many peer workers that working alone was challenging, a theme that is discussed in more detail below in 'IV Characteristics of Individuals: d) Peer-STOC peer worker professional identity'.

Wider peer network: Many peer workers described being heavily involved in the peer space, through involvement in advocacy, committees and working groups. One individual also saw engaging in this evaluation as a chance to engage in more peer work development:

> *I jump at these opportunities to give feedback. And even feedback, I was actually in my last district I spent a bit of time on the consumer peer workforce council, which is the state body that has representatives of peer workers from each district. Which kind of is the state kind of consumer, sorry, the state peer worker, consumer peer worker representative body…* (PW8)

A number of peer workers spoke of the importance of these opportunities to sit on committees and working groups, to support career development. One senior peer worker spoke of the importance of engaging with other senior peer workers:

> *I've been trying to like build this like a peer work leadership co-reflection group, which we've only met a couple of times, but it is in the sense a relief to hear from other senior peer workers. That we have a lot of the same issues. Because it is a bit isolating...* (PW3)

There was a sense however that it was possible to feel somewhat frustrated by some of these types of engagements, with one peer worker feeling like more governance around these types of committees would be helpful to move things forward:

> *My time on the committee like just reflecting on that, I was hoping that we would be able to have that kind of feedback and being able to shape our workforce and I just felt like from most of my experiences like that committee needed a bit more governance, in terms of, in terms of probably from Ministry having a bit more, giving them a bit more guidance and governance when there were like issues that popped up that needed to be dealt with.* (PW8)

A number of individuals spoke of consumer and peer conferences as being a particularly helpful avenue for engaging with other peer workers and learning about what is taking place in the peer space in different locations and contexts, and learn about new approaches and tools that might enhance their work:

> *Being able to attend the peer workforce conference in Sydney was really good, as a professional development opportunity, and being able to learn and grow from that. I think as well they're likely to be involved in different areas, and I think because it's my own interest I'm involved in a whole lot of different committees and things anyways, and I could probably enjoy and look into how I can contribute in different organisations and at different levels, that was quite good to be able to be supported in regards to doing that.* (PW19)

One peer worker had not had the opportunity to attend the conference, but had heard that it was a helpful event from other peer workers they had engaged with through their own casual networking practices:

> *From what I've heard as well, we all go to, what was it, it was like a consumer, some kind of consumer conference once a year. And apparently that's very, very good. And other than that it's kind of just informal networking, like meeting some people on the different teams that I've sat on and shadowed. And saying 'oh we should catch up for a cuppa and talk about what you're working on' things like that and your ideas about it.* (PW12)

ii Impact of COVID-19 on networking opportunities

COVID-19 had a strong impact on limiting opportunities for networking during 2020. Conferences and similar events could not occur, or occurred online with limited opportunities for informal meeting, sharing and discussion. There were some examples of peer networking taking place via online video-conferencing platforms:

> *…there's some great peer workers in other sites that we, maybe it's a COVID thing, that we just network through zoom meetings as well. But definitely us all knowing what we do and how we can help each other and opportunities to do that, that's just great management. That's just great cross pollination, that's great cross fertilization. Everybody wins. And having space, you know, agreed space, to do that everybody wins.* (PW2)

This peer worker also commented that they felt some fatigue through the constant use of online meetings for mutual support, particularly given peer work's general focus on face-to-face engagement:

> *… we're doing a lot of internal support with each other by Zoom, and it's you know it's not the preferred language of anybody, I suppose, but especially peer workers who want to meet in the flesh and want to understand, see all the nonverbal stuff and connect with all the nonverbal stuff as well, so that's actually really demanding I find. It's really tiring. I call it death by 1000 zooms sometimes. Bleeding cut by cut. So I think that's demanding, so I think there probably needs to be spaces and to sort of deal with zoom lag. You know how you get jet lag? There needs to be spaces you know to deal with Zoom lag, but often we have things that we have to do from teams we're in or zoom meetings we have to attend and the peer worker thing.* (PW2)

d) Organisational culture

Organisational culture has a profound influence on implementation. In the case of Peer-STOC specifically, three key elements emerged through the interview process: other mental health workers' degree of openness to peer work and peer approaches; philosophical tensions between clinical systems and peer work perspectives; and the Health system's general ability to change and develop with the implementation of Peer-STOC.

i Level of understanding and acceptance of peer workers by other mental health workers

Other mental health workers' attitudes to peer workers and Peer-STOC was a key topic raised during the interviews, with a variety of attitudes and assumptions described by interviewees. Most interviewees themselves exhibited strong engagement with and support of peer work and Peer-STOC, which is likely due to the nature of self-selection for interviews. Many of these interviewees described others with a broad range of attitudes and assumptions concerning peer work and peer workers, summarised below.

Positive understanding and engagement: Peer workers described some key examples where clinical leaders took on a key supportive role in the inpatient units, which helped to lead the way for other clinicians to accept Peer-STOC and peer workers. In one case a senior peer worker described both the Nursing Unit Manager and the community mental health team leader as being supportive and engaged with the peer work team:

> *…the NUM [Nursing Unit Manager] that they have is very warm and accommodating and really engages with our team when we come in and she sort of models that for the other nurses who therefore are heaps nicer to us than they are in other units. It's noticeable…for her being nice to us like all the other nurses are nice to us, which is different to other places. So, the NUM being on board is really important, I think. And the manager in the community is very like, like a, what's the word, he's basically like, one of us, but a clinician. Like so he's real like lefty kind of gentle guy that's really open to different life experiences and not judgmental. And he leads the group, and the group are therefore very accepting to him.* (PW3)

Senior clinicians who participated in interviews expressed their understanding of their role of leading changes within clinical environments, and encouraging other clinicians to change their attitudes and language use now that Peer-STOC peer workers were engaged in the units:

> *…certainly I, you know, we've asked people to take a more trauma-informed care training to then undertake communication course training to then, you know, really embed into the work culture some sensitive language and some trauma-informed care language, and then make that be part of our normal everyday vocabulary…So certainly that small change has certainly helped our Peer-STOC workers feel more comfortable, less confronted and less, yeah less, just less, yeah just less on the outside, but be more part of the team.* (OW20)

Ensuring positive engagement with clinicians did require ongoing effort. One LHD has been developing resources to educate staff about the value of Peer-STOC and peer work:

> *We've been doing some internal stuff. So we've just created some resources around the value of peer work, one of them is a video, that has clinicians and peer workers and*

> *directors and whatnot, talking about the value of peer work and what that looks like in the [LHD]…* (OW35)

Peer workers have reported that while things might have been difficult initially, in their area the acceptance of peer work has reached a point where clinicians not only accept, but prefer, peer workers being present:

> *I remember back when peer work was like, peer work was just getting out here in [location], like a lot of, a lot of clinicians were a bit hesitant on the idea, but a lot of them have turned around and actually would prefer working alongside a peer worker. Not just myself but the other peer workers that I work with.* (PW4)

This generally positive trajectory towards acceptance of peer work within clinical environments was seen in a number of instances across the state.

Passivity, lack of knowledge, lack of interest: There were a number of examples where clinicians and managers were not seen by peer workers as actively hostile, but were not engaged or interested in learning more about peer work and how it might support consumers. When one peer worker was asked whether they felt supported by upper management, her response was ambivalent:

> *In general, yes but in action not as much. So again, it was a bit like the Peer-STOC guide and model thing, it was all there in one way, but it wasn't there in another way. For example, it came a time where we were meeting up with our boss every week to discuss the clients and where we were up to. This turned out to be going from one week, turned out to going to two weeks, turned out to going whenever the person wasn't busy, go to hardly at all, so we had to ask for that and that's the sort of thing that's happened on more than one occasion. But to be fair, with other individuals there's been more support, but it's never been a support like I value you as much as I value the clinical nurse - you never really get that feeling.* (PW18)

This type of apathy or lack of interest was described as being at higher levels within an LHD that caused particular issues for one peer worker new to the role:

> *...essentially there's not a lot of commitment to change or to integrate. So even if I kind of put that forward you know, 'I want to work on some kind of structure or some kind of recovery curriculum or implementation plan', it's kinda just like, 'yeah that would be nice, but we don't have time to help you with that'. Do you know what I mean?* (PW12)

In this instance the peer worker was seeking to implement basic elements of Peer-STOC, and it might be questioned as to whether this should have been their responsibility in the first place.

Active hostility to Peer-STOC: While not overly common, there were a number of examples described by both Peer-STOC peer workers and other mental health workers of clinicians who were hostile to peer workers and peer work. This was attributed by one peer worker to the nature of clinical work and those that are 'burnt out' by the system:

> *The problem was the cultural change, there were too many people there that have, were severely burnt out and should've left health, should have, should not have been allowed to stay in a crisis team…* (PW3)

Though not described as systemic, an individual in a lived experience management role spoke of the defensive attitudes of some clinical staff members in one location, when broaching the topic of the incoming Peer-STOC program:

> *It was a kind of internal resistance, professional defensiveness, stigma-based attitude or apprehension and it's interesting that when we actually went to implement that position, that kind of thing came up with other people within that service…There was a lot more fear and apprehension. There was a lot of risk aversity and overstated risk aversity. There was some, some quite condescending attitudes towards the peer worker. One staff member was asking really, like, almost defensive questions around what you would do in particular scenarios. It was just the nature of…I think it's just that…the little bit of culture in that particular spot in the service.* (OW15)

One clinician felt that one aspect of peer work that might place peer workers in a difficult position in relation to clinical staff was when they were having to stand up and disagree with clinical staff on behalf of a consumer:

> *I do wonder if it can be quite isolating at times being the only Peer-STOC worker and sometimes they have to have the unpopular opinion sort of thing. If the team's saying, for example, let's do this – take their phone away as a consequence – and then that Peer-STOC worker is then standing up for the patient and saying well no, you can't do that, it's not in the policy. So, I think that would be quite challenging.* (OW6)

Stories of active hostility were often related by peer workers second hand, from people who were experiencing this in other locations:

> *I've spoken to other people in other districts who had really hostile health systems. Our health system wasn't hostile it was more ignorant if that makes sense, so we came in and because myself and the consumer advocate were both fairly well educated and well-spoken so that makes clinicians respect you…* (PW23)

The notion of gaining respect from clinicians because of levels of education and / or manners of speech relates to the assumptions held about peer workers and lack of recognition of their previous skills and/or employment, discussed below in f) Remuneration and recognition of Peer-STOC peer workers'.

ii Potential philosophical tension of peer workers embedded in clinical settings

There were a number of challenges embedding peer work as a non-clinical role within a clinical setting. On the positive side, the presence of peer workers can have a positive impact upon attitudes and language use in clinical settings, yet this can be a difficult position for a peer worker:

> *…I was worried once they got to know [peer work] they wouldn't like it, or the kind of tensions, how where talking about a person being the expert in their own recovery rather than the doctor being the expert is kind of a tension in that world view and I was worried that they would not enjoy [laughs] that and that it's hard to kind of speak up about cultural change when you are the newest and the lowest paid. So yeah I think I was acutely aware of the strategy but you know peer workers are often put in multi-disciplinary teams to make the culture more recovery orientated and yet if it's not very recovery orientated it can be pretty harrowing to be a part of and certainly that was my experience that it's*

really challenging to sit through handovers or care reviews or multi-disciplinary team meetings where people are spoken about in terms of their diagnosis and symptoms and you don't hear a lot about CHIME or Strengths or personal recovery. Yeah, just still stuck in that old school clinical recovery paradigm for the most part. (PW13)

Another peer worker described this tension as becoming particularly noticeable when some clinicians didn't want peer workers in particular training programs:

Some people would say you shouldn't attend it because they just potentially feel threatened by it, you can kind of sense that. I think at times that was actually sensed, that it was more potentially feeling threatened, and that's why not wanting the peer workforce to work for that training, rather than we're really unsure if it's actually going to be applicable. I mean it's just the way it comes across, you can kind of just tell where some of the tensions are at. (PW19)

Both peer workers and other health workers described the advocacy aspect of Peer-STOC as a very important and oftentimes difficult part of their role, particular in cases where they may disagree with a clinician. A mental health worker with lived experience in a management position spoke of the importance of maintaining that advocacy and peer identity within the clinical space, particularly when always working with clinicians:

I think the Peer-STOC workers need to be mindful of their role and not become sort of defacto clinicians. That's not what the peer workers are about. It's not about mindlessly parroting what a clinician has told you. It's about advocacy and meeting needs for your consumers. It can be really easy to fall in the trap of, especially when you are embedded into a team that's full of clinicians, it can be really easy to fall into the trap of thinking like a defacto clinician sometimes. Peer-STOC workers need to be really secure in their role and what they are doing and believe in what they are doing because sometimes it can be really uncomfortable to disagree with clinicians or to advocate on behalf of the consumer who disagrees with the clinician. Peer workers [need to] make sure that they have a really clear vision of who they are and what they are doing. (OW27)

iii Cultural change

Both clinicians and peer workers spoke of the change required in language and attitude towards peer workers and consumers in the clinical context. There were some positive examples of shifting attitudes that came simply through the presence of peer workers in medical teams:

I think having the Peer-STOC workers helps us to be more person-centred in our approach to clients and I guess how we kind of work with the clients is enhanced by having Peer-STOC around…helps to kind of be more aware of the language they are using in terms of being more respectful of our clients. It helps in that regard. (OW16)

Some peer workers reported be directly engaged in staff training and advocacy:

I was allowed to be involved in lots of the ongoing improvement of the hospital. I was involved in uhm, me and the consumer advocate sort of tag teamed in orientation sessions for new nurses. So we actually got to chat with new mental health nurses about, you know, what a lived experience is, what a peer worker is, how we talk to people in a way that

> *doesn't further traumatize them. So, we got to do fun things like that and that was I think a product of a system that was ready for us to be there…* (PW23)

A deeper shift in attitude was still seen to be required, with language and attitude towards consumers, as well as peer workers, beginning to change:

> *I think that's part of the real value, you know, like I said that it's taken some time for people to appreciate the value and the complementary role of the Peer-STOC worker can play as part of the treating team. So, I think the change in that culture is something really important and I think it just changes things, it changes the language people use in meetings now, it just makes people a bit more aware that we're talking about a person here not issues around symptoms and management, it's the person, it's those subtle things that I think have made a significant difference to just the culture of the service.* (OW18)

The need to constantly advocate for themselves and the consumer perspective was also felt by many peer workers as an ongoing and somewhat tiresome burden:

> *The issue with that education is that it can feel like you're on a merry-go-round because you constantly need to be doing that education and that's in part because there's so few peer workers around and that recovery-orientated practice has, and culture, has not been embedded into services.* (OW33)

The presence of appropriate senior peer workers and leadership by example from executive management and clinicians was seen as vital for the process of change to continue, as well as alleviating the burden on Peer-STOC peer workers who were already overburdened with providing direct service to consumers.

e) Implementation climate

This theme is concerned with the organisational and social climate within which Peer-STOC is being implemented, which includes LHD/SHN capacity for change, and their compatibility with the Peer-STOC model. The investment in Peer-STOC is in-and-of-itself testament to NSW Health's positive attitude towards the value of peer workers. The environments within specific LHDs varied widely in terms of attitudes and level of acceptance of peer work and the Peer-STOC model.

i Understanding of strong need for Peer-STOC after successful implementation

Both peer worker and clinical interviewees described a positive working climate for Peer-STOC once it had been thoroughly implemented and established:

> *We're kind of seen as like a bit of a darling of the service at the moment because of our ability to foster connections with consumers and also foster their trust in the service. So like for instance people, you know someone who was not interacting, wanting to have nothing to do with their care, when that's striking up a good relationship with a peer worker their trust builds with the service.* (PW8)

Some referrals to Peer-STOC were seen by peer workers as somewhat inappropriate, though coming from a perspective that peer workers were known to be able to connect with consumers where clinicians were sometimes unable to. This could lead to peer workers feeling that they were being taken advantage of, where in a challenging situation, clinicians would simply 'call the peer worker' as a stop gap measure:

'We're too busy, get the peer worker to do some stuff', yeah, it's not the right way as well, or 'this is in the too hard basket for us we'll just give it to the peer worker'. Yeah, some of the wrong way and I see that happen quite a lot, really, actually. And I think no, we could actually just cater for the needs of the health system by matching those needs within peer work, as they should with the doctors, the physios, the OT's [Occupational Therapists], all that, ideally they should as well, yeah. (PW2)

Many clinicians saw peer workers as not just added service, but an essential part of the offerings of the LHD that went hand-in-hand with clinical services:

[Peer-STOC workers] were able to increase their hours to two days weekly which has just been a godsend…our experience with them has been nothing short of a wonderful…the Peer-STOC program for me, and particularly for our wards, adds another layer of care and resources that we are able to offer our clients. So [consumers] come into the ward, usually on both my wards, in an acute state. And as they, as their issues resolve or we're able to help them through that, having Peer-STOC workers on the, on both wards, allows our clients to have another person or another face, another angle or perspective to talk to and to certainly bounce ideas off, ask for help from, and communicate with. Our clients seem to naturally gravitate towards our Peer-STOC workers when they are here, which is great and overwhelming at the same time. But certainly, they offer our clients non-judgmental, non-confrontational person within the system to help them navigate not only the system, but the different supports and, you know, the possible consequences or the possible steps from being discharged to then linked in the community to then staying well and managing issues while they're out on, you know, at home or in the community. (OW20)

The 'overwhelming' level of interest from consumers may account for situations like the over-referral experienced by some peer workers described above.

ii Working relationship within clinical teams

In the context of medical teams within which Peer-STOC peer workers were based, examples of both positive and negative working relationships emerged in interviews. One issue that was raised was the nature of Peer-STOC having to be split over multiple units, often belonging to a number of teams whilst not being fully included or recognised as a team member:

Oftentimes if you're part of a team, then the team kind of like protects you, defends you, and you're part of them. Sometimes if you're a Peer-STOC and you're jumping between different teams and different regions you're kind of like a little bit in every area, so you're kind of like jack of all trades, master of none in some ways. And some teams will kind of like adopt you and be like yeah, sure you're all part of us, and some will be like not quite. So, I think Christmas parties are a good example of which teams people feel you're part of, and if you're invited to different Christmas parties of certain teams, the team would feel that you're part of the team, and if you're kind of like not, it will almost like well that shows that that team doesn't feel you're as embedded with it or not. (PW19)

A consumer reported that there seemed to be organisational confusion in terms of who had seniority, peer workers or case workers, which may allude to a less harmonious dynamic within the team:

> *Sort out the confusion between case workers and peer support people. There's confusion. Who's over who, who's over the top of who. There's confusion there. No one has power and supreme – I'm being funny here – power and supreme rights. I'm being extreme to give you an example. There's confusion ok. So, everyone has got their own little bit. Someone should be over someone and guess who should be over? The peer support people should be over the case workers.* (C9)

The size of the units and teams also had an impact on this issue, where in one location there was a smaller staff and therefore an easier process of moving between inpatient units and community:

> *…we're lucky in that we only have one main hospital, we only have one inpatient unit, we, and that's also in the same facility as the community teams, so that transition has been quite easy in that they haven't had to build rapport with two different facilities. Yes, they've had to build rapport with two different teams, but, but those teams all know each other, we've all worked interpersonally for quite some time, so I think that being such a remote location and only having a couple of, like, one main hospital, has actually been beneficial for trying to implement a Peer-STOC program.* (OW35)

Other peer workers saw themselves as quite independent and autonomous, preferring the flexibility and decision-making abilities that such a situation provided whilst also feeling they could approach people for help as required:

> *My direct day to day supervision is actually quite low which is fine. I don't have a problem with that. But yeah, having that, like if I am having a problem with something, that I can, pretty much immediately, approach someone in a supervisory role and discuss something, in a very timely manner is good. The role itself is fairly autonomous anyway.* (PW7)

Others felt that the Peer-STOC role was less valued and integrated in inpatient teams, given the nature of the role as not always being present on the wards:

> *…when you are doing in-reach when you are not part of the in-patient team, you are always seen as a bit of an outsider and if you're not present you just do not get thought about.* (OW10)

More on the theme of Peer-STOC peer worker self-efficacy and professional identity is discussed below in 'IV Characteristics of Individuals'.

iii Degree to which Peer-STOC alleviates burden on clinical roles and hospital system

As corroborated by the statistical data presented in this evaluation report, interviewees believed that the Peer-STOC peer workers helped to alleviate pressure on health systems. This was attributed to Peer-STOC's key role in improving uptake of community-based resources, organisations and services, lowering dependence on clinical services.

Clinicians cited that length of stay of consumers returning to inpatient units was lessened as a result of Peer-STOC, as well as consumers demonstrating a level of understanding and insight:

> *…what we have seen is that when people come back in, or have been readmitted frequently, that often if they've had a connection or, or some time with a Peer-STOC worker on their consequential visits, their agitation, their irritation and their insight, you*

know, you can really see that their insight has grown and that there is, not an accepting, but more an understanding of the system, of medications and of their purpose of what they want to get out of the admission. So we are seeing admission, maybe not the types of admissions drop, but certainly when people come into hospital that their length of stays for their consequent admissions after meeting with Peer-STOC workers reduced greatly. (OW20)

In addition, consumers reported Peer-STOC peer workers as giving them ways of coping without needing to rely on hospital services:

…they said instead of going to ED [emergency department] I can bring up some other service like Beyond Blue or Lifeline or something. (C3)

In one example, a peer worker believed that the consumers they worked with were better off during the COVID-19 pandemic, and associated lock downs, than were the general public, due to the well-being and recovery planning and tools developed with consumers during Peer-STOC:

I see them walking away with more strength, more resilience, more positive about what they could achieve in their own lives, even though they have, like even through COVID, we haven't, my mental health patients have coped a hell of a lot better than the regular community…Just because they have that strength and resilience. And they know that they can, you know, they have ways of, you know, staving off whatever's going on. They know they can pick up the phone, they know what to do when they feel things are going off the rails. And for a lot of people in the general community that's not necessarily something that they'd learned. (PW21)

iv Impact of COVID-19 lock downs on Peer-STOC activities

Across the state, during the height of the COVID-19 pandemic and associated lock downs, Peer-STOC peer workers were not allowed to enter inpatient units. As described above in 'I Implementation Characteristics', peer workers relied on other means to remotely engage with consumers in inpatient wards. The impact was less pronounced within the community, where activities could still continue with appropriate social distancing and risk minimisation procedures in place. There were some peer workers who felt that they should have been allowed to continue supporting consumers in the wards during the lockdowns, and felt that their services should have been seen as 'essential' in that sense. However most understood that COVID-19 presented a unique and high-risk situation that required some sacrifice of service in order to ensure everyone's safety.

f) Remuneration and Recognition of Peer-STOC peer workers

This theme emerged from both peer worker and health management interviewees as central to the health of the peer workforce, peer worker recruitment, attrition rates, and stability of the Peer-STOC program.

i Salaries

The key concerns expressed by both peer workers and other mental health workers was a) the nature of the award under which the Peer-STOC workforce is paid, and b) the lack of standardisation concerning the recognition of 'relevant' graduate education.

While exhibiting keen passion and commitment to peer work, peer workers questioned the suitability of the NSW Health Education Officer (HEO) award (graduate and non-graduate), which according to one peer worker "*neither acknowledges my previous skills nor my current role*" (PW21). This was echoed by a number of peer workers, one of whom indicated that the low pay rate hampered their ability to promote equality in the health system: "*it's hard to kind of speak up about cultural change when you are the newest and the lowest paid*" (PW13). Mental health workers in management roles expressed concern that peer workers were generally placed at the lower or lowest end of the award scale, feeling that this might discourage more qualified or experienced workers from being recruited to Peer-STOC, and may contribute to attrition rates.

In terms of recognition of graduate education as relates to pay-scale, some Local Health Districts took a liberal definition of 'relevant' education, and paid their peer workers accordingly: "*they managed to say any degree is a related degree, and if you have a degree you have a degree, and we'll just pay at the degree rate*" (PW19). Others took a narrow definition, given that the Cert IV Mental Health Peer Work is the highest qualification currently available in Australia, therefore no graduate degree was seen as directly relevant.

ii Career pathways

Many of the peer workers interviewed displayed deep engagement in peer workforce development, consumer advocacy, and leadership development for themselves and others. In LHDs with a well-developed peer workforce, including senior peer workers, peer managers, and opportunities to join committees and working groups, there was a sense of career progression and development, contributing to workforce retention: "*I think you know more of those kind of opportunities and pathways is, you know, you're gonna have a workforce that sticks around, with those opportunities and positions*" (PW8).

Where the workforce is less developed, for example in LHDs with fewer peer workers, peer workers felt that there was a lack of scope for career progression within the structures of Peer-STOC:

> *I do think that with Peer-STOC and peer workers in general there still needs to be much more of a career path...I think there needs to be management roles and as much as we are offered supervision none of the supervision, well nominally offered supervision – there's a list you can look up on the intranet. There's not one peer worker that's a supervisor. So it is more about getting peer workers embedded within the management of what's going on in the system.* (PW17)

iii FTE issues

The Peer-STOC guidelines distributed by the Ministry specify a minimum 0.6FTE for a Peer-STOC peer worker. A number of peer workers expressed their liking for both the capacity to work full-time in order to meet consumer needs, as well as the choice to work part-time in terms of maintaining well-being within the role "*I'm very fortunate and thankful to be able to work part time and how reduced hours and you know different things like that which really help my health*" (PW10). Other peer workers expressed some concern about being able to meet consumer needs effectively on a small number of days if other peer workers are not available to work the other days:

...at the moment it's just, there's just one me. And I'm only here 3 days a week, you know, what happens to the other two days of the actual week? And for goodness sakes, why aren't peer workers working on the weekends? (PW15)

This relates to the concerns of peer workers if a consumer is being discharged on a day where it would be difficult for the Peer-STOC worker to follow up with them promptly. One peer worker drew a favourable comparison with community organisations who might only be able to afford part-time peer workers, noting the challenges of meeting consumer needs when only working part time. Part-time positions can be a particular issue for geographically large LHDs:

So, if you've got two days a week work...[peer workers] potentially only end up having one day a week to actually have contact with clients because by the time they drive 3 hours to the next clinic, and then drive home again, like it's the tyranny of distance is the other big issues because the areas that they cover are huge. (PW17)

This theme concerning geographically large LHDs and the associated challenges is discussed in more detail above in 'Characteristics of LHDs'.

Clinicians also remarked on the importance of having a peer worker present, and the impact it can have on the atmosphere of the inpatient units: "*When he's not here you can really feel the difference...when he started, I think it was more part time but we somehow got more funding and now he's full time*" (OW4)*; "It's been so successful, successful up to this point that we, we would love to have more, more Peer-STOC workers, and we would love to have them across more days*" (OW20). This may relate to the model of having peer workers assigned across inpatient and community teams, rather than dedicated to an inpatient unit. More Peer-STOC workers may translate into more days when a Peer-STOC peer worker can be available in the inpatient unit.

iv Recognition (informal and formal)

Recognition of peer work and peer workers depended on the size of the peer workforce within the LHD - for those with a larger and more developed peer workforce, general recognition of the importance of peer work, as well as formal awards, were present. For those LHDs with a small peer workforce, there was not only little opportunity for career progression, but also difficulty in receiving recognition for peer workers' level of skill and experience.

A number of peer workers and clinicians mentioned formal awards received by Peer-STOC peer workers, including early career excellence awards and health care team awards. This was seen as helpful in terms of raising awareness of peer work and its importance.

In some other LHDs with a less developed peer workforce, the lack of recognition of peer worker skills and experience beyond peer work was seen by some peer workers as a significant barrier to career progression:

I think the hardest part is not having exact career pathways or options makes it much harder to be able to be in the area that you want to do. For example, having different sort of skill sets and interests...people would sometimes feel a little bit I guess, almost be surprised that peer workers can achieve other things, when people forget that. Again, that's almost a level of discrimination rather than actually viewing a person as what your skills, experience, expertise are, rather than you have had this illness before and you can/can't achieve certain things. (PW19)

This lack of respect for other skills and experience was a recurrent theme, particularly for those peer workers who have come from other professions:

> *I mean I'm a peer support worker, but I've had jobs before, I've had a life before, don't discount the fact that I actually do know what I'm talking about...I held down an important job, I've advised Ministers and I've advised CEOs, I know what I'm doing.* (PW21)

This issue seems to be less of a concern in those LHDs with a well-developed and large peer workforce that provides ongoing career development, management opportunities and a well-informed clinical and executive staff.

g) Documentation of consumer progress

This theme refers to the ways in which Peer-STOC peer workers and clinicians communicate about consumers, and issues related to progress notes, confidentiality and the eMR (Electronic Medical Record) system.

i eMR and progress notes

As the standard means of recording consumer progress across the state, eMR (Electronic Medical Records) was reported by many peer workers as not being optimised for peer work. There were issues in terms of lacking a clear category for peer work on eMR, where other types of health workers have a clear identity on the system, such as social workers or occupational therapists. One peer worker saw this as an impediment to being utilised fully in the system:

> *I think in some of the systems who use eMR there should be space or a category for where peer workers can put in appointments, or be available, say, look we're available, use us, or you know ask us to see things. There's no space there it's all just clinician-centric. So yeah, I think if they just added space there, one peer column, as well, that they could see our availability, they could see who we're having appointments with, who might be available, and then come to know what sort of strengths we have, nuanced strengths we have. If we're really happy with different culturally and linguistically different environments in other languages. It's kind of a like 'wow, we've got all these things', but it's, there's no way of gathering it all together. It's like they're trying to make a cake, but they don't realise you've got some other ingredients they can use as well.* (PW2)

Additionally, eMR was not set up to manage some of the resources and tools used by many peer workers, such as WRAP or RAS-DS, which would instead have to be manually scanned and attached:

> *The only thing, like with the RAS-DS scale with our computer system, it actually, we've gotta scan it in like the actual sheet. It actually hasn't been transitioned on to EMR as of yet, which has been an ongoing issue for the last two years.* (PW4)

This contributed to difficulty in collecting data, both in terms of tracking consumer progress but also peer worker contact with consumers:

> *They had trouble figuring out how to code me and that changed a few times. I think it ended up sitting at mental health – non-clinical. They were going to add in, because some health districts in EMR actually had peer as a staff coding. They didn't have that in my LHD.*

So even in EMR you couldn't track peer interaction because there wasn't peer coding, it was all just mental health non clinical and that can be like lots of stuff. (PW23)

This lack of recognition in eMR may relate to the lack of recognition of peer workers and the nature of peer roles in the award, as discussed above in f) Remuneration and recognition of Peer-STOC peer workers'.

The process for completing progress notes on eMR varied across the state, as did the level of detail required, in some instances set within a note-taking format more suited to clinicians:

It's a system that works better for clinical staff and doesn't always easily match with peer work activity. So I guess like the progress notes [inaudible] is the SOAP acronym – so situation / perspective objective assessment and plan - and as peer workers we don't assess people. (OW10)

Some interviewees also suggested that there were cultural issues in some instances around clinicians feeling unsure about letting peer workers have access to consumer information on eMR:

…there are some people that just don't believe in peer work and probably never will, and, and are quite cagey around, you know, if people should or shouldn't, if peer workers in particular should or shouldn't read case notes or have access to eMR or be alone with consumers or, yeah, be there prior to assessing consumers, I think there's always those, those kind of challenges based on viewpoints that might always, you know, that will possibly always be there… (OW35)

A number of peer workers felt that clinical notes in eMR were very problematic from their peer perspective:

I had to learn pretty quickly don't read the clinicians' notes because they weren't helpful for forming an opinion of somebody based on their strengths and hopes and identity. It was just a lot of risk management and deficits and symptoms… (PW13)

Another peer worker related the level of distress caused by reading clinicians' notes on eMR, and felt uncomfortable writing progress notes about the consumer, finding instead a different way of engaging in the process that was more consumer-oriented:

I'd end up feeling angry at my clinical colleagues. I'd end up just seeing this person as risk and deficits, so I tried just to put my notes in, and I tried a form of co-documentation where I'd either write the notes with the person. Not many people were keen to do that actually together. They'd say they didn't care but I cared, I felt really freaked out about what was written about me in my absence so I wanted to be super transparent so I would just try to write an email reflection to the person after the peer session we'd done saying hey thanks for meeting me for coffee, or thanks for meeting up for a walk. I'm just reflecting on our conversation and these are the things that really stood out for me. These are the links to the whatever it was I was telling you about and then I'd copy and paste that and I'd put that in eMR so that way I'm not writing about the person in their absence, I'm writing to the person and I'm kind of copying eMR in. (PW13)

In general peer workers reported using progress notes more to record that an interaction had taken place, rather than any form of assessment of the consumer or their progress.

ii Complexities of communicating information about consumers to clinicians

Peer workers described the need to communicate with clinicians in certain cases where a consumer might be at risk of harming themselves or others, and discuss this with the consumer when explaining *"how we liaise with other teams and, you know, our duty of disclosure if they've got, you know if there's risk of harm to themselves or others."* (PW20).

Some peer workers reported feeling uncomfortable about providing too much information about consumers in their progress notes, instead recording the amount of time and the broad nature of their engagement. There was a sense that peer workers needed to maintain the trust of consumers, and that to pass on too much information was breaking that trust:

> *The good thing about what I do is I can say to the client, you tell me what you want the notes to read, unless you're putting yourself in harm's way or I think that you're going to do something that is harmful to yourself for your recovery, the only notes I have to put in there is I saw you for an hour. And that gives them a great deal of freedom. I don't have to say, you know, she rocked up and her hair wasn't brushed, she, you know, spilt her coffee down the front of her shirt or whatever. I don't have to put any of that detail in and I can say to the person, I'm going to document this because I think it will help the clinician next time you see them, and they can say yes or no.* (PW21)

In situations where a consumer passed on information that alerted the peer worker to any danger facing the consumer or others, in one case the consumer showed relief that the peer worker could assist in explaining to clinicians what was going on:

> *…she was so reticent about disclosing, but at certain points I said to her, I said, 'look, you realise that some of the things you're telling me I'm going to have to tell the clinicians' and she said, 'you'd tell them for me?' and I said, 'of course I will, if that's what you want?' And she said 'oh that would be fantastic.'* (PW15)

This was a theme that involved complexity, nuance and experience on the part of the peer worker, and key to the trusting relationship developed through the nature of peer work.

h) Learning climate, education and training for Peer-STOC implementation

This theme refers to the climate of learning and openness to new ideas and approaches, within which Peer-STOC is being implemented. It also encompasses opportunities for training for peer workers, as well as peer worker engagement in the training and education of other staff about peer work. A great variety of learning climates were described in interviews, with positive and negative examples of levels of individuals' willingness to learn about peer work, and LHD engagement with providing training and education to its staff.

i Provision of staff training about Peer-STOC and peer work

As described by interview participants, approximately half of LHDs/SHNs provided education programs for other mental health workers about Peer-STOC, or were in the process of developing staff training. Interview participants saw education of clinical staff as an important part of maintaining the Peer-STOC program, particularly in situations with regular changes of staff:

*…because the staff rotate – that needs to get revisited and I often find that I just touch base with the peer workers on a relatively… when new roles come in we try to roll that out and give the staff an opportunity to talk about it and introduce them to the concept of what peer work is but then I sort of touch base with the peer workforce [and ask] how's that travelling, do we need to revisit that and you go back and then you'll find that there's a whole other layer of conversation that has come up with the staff around peer work once they've had a peer worker in. So, sort of like something that you need to be revisiting…(*OW15)

In some locations peer workers were heavily involved in clinician education offerings, not just about Peer-STOC but about consumer-perspectives and trauma-informed care:

Regularly it's like, oh, well not regularly, probably once every six months…And they sort of do a little like roadshow….But they also, our service has a recovery college….And there's an opportunity for everyone, clinicians and peers to be peer educators and clinical educators, so they do some of that. And also, our workplace mandatory training team, they really want to have everything co-delivered and co-designed, so some of our peer workers have gotten involved in doing trauma informed care training… (OW3)

One consumer suggested that social workers in other areas, such as HASI, should engage in learning about the advocacy role of peer work, which they felt was a particular strength of the peer worker that they felt other social workers lacked:

I think like if the peer[STOC] worker could have done some training to the other support workers around advocacy and how to advocate within the LHD because he's part of the LHD, so he had a good standing in advocating for me whereas the support work services, they are outside of the LHD so it's a lot more effort on their part to advocate for me. (C15)

The process of educating clinicians and other mental health workers about peer work was seen as an ongoing and sometimes onerous task by many peer workers, partially due to existing power imbalances within health services.

ii Cert IV mental health peer work

A key component of the Peer-STOC role that emerged uniformly across the state was the completion of the Certificate IV in Mental Health Peer Work by Peer-STOC peer workers. This was completed in some instances before recruitment, where others were in the process of completion supported by the NSW Health scholarship and their LHD.

The Cert IV was cited by many peer workers as a very helpful process, providing helpful tools and approaches that could be used in the Peer-STOC role as well as providing some boundaries around what peer work is meant to be:

I found the Certificate IV was really beneficial. I know at the moment it's not a pre-requisite for peer work but I really believe it should be because I've worked in other NGO environments where it's not and while we are hired under the guise of peer work, what we are doing is carer work, not peer work in the slightest. And so I think going through that 12 month course really outlines what peer work is and it helps the peer worker, the individual, know exactly what peer work is so that they can find a job that actually abides

by that and I feel like if the Cert IV was a pre-requisite for peer work, there would be less manipulation of the role as well. (PW6)

Another peer worker described the Cert IV as helping them differentiate between a mental health support worker with lived experience and a peer worker:

…before I did the Cert IV mental health peer work, I was probably, like, a well-intentioned mental health support worker with lived experience. And then once I did the actual certificate I was like 'wow, peer work. You're doing it wrong.' And that really changed my mind about like thinking about what's different about us, so it's not just being a support worker, there's an element of support worker-ish-ness to us, but it's actually about how to learn together and how to grow together. (PW3)

iii Peer worker access to further training

While all peer workers interviewed felt that ongoing training was very important for their professional development, they described widely variable levels of access to further training across the state. Some peer workers described a deep level of engagement in training opportunities that were readily available:

[Asked if they have access to training:] Yeah, yeah. And supported. Like, you know, I did supervision of people with a lived experience. My team leader at the time was happy to support me doing some training with the mental health coordinating council with that. So they've been quite supportive of any training that I've wanted to do. (PW20)

Others described a lack of opportunity and a lack of support to engage in training:

Oh, I've learnt over a long time that if I want anything, I've got to stick my elbows out, so I'm the squeaky wheel around here. Yeah, if I don't push and shove and, you know, be a pain in the ass, I don't get training. (PW21)

Training in terms of new peer work practices and ideas was also available in some instances:

I guess what works well is when people get access to the Cert IV mental health peer work, which everyone does here, and regular like extra supervision on different things like hearing voices network approach or intentional peer support. Oh, you know just any new innovations that come through just to keep having conversations. (PW3)

Opportunities for training, particularly peer-led or peer-specific training, could be facilitated and enhanced by senior peer workers, as a part of supervision and career development, discussed above in b) Support and supervision for Peer-STOC peer workers.

IV. Personal attitudes and beliefs influencing Peer-STOC implementation (CHARACTERISTICS OF INDIVIDUALS)

a) Knowledge and beliefs about Peer-STOC and peer work

The three groups interviewed for this evaluation, consumers, Peer-STOC peer workers and other mental health workers, had varying degrees of knowledge, experience and understanding of peer work. Below summarises some of the variation, and separates 'other mental health workers' into those with a lives experience, such as senior peer workers or peer work managers, and clinicians.

i Consumers:

Consumers who were interviewed for this evaluation were all participants in some version of the Peer-STOC program, and so all new a certain amount about peer work and peer workers. When asked about their understanding of what peer work was, a number of themes emerged. One of the key themes revolved around the peer worker bringing a level of understanding and hope to what can feel like a hopeless situation:

> *I think like definitely there was a bud or something, you know, a seed was planted, you know what I'm saying?...[Peer-STOC worker] was like able to leave a little bit of something where, I thought my world was over. It was over to me, yeah. It was [inaudible] you know. Just a little bit, just a little sprinkle, which is not, you know, it's difficult working with people in crisis. Trying to give them some hope [laughs] when everything seems so hopeless. For sure, a seed...* (C19)

Another key element of peer work that consumers noted was the practical nature of the support, enabling the consumer to know where to go and what to do in order to meet their own needs:

> *I was very stressed and disorganized and sort of everything was sort of falling apart whereas now I feel pretty comfortable. Ah, I've got the ability to organize myself more. I've got a network of people who I can talk to, to try and sort things out. So, everything's not a mess anymore. He's [Peer-STOC worker] has helped me organize everything and take small steps but to accomplish big things*. (C17)

Consumers also spoke of the strategies that peer workers developed with them through Peer-STOC that were designed to help them manage anxiety or stress:

> *We spoke about ways of managing the anxiety, how I could have handled the situation, what I can do next time to alleviate the anxiety, like thinking about my feelings before it got to the point that it did, like how could I next time tune into those feelings. Also, they sent me relaxation meditations recordings that I could listen to. Uhm, we spoke about different avenues that might be available within the community I live in. Yes, so just giving practical suggestions on what I could do to better manager and cope.* (C10)

They also described the approachability of peer workers, and the relaxed and friendly nature of their interactions:

> *He would say things that made me laugh. He shared a bit of his experience with me. He, uhm, was warm and really, really open. He was a really open person and he talked a lot which is really good for me because I don't talk a lot but I'm happy for other people to talk to me and he was great at that. So, it was a good connection and we gelled well.* (C15)

Consumers' description of peer work approach was in this way descriptive of positive, helpful, responsive and holistic on-the-ground support.

ii Peer-STOC peer workers:

All Peer-STOC peer workers interviewed for this evaluation displayed a strong understanding of the key aspects and intentions of peer work, though described in many different ways. These ideas were expressed with passion, being very meaningful to both the peer worker and

to the consumers they work with. As with the consumers' description of peer work discussed above, the giving of hope and the recovery focus of peer work, coming from a lived experience, was a key universal theme:

> *…just having someone who can share their experiences with the consumer on a level playing field if you like with somebody. There's that debriefing that goes on about the process of actually how you end up in hospital. It's very holistic, it's a very holistic thing. And someone sitting there saying well I tried this when I felt like that and that worked for me and just really talking about it as peers you know. I think it's the fact that peer workers like myself we, what can I say, we just take everybody as an individual. We don't look at labels. We don't look particularly at diagnosis unless that person really wants to explore what that means to them.* (PW16)

Peer workers also strongly related to the advocacy role of peer work, and the notion 'walking alongside' a consumer through their recovery and transition journey:

> *…a lot of what we do is obviously walking along beside, psycho education, it's making sure that you know if often we are the ones that do, you know, find out if they need that extra assistance and to be linked in with an NGO, so make sure that referrals happen and things like that.* (PW17)

Peer-STOC peer workers also described the process of supporting consumers through recovery as a very practical and grounded process, whether connecting consumers with appropriate services and organisations, of facilitating social engagement:

> *For me, Peer-STOC is, I guess it's two-fold. It's advocacy on behalf of the clients that we're working with, and it's also psycho-social integration back into the community, so that we give them the skills and the confidence they need to participate in their own lives.* (PW21)

A number of Peer-STOC workers had come from previous professions, with graduate degrees and experience in a range of fields. Complications concerning lack of recognition for previous careers, education, skills and experience are discussed above in 'III Inner Setting: f) Remuneration and recognition of Peer-STOC peer workers'.

iii Other lived experience mental health workers:

Of the 22 other mental health workers interviewed for this evaluation, approximately 6 individuals had lived experience and were in peer-related roles. Their understanding of peer work was related to their role within the broader health system, having in many cases been involved in the implementation process:

> *…my role oversees, it doesn't line manage the peer workforce but it oversees and supports the peer workforce and the implementation of it so I work in quite a connected way with the peer workers around various different initiatives… With our LHD I have worked quite actively with some managers in the individual services to be supporting the transition of these roles into the services.* (OW15)

These individuals were also more engaged in the development of peer work over time, and were often involved in the process of developing and shaping peer work:

*…providing support to the peer workforce within my district, so supporting them through the provision of professional practice supervision and professional development and also supporting service-wide development and quality improvement, so that's my sort of role broadly…(*OW10)

Lived experience individuals such as these can have some influence in the development of policies, procedures and strategic direction. They expressed a number of key understanding of the role peer work can play in changing the system for the better, particularly in terms of changing the nature and attitude of mental health services towards a more recovery-oriented system:

[Peer-STOC has] allowed [health system] to really see the benefit of peer workers, not only for consumers who are accessing their services, but also for the peer workers themselves and other staff. So they're kind of starting to see this shift in, like I was saying, a bit of a shift in the culture of the services that those peer workers are employed in to being more recovery-orientated, being more, you know, overall more safe, calm, sort of pleasant environment to be working in in terms of a mental health service. (OW33)

As the peer workforce expands over time, providing opportunities for such lived experience leadership roles will offer career opportunities for career progression, greater representation at higher levels of the department, and a strong voice in the development of the peer workforce in NSW.

iv Clinicians:

The vast majority of clinicians interviewed for this evaluation were overwhelmingly positive towards Peer-STOC and peer work, and displayed at least a basic understanding of peer principles and objectives:

So, my understanding is that their involvement with working with the patients while they are in the inpatient setting and providing support for the patients and in particular around the recovery journey and providing hope that recovery is possible and trying to break down any stigma around having a mental health issue and being an inpatient. And as well they are providing support after they leave hospital so continuing to support their recovery once they leave hospital. And also, I guess I see the role being also important in I guess educating staff around language use when discussing patients and providing, kind of like making sure there's always a voice of the patient in all our patient discussions and team meetings – that there's always that perspective that is present in the room. (OW6)

Clinicians also told some stories of a very different attitude amongst some of their colleagues, particularly those who are unfamiliar with peer work and peer workers:

I do think that the registrars and residents do struggle with it a little bit. They don't know really what the peer support worker does. Um and when we have consultants come down on an ad hoc basis and they see someone who's not within our usual scope, they will come and say to the peer support worker 'what's your role here. What are you doing here' so they are a little bit defensive kind of thing. (OW4)

By and large the interviewees however did not display such views personally. One participant noted that they and their colleagues had to undergo a change of attitude themselves, once peer workers had been recruited and had started to attend clinical meetings such as MDTs:

…having a chat with our peer support worker and understanding how the discussion and the language used in the meeting really offended and hurt her, and also then having to go back to our team and say, look, you know this is unacceptable that one of our team, it is unacceptable that one of our team is feeling blighted and bullied and like we're being really insensitive by the language we used. So that we needed to draft a new vocabulary that was tolerant and accepting of all, and sensitive, you know, just sensitive to how people, to people's points of view, but also to how they felt and where they were coming from. (OW20)

Some peer workers felt that their work was not respected or valued by clinicians, seen as 'fluffy' rather than a serious aspect of mental health care and support:

It's not fluffy. It's very serious, and I take my job very seriously. I don't want, I don't expect you to necessarily understand everything that I do or why I do what I do, but respect me as a fellow person who's trying to help someone with mental distress. That I find quite, gets on my goat every now and then and I kind of blow up and go crackers. But occasionally I'll, you know, get frustrated and go, ugh, anyway. And just the fact that, I mean I'm a peer support worker, but I've had jobs before, I've had a life before, don't discount the fact that I actually do know what I'm talking about and that, you know, I'm not just some [idiot] *who's walked in and said, I want to be warm and fuzzy, you know.* (PW21)

One clinical manager expressed her concern that peer workers should not be going for coffees with consumers, that their work should be of a different nature:

…we need to be clear then that your support is actually very clear so the consumer understands what support is because a lot of the time it would be more social, but then they didn't, couldn't get their planning together and they just were ringing up and going out and having coffees for no reason, it was just socialisation. And I said is that actually, do you see that that's actually a benefit or is that just something of your benefit, that's, I had to turn it around back to them and say are you getting more benefit out of this than the consumer? (OW24)

This attitude was not shared by other interviewees, who tended to see socialisation as a part of the Peer-STOC workers remit if that is what the consumer needed or wanted. However, there may be some assumptions that the seemingly simple of casual engagements peer workers have with consumers are potentially 'fluffy' or unimportant, whereas peer workers view these kind of engagements as the very serious and important aspect of their work. Clinicians and peer workers in almost unanimously raised the importance of ongoing staff education as the key to ensuring ongoing development of peer work in NSW, which is discussed above in 'III Inner Setting: h) Learning climate, education and training for Peer-STOC'.

b) Peer-STOC peer workers' sense of self-efficacy

This theme refers to Peer-STOC peer workers' sense of self-efficacy in the role, including their sense of feeling supported, represented and heard within the organisational context of their LHD/SHN.

i Importance of supervision and support

Appropriate supervision and support is vital in terms of peer workers sense of efficacy in the role:

> *Well, if you want longevity in your staff and you want to keep them well then I think it's essential. And for best practice, I mean, you need to be able to reflect on what you are doing to be able to improve, change or even know that there's something wrong, or not working well. And whether that's on an emotional level or whether that's actually in physically how you are working, how the program is.* (PW17)

This type of support can be provided by senior peer workers, particularly when Peer-STOC is in its early stages of implementation:

> *…the senior peer worker in the district was really I think the most useful person in terms of brokering dialogue between myself and various clinical teams, helping… she had already established a peer support group on the ward as part of that kind of first iteration so we rebooted that.* (PW13)

Support and trust by clinical staff enabled peer worker self-efficacy in the Peer-STOC role, particularly in the inpatient setting:

> *If I told the clinical lead for the adult team that someone needed longer, he did not question me – 'Yeah, cool, you are probably right'.* (PW23)

Lack of appropriate supervision resulted in peer workers feeling like they were floundering in the role, particularly in cases where Peer-STOC was in the early stages of implementation, as discussed in more detail above in 'III Inner Setting: b) Support and supervision for Peer-STOC peer workers'.

ii Responsiveness of LHD/SHN to peer worker initiatives, needs and requests

Some peer workers described very positive examples where clinical staff and supervisors responded to their needs when they requested a change in processes or procedures to better accommodate the peer worker role. In one case a peer worker was feeling overwhelmed by the number of meetings they were required to attend:

> *[Managers] agreed that yes, perhaps only go to a clinical review if somebody that I'm working with is being reviewed…that's freed up about, you know, 4 hours. Oh no more than four hours a week. Yeah, it's straight up nearly six hours a week. So, yeah. So, they have listened, they have really listened.* (PW15)

This kind of responsive support was also facilitated in some cases by senior peer workers, who could address peer workers' issues partly due to the non-clinical relationship of support rather than oversight:

> *I feel like I'm in a really fortunate position where I do provide that support and guidance but I'm not in a team leader position so I don't get bogged down in that day to day operational, you know like, approving leave and complaints management and all that sort of boring stuff that team leaders take on…I feel like the peer workers can potentially be more sort of open with me about their kind of you know what's difficult and where they need support and that kind of stuff because the relationship, the professional relationship is*

quite different. Like you know I'm not responsible for performance management or anything like that. If there are issues with performance yes, I will have to escalate that to the team leader but I guess there's an extra level of comfort that you know uhm I'm very much focused on supporting them to do their job well and to really flourish in the role without focusing on you know, you are taking too much leave or any of that kind of stuff. (OW10)

A number of peer workers did not feel that there were clear pathways for addressing issues or overcoming obstacles, particularly in situations were insufficient supervision and support was available:

I'd like to see peer support available. I'd like to see more psychological debriefs, more involvement of the clinical leader in what's happening, and the clinicians. I'd like the clinicians to be aware that, you know, the impacts on a peer person or a peer support can be different to what they are on them and to recognise that. (OW21)

In these instances, appropriate supervisory frameworks would help to overcome such communication channel issues.

iii Professional development and career pathways

As described above in 'III Inner Setting', appropriate training and access to mentoring and supervision support peer workers in their feeling valued and feeling like there is a progression to be made in peer work within the Health system. This theme also relates to the lack of recognition in the award rates and general assumptions within the system concerning peer worker skills and expertise:

I think even when I was a peer worker I had [undergraduate and graduate degrees]…it was often interesting people would sometimes feel a little bit I guess, almost be surprised that peer workers can achieve other things, when people forget that. Again, that's almost a level of discrimination rather than actually viewing a person as what your skills, experience, expertise are, rather than you have had this illness before and you can/can't achieve certain things. So, I think that is still a significant barrier. (PW19)

Again, a growth in senior peer worker positions could facilitate career progressions for experienced peer workers, as well as advocate for access to training, mentoring and external supervision as required.

c) Professional stage of peer workers

Both Peer-STOC peer workers and LHDs displayed a range of stages in their levels of experience and knowledge of peer work. Peer workers stemmed from a broad range of backgrounds and contexts, ranging in age from their early 20s to their mid-60s. Most had completed the Cert IV Mental Health Peer Work, and ranged in experience in peer work from 2 months to 8 years. The majority had been working in peer work for at least two years or more, and some for much longer, working in a range of peer roles and across a range of organisations:

I've been working in Peer-STOC for about two years in November. I've been a peer worker now for about 6 years, but I have worked in mental health since 2010. So I've basically at this stage I'm working Peer-STOC three days a week and I also work as a peer worker at

> *[NGO] voluntary unit here in [location]. I've also worked with [another NGO] in the past as well.* (PW4)

Others had only just come to the Peer-STOC role, which was their first entry point to a peer work position. While peer workers were representative of a broad spectrum of backgrounds, levels of experience, age and stage of development, they were united by their lived experience, discussed below in 'd) Peer-STOC peer worker identity'.

A number of interviewees described the award rate as being problematic as it would discourage more experienced peer workers from applying. This was not as much of a concern when Peer-STOC was already established and a senior peer worker would be overseeing their supervision and training. However, it was a deep concern for some that inexperienced individuals would be thrown into situations they were unprepared to manage, with inappropriate support:

> *…given my expertise and my education, I struggled at first, I mean, OK so who's a suitable candidate here? That was a, was a big learning curve for me. Something I'm capable of, and given time, you know, I would have done it very well and I believe that I was getting there. But man, someone without that, without that knowledge? It's like sending in a, a, someone to the wars, to the sharks maybe, to be eaten alive!* (PW14)

This would lead to a greater attrition rate in peer workers, and a slowdown in the implementation process if not properly managed. These themes are discussed in more detail above in 'III Inner Setting'.

Complications in recruitment to Peer-STOC positions in some cases led to large gaps where roles remained unfilled. This was seen as problematic both in terms of on-boarding a new person with no handover process in place, as well as slowing down the process of implementation with no-one in place to lead and develop the program from within. COVID also presented significant issues for both recruitment and implementation of new peer workers:

> *We've had some challenges in delays of recruitment and then we've had one Peer-STOC worker transition to another role in the LHD, so that was a vacancy and had to refill that so we've got a new Peer-STOC worker stepping in in the midst of COVID but one of our positions… I think we've got quite a good worker, but they've had a lot of disruption so with that particular position it's been a little bit difficult to discern because we haven't had that person at work – they've missed a lot of days' work because they are dealing with some quite challenging things…our newest recruit, he was diverted through into the inpatient unit for the first period of his employment because he started right when all the lockdown happened with COVID19. His position was diverted so we are still in the process of reconnecting him out and re-orientating his whole team in both of the services to the fact that he's a Peer-STOC worker, not an inpatient unit peer.* (OW15)

Gaps in management positions were also seen as problematic if that meant that there was a lack in terms of strategic support for the implementation process. It was suggested by one interview participant that LHDs should be provided with specific support in order to ensure all procedures, documentation and implementation details were seen to, even if for a short development period, as discussed below in 'V Process: c) Leadership and Peer-STOC 'champions''.

d) Peer-STOC peer worker identity

Peer workers interviewed for this evaluation were representative of a broad range of ages, backgrounds, contexts and environments, united by the common factor of their lived experience perspective and their wish to advocate for consumers:

> *…we're just looking at different things as well, so we're much more strength-based, person-focused, person-led, trauma informed, and we're not afraid to be with them to advocate, to ask questions. Ask questions about, to psychiatrists. Ask questions about medication. It's that world that the peer workers know really well and we're happy to support people in that whole process, who often are very traumatised just by being scheduled but very traumatized by what's happening to them and feel like they just have to listen to the person who holds the most authority. Which is the psychiatrist in our system. And we say no, you can ask some questions, or you can disagree, you can ask them for a rationale, and we will sit with you. Will be with you while they're doing that. So just having some advocacy is really crucial to transformation of, just for client transformation, for patient transformation, for patient enabling, and also for the system.* (PW2)

A peer worker's identification as having lived experience was viewed by clinicians as the key to forming a connection and rapport with consumers:

> *Insight, empathy, kindness, compassion, being able to develop rapport – developing that therapeutic relationship as a peer worker. I think empathy would be 100% there and that's what our two peer support workers have…They are very down to earth and very honest and just able to relate to the clients here.* (OW23)

One peer worker felt that enhancing the diversity amongst the peer workforce would help to provide a greater a diversity of peer workers to match the diversity of consumers:

> *… it's sort of like a one stop shop, but there's a lot more nuance that could be catered for as well, in Peer-STOC as well. And we try the best with our internal resources of those from different communities as well. But I think they could even nuance it even more. And say we're gonna have a, you know, a Peer-STOC rainbow worker or a Peer-STOC CALD [Culturally and Linguistically Diverse] worker or a Peer-STOC Aboriginal worker which would be amazing, that could have a bit more autonomy or a bit more, could rove a bit and sort of really meet the really particular needs of people. But just thinking that Health is thinking that, you know, just shove a peer worker in, throw a peer worker in and everything will be alright.* (PW2)

The uniting factor of lived experience and the acknowledgement of the diversity of that lived experience emerged as key elements of the Peer-STOC peer worker identity, more so than level of experience or seniority.

The nature of peer work was described by a lived experience manager as having political motives, adding to the complexities and demands of the role:

> *…peer workers have a complicated task because they have tasks they need to do which are complicated, but they also have, I guess, the purpose behind their role, and it's one of the only roles in mental health that actually is kind of values and purpose driven, it's not just you come in and do this part of the MDT slice. It's challenging stigma, and it's*

modelling that recovery is possible when it's putting themselves in a vulnerable position. (OW34)

Peer work necessarily blurs the line between personal and professional through the identification as having lived experience. In one case a peer worker discussed the need to maintain some level of personal boundary in order to support their mental health and wellbeing:

> *I have a very clear plan that what, you know, stays at work, stays at work. And I don't, you know, it's part of my own care plan is to be able to do nice things for myself and keep what, what is at work at work and not take it home with me. And to have those boundaries…* (PW11)

This was also described by some managers as a concern, that peer workers were taking on too much responsibility for the consumer in some cases:

> *I think one thing I've spent quite a lot of time as manager in doing is encouraging and making sure that the peer workforce doesn't… to make sure they can set boundaries because they are so eager to help people that they want to do everything. It's like, oh can I come in and do some extra hours or can I stay back and help that person and I have to say no you are here and paid for a certain amount of time and you need to be linking people with services and also encouraging resilience and self-reliance so no you can't just do everything that that person has asked you to do. Do you know what I mean? That's not the role.* (OW18)

Another clinician was concerned with boundary setting more within the system, in order to ensure peer workers were not being pulled in too many directions, due to the high demand for their time:

> *…they're not just working with consumers, there's lots of other things that they get pulled into. But that's our job to help, have boundaries around what peer workers do and don't do. Because there's lots of demands, they're in demand basically.* (OW3)

The Cert IV Mental Health Peer Work was cited as a helpful place to learn about setting boundaries, safe storytelling, and maintaining wellbeing as a peer worker. Supervision also played a role, as discussed above in 'III Inner Setting: Support and supervision for Peer-STOC peer workers'.

A common theme emerging from both peer workers and managers and clinicians is the need for more than one peer worker in any setting. This related both to the isolation of solo peer workers in clinical teams, as well as the intensive nature of the work with consumers:

> *I think it's really tough for peer workers to work in community health or hospitals by themselves. I think it's horribly unfair and unjust...they're having to negotiate some of the, you know, fixed views of doctors and psychiatrists and nurses and they're having to negotiate the huge amount of needs that are happening for the people that are there.* (PW2)

One lived experience manager suggested that part of the reason for the need for more than one peer worker per team related to the sense of identity and advocacy that needs to be maintained in the clinical setting:

I would be encouraging that the Peer-STOC workers aren't solo… they are not like a solo team doing an isolated task - that it fits with best practice to have enough Peer-STOC positions that when it's funded. For example, our service wanted to have them in different locations off the inpatient units, but it would have been really, really good to have two Peer-STOC workers on both inpatient units…they can't really do much as a solo rider. You know, they can't fix everything. There's that expectation that if you put a peer worker there, it can do all this, but it can only do so much really. So I think for the peer workers' benefit and the service's benefit that it would be better if we had more Peer-STOC positions so that they are actually a team… (OW15)

The level to which peer workers felt welcomed and accepted as a team member by others varied across the state, as discussed above in 'III Inner Setting: e) Implementation climate'.

V. Planning, engagement, leadership and evaluation (PROCESS)

a) Planning and readiness for Peer-STOC implementation

As flagged above in 'I Intervention Characteristics' and 'III Inner Setting', interviewees reported varying degrees of readiness for the implementation of Peer-STOC. Some LHDs thought through both formal and informal processes of welcoming new peer workers into the workforce:

obviously a lot of it is what you would do with a new staff member, all those practicals that we've got to make sure that they know all the systems, all that sort of stuff and then also being active in linking them to activities, like, even to our homeless health team for example – making sure they have some time because a lot of our folk will come to the inpatient unit, homelessness is a big experience for a lot of our people, alcohol, drugs, all that kind of stuff. So kind of tapping them in and getting them to spend a little bit of time with teams who, while they mightn't deal with that team super regularly, but good to get to know them. So really trying to, like, kind of make it I'd say formal but just making sure we made time for them to go see some of the staff and talk about how that team works and just, you know, fostering the links between the different parts of the service. (OW5)

Others showed less forward planning. Often models of care were not completed before peer workers began working in the position. In one case the Peer-STOC peer worker was recruited to a position that was not developed and had no structure to speak of:

…my concern is that without that structure it might not be able to be as effective as it could be. So, a whole part of the role is that it's unstructured and kind of not directly purposeful, but I think as a new peer worker, it's important to have some kind of structure to then iterate around. (PW12)

In another case, an individual in a lived experience role had been trying to implement Peer-STOC but was facing lack of communication from management, resulting in unpreparedness for the incoming Peer-STOC peer worker:

…recruitment took a ridiculous amount of time and even though I'd be attempting to communicate as to when that peer worker was starting, nothing was prepared… no communication was responded to and so that peer worker started, and I found out I think the week before from the actual peer worker that they were starting and nothing was organized or thought about or prepared… (OW15)

Some clinicians expressed concern over the lack of experience of incoming peer workers, which may relate to the lack of recognition of experience and skills in the award within some LHDs. One clinician noted that it would have helped to recruit peer workers who were experienced and qualified with the health system, particularly when trying to embed a peer worker into a clinical team for the first time:

> *...we didn't have people that had had a whole lot of experience. I think ideally we needed experienced people who knew the health system, who'd worked in the health system to step into a Peer-STOC role to make it work successfully...And I think mental health teams can potentially be a bit intimidating – psychiatrists and big multi-disciplinary teams you know and to make sure you need some confidence for the peer worker to come in and have their say and feel equal to that team.* (OW18).

This sentiment was also expressed by some peer workers, concerned that recruitment processes did not help with the level of un-preparedness for the role and its clinical context:

> *...peer workers are coming from other careers and other sectors and aren't already in the loop. So, finding a way to refine the massive delays in recruitment and on-boarding but also staffing at a higher percentage because of the nature of lots of churn because lots of people rock up, see the system from the inside, and go oh [wow]! this is not what I expected.* (PW13)

There was also a sense, however, that this did improve over time as the peer workers became more embedded in the service, and other staff learn more about the peer worker role. There was also a sense that senior peer workers can assist in supporting and training newly recruited peer workers and ease the passage of those new to the clinical environment. The role of senior peer workers and implementation champions is discussed below in 'c) Leadership and Peer-STOC 'champions''.

b) Engagement with key stakeholders

i Recruitment of peer workers

Most peer workers interviewed for this evaluation were recruited through seeing the Peer-STOC positions advertised just as any health position is advertised. Some peer workers described the process of engaging in peer work for the first time at a point in their recovery where they were looking for a way of providing support to others:

> *When I went back to work after the accident, I found that I needed to try and find a way to help others avoid what I had to go through. And at the time the peer work movement was just really starting to build and the Ministry were looking for peer workers and I thought, this is my opportunity to show people that it doesn't have to be as hard for them as it was for me. So, I gave up my big huge office and decided I'd join the community and actually participate in helping other people, make it easier for them.* (PW21)

One individual explained that they came upon peer work by accident when helping a family member try to find work, which led them to undertake the Cert IV, and eventually apply for the Peer-STOC role:

> *…it was only because I was sitting at home trying to help my son find a job…and all these peer worker jobs started coming up and I looked at them and I went 'what are these?' So*

had a bit more of a look, and coming from the background where I have actually, at that stage, I had zero qualifications…So I looked at these peer work jobs and went, what degree do I need to have to do these, and the first criteria was to have a lived experience of mental health, and willingness to share. All I do is share, all I do is talk, all I do is listen, all I do is care, and it took five times that I had to read that ad before it actually sunk in that they weren't expecting somebody with the university degree. (PW15)

Some individuals were already active peer workers and/or consumer advocates before applying to a Peer-STOC position:

I've only just come to this role and I've been in it now for almost 3 months, that particular Peer-STOC role. Previous to that, because I've been working as a peer worker in, overall for close to four years now, I was actually working, I wasn't working in the Peer stock model. I was working in another district in, in a community mental health team, so I was embedded in a team of clinicians and I was the allocated peer worker in a community mental health team. (PW8)

According to some interviewees there had been some difficulty in filling some Peer-STOC positions, with a lack of appropriate applicants, and / or a lack of engagement in the implementation process as described above in 'a) Planning and readiness for Peer-STOC implementation'. This seems to be changing as in some circumstances recently a large number of applicants are applying for peer roles, partly attributed to the availability of the Cert IV expanding the pool of applicants:

There are so many more people now that have done the qualification and they've got some experience. So, I think we, they recruited for a peer worker here, they got 52 applications, that just didn't happen back in 2017. (OW34)

Through the interview process it seems that there is a positive trajectory towards the normalisation of the peer workforce overall, as more individuals over time are becoming aware of peer work as a viable and meaningful means of employment. Over time this will provide LHDs and SHNs with a greater pool of peer workers as well as a more experienced peer workforce.

ii Referral processes for consumers into Peer-STOC:

Referral criteria reported by interviewees varied across the state, as described in 'I Intervention Characteristics: ii Models of Care'. Aspects of the referral process in terms of engagement with stakeholders include: how consumers learn of the program; who makes referrals and how; determination of referral criteria.

How consumers learn of the program: Consumers were reported to learn about the program through the presence of Peer-STOC peer workers in inpatient units, where they engage in a variety of ways through running groups as well as making ad hoc casual contact:

We were introduced to a lady named [name] – she was just introduced to us as a peer worker which is like, they are few and far in between but it was just nice to have somebody there, but it wasn't mentioned per se to be a program. We were told and introduced to the [Peer-STOC worker] during like morning meeting. It's like a thing that they do on ward where they get all the consumers together in the morning and talk about what's happening

for the day. So that's where I met the Peer-STOC worker and where I first interacted with the program… (C19)

There were also reports that consumers are provided with fliers and information sheets about Peer-STOC.

The majority of consumers mentioned learning of the program closer to their discharge, with a few consumers reporting their first meeting with the peer worker very early on in their hospital stay:

…one of the peer support workers approached me, was talking to me while I was still in observation actually, so I was still not very good. That means I hadn't been in there very long…There was no discussion at that stage about him staying with me at all though. He was just very nice, and I didn't know what it was all about, but he was very nice and helpful. (C9)

One consumer suggested that information about Peer-STOC might be made available on the wards through the television screens that often provide program and service information:

Possibly have a Facebook page or there's something about us, or possibly put something up on the screen on TV in the hospitals that can show things in the hospitals. For those with mental health, they've got screens in the hospital, was like a slide show thing. They could sometimes put it in the middle of TV shows, commercials, you show it in the hospital that they've got available. For those who want it. (C3)

Referral and discharge processes: As mentioned above, the referral process in most cases began with making contact with consumers in the inpatient ward and seeing if they might be interested in Peer-STOC. This contact was sometimes made at the suggestion of a clinician, or through Peer-STOC peer workers in-reach in the form of group sessions or informal chats. In the following instance, after the consumer had shown interest the peer worker would subsequently gain referrals from both inpatient clinicians and community team members:

…when they are coming up to discharge, we'll raise the topic of Peer-STOC with them and explain what the program is. We'll see if they are comfortable with it. If the consumer agrees, what we do then is get a referral from one of the nursing staff or one of the health practitioners whether it's like an OT or a doctor, whoever and with that referral, we then go to the Community Case Management Team so whoever that person's case manager is and we'll then make contact with them. We'll get a secondary approval slash referral – all of this is documented in eMR. (PW7)

MDTs (Multi-Disciplinary Team Meetings) were also described as a key component of the referral process, in terms of providing peer workers with a conduit of information about consumers, as well as a means for peer workers to express their views about consumers, and represent the consumer voice. One peer worker felt welcome to engage with MDTs when she was working with a particular consumer that was to be discussed:

If I'm working with a particular person or I have worked with them and there's an MDT going on, I'll make an appearance, absolutely. And very welcome. No problem. (PW22)

One clinician described the valuable insight of the peer worker during an MDT, though ignored by the treating doctor:

the Peer-STOC worker during MDT [multi-disciplinary team review meetings] recommended a couple of things to do and the doctor didn't listen and I was really unhappy for the Peer-STOC worker because I thought she came up with some quite good recommendations…It was a bit of a negative outcome because that Peer-STOC worker worked really very well with that client and found out… just given us an insight that I don't think we would have been privy to had she not been there. (OW9)

This type of attitude within MDTs was reported by a number of peer workers, who felt concerned about the over-medicalisation of those meetings and lack of engagement in the discussion of consumers around discharge:

It's been very difficult. I've attended MDTs [multi-disciplinary team meetings] on the inpatient unit on a regular basis. That's prior to COVID happening and the MDTs [multi-disciplinary team meetings] have been somehow wiped temporarily but the problem in the inpatient unit as you can well imagine is very medical and it's medication centred and the peer workers are not really incorporated into the system. From that point of view, it hasn't really met my expectations. I've worked on it. I've made submissions to the area but as yet I've had no response. I'm wanting an integrated framework for Peer-STOC into the inpatient unit particularly in relation to the discharge planning process. But until we get that, we are on the outer. (PW9)

Some interviewees reported that formalised referral processes were helpful in keeping clear records and promoting the importance of Peer-STOC as a viable and important mental health service, just as any other service offering such as allied health:

Some people would say look, we just want to give you a verbal referral rather than giving you a written referral, when the concept was well if you're going to do a written referral for social workers, for psychologists, for every other area, then why would this area be any different? It's just a different profession. So I was pretty firm with being like no referral, we're not going to accept it, just to be more, and sometimes you just, if they were being really frustrating and you really wanted to help the person you might have to fill it in yourself, but really one part of it was trying to say no, you need to respect this as the same as any other profession and do it in that way, but at the same time not wanting to be like not help a consumer who might need that help and assistance just because of that, so there's a bit of that juggling act. (PW19)

Other individuals described a much more casual and ad hoc arrangement for referrals, with a dislike for more formalisation around the peer role:

It's all done very informally, and I quite like that you know – such and such needs to speak to you or would like to speak to you or can you speak to this person, fine, you know. The moment you shove a piece of paper in front of somebody and say, oh write your name and details on that for referral, they just go I'm not going to, yeah. They have enough of that happening in the hospital without you know. This talk about having a proper referral form and stuff like that, you know, under the current lived experience coordinator who wants to create more professionals around it but yeah, I just find that it would be an impediment. I'd rather just be able to give [them a] brochure. (PW22)

As described in the subsequent sub-section ‘c) Leadership and Peer-STOC ‘champions”, senior peer workers and clinicians can support the referral process as well as appropriate staff education and understanding of the role of peer work.

Referral criteria: Consumers’ placement within the geographical boundaries of a given service was a key criterion for inclusion in the Peer-STOC program, as discussed above in ‘III Inner Setting: a) Characteristics of LHDs’. Other referral criteria varied across the state, but were generally quite loose. One senior peer worker described how they ensured the peer worker would be safe when working with a consumer referred to Peer-STOC*:*

> *…we rely on the EMR, the electronic medical record to find out some basic information about people and if they have any alerts against their record. We will discuss it with the team leader and also have discussions with the primary worker that’s attached to that consumer. That primary worker would have completed a safety assessment to identify you know what, was that alert an historical thing that now has no or very minimal impact on what’s going on for the person right now or is there currently a still very high risk of violence or aggression.* (OW10)

A clinician described similarly open criteria, mostly centred around whether the consumer would benefit from the program or not:

> *We kind of took the mindset of we wouldn't know if the Peer-STOC system and support would work unless we just gave it a really good red hot go. And so it was a very loose referral system to then be able to filter through, you know, essentially now to who we think would be most appropriate at what stage, you know, their, their at a capacity to be able to engage, engage in and how beneficial it would be…* (OW20)

The other criterion mentioned by some peer workers was to prioritise those individuals who would not have support when leaving the inpatient unit, or who were going back to potentially unsafe environments:

> *The key criteria is limited support, so people that have troubled homes to go back to. They have difficulty there with DCJ…involvement…They are looking to domestic violence and cases of unsafety, that are unsafe environment at home, and they help investigate what’s going on and get the right supports in place to make sure it’s safe for them to go back home etc.* (PW5)

To some extent the determination of criteria depended on the LHD and the Model of Care drafting process, which again varied in terms of the level of co-production and engagement with peers.

iii Exiting processes

Few interviewees described formal exiting processes for consumers finishing with the Peer-STOC program. Interviewees mainly reported that peer workers had provided information and connections to services, and once those were complete then the consumer was ready to ‘exit’ the program, given that Peer-STOC was not designed as an ongoing service but a transition service:

> *…ensuring that if they’ve got, ensuring they’ve got support ongoing if that’s what they’re wanting, and needing, with whatever other service is appropriate. And also, there’s that*

opportunity to join up with a community group, or the recovery college if they want to continue on with something that's linked to the mental health service. Yeah. But you know more that it's a positive with, you know, you've achieved the goal of what we were working towards, and then, but ensuring that it's a positive sort of conversation. Because sometimes people do want to keep seeing peer workers forever, and form a really good supportive relationship, but it's sort of the peer workers are very aware that it can't be ongoing and it's really time limited. (OW3)

Some peer workers conducted a form of assessment to ensure the consumer was at the point where they can move on from Peer-STOC:

I guess I'll do my own little assessment. I use the clinician's assessments as well to make sure that they're mentally feeling well, but I do my own little assessment as to have we achieved what you want to achieve, is there anything else that you wanted to do, are you feeling strong and capable and confident that you can move forward and do things on your own? Just trying to tick those sorts of boxes for them and make sure that if they're not or if they feel like they just want to give it a shot, let them know that at any point they can come back, that it doesn't have to end… (PW21)

Others described some form of communication or handover with relevant clinical teams, GPs, or other health workers, offering the RAS-DS, YES surveys and WRAP:

What I would normally do is a handover with the clinician. I would say 'look this is what we have been working on, this is what we've got'. I would involve the clinician in the wrap up of the relapse prevention plan or WRAP plan. I would move on that way. I would also get them to fill out a RAS-DS and an evaluation form. (PW9)

Exiting processes were not uniform across the state, and more development in this space might be beneficial, such as exit summaries or reports, though some of this does seem to take place in eMR.

c) Leadership and Peer-STOC 'champions'

i Buy-in from higher levels crucial in acceptance by clinical teams

Many interview participants described the importance of support from higher up within the LHD as crucial to the successful implementation and maintenance of Peer-STOC, with one interviewee suggesting a form of 'executive sponsor' role as helpful in implementation:

I think having executive sponsorship for it would have been good…Exec sponsor basically is where you have someone very senior who comes on as basically to sponsor the program to say, I endorse it, we'll put whatever resource we need towards it, if there's issues you can escalate it to me, so they basically come in as a kind of like top tier manager, I'm here if things aren't going well. So, as opposed to us having one contact that someone's nominated, and a senior peer worker, who's kind of in charge of implementing it, but often don't have any real power with the people that will. So, for example, they might have nominated someone in a health manager role… (OW34)

Positive examples of buy-in and support from all levels of leadership was felt by peer workers to make a difference to the level of acceptance within the LHD:

…from the actual top of the district, like the chief executive and their team, as well as like the community managers and the nurse unit managers, the leaders of allied health in the hospital. Like all of the big wigs that are like, if they say it's cool we're like part of the cool group, you know what I mean? Makes a difference. It's a bit like high school. You need like a cool friend. (PW3)

Another peer worker had proactively sought to build strong relationships with management, in order to feel safe to discuss issues and work effectively within the system:

the support I have, I'm happy with, and I've created it. And I think it just comes down to, you know, developing the right relationships and that goes with any job, even yours. You've got to have real relationships with your management – people that you can feel safe to talk to. (PW22)

The positive impact of this type of high-level support was highlighted by those instances where adequate executive support was starkly absent, or indeed hostile, in one case causing significant roadblocks to implementation:

The manager there wanted to do something different with the funding in the first place, so I had challenges even starting a discussion around implementing it. I would be sending emails and not really getting a response and then I'd have to follow it up and then my manager would follow it up. So, we just had this big dodge ball thing for ages because the manager didn't want to do a Peer-STOC position. When we did manage to move that through and reinforce to the manager that we actually need to implement this as a Peer-STOC position, and we needed to start to implement it because it's part of a state-wide program and it will be evaluated and everything. So, it took some time to even reinforce that and actually get that happening. (OW15)

The attitude from those interviewees in leadership roles spoke to the influence they understood they had in terms of leading clinical staff in their understanding and acceptance of Peer-STOC:

I think the main thing is certainly spearheading the leadership of the ward. So not only making them aware of what the Peer-STOC program is but what their role is, and how they can function in the ward, because I think having, particularly having the leadership on board will really see those inroads be built without much effort. Certainly I've seen it be a big, it's been a major factor on our wards of how, how well I feel it, we've been, you know, they've been integrated into our team. Without certainly the leadership really having an understanding of that and then advocating for that at every turn. So I know for the first couple of weeks, you know, we go to have meetings, and regardless of, you know, whether they were late or here, you know, there was enough handovers printed to include them, so even if they were late there was one set so that the whole team understood that they were included as part of the team and the expectation was that a place for them would be held. (OW20)

This shows the importance of those in clinical management roles leading by example, and championing Peer-STOC from within.

ii Responsibility for implementation at the local level

The Ministry showed significant buy-in to the peer workforce by the size of the investment in Peer-STOC. The implementation process from the Ministry through to the individual LHD/SHN

was supported by a steering committee made up of representatives from each LHD/SHN. It was mentioned by a number of interview participants that there was some lack of clarity over the implementation of Peer-STOC, even from those engaged on the steering committee:

> *I think the whole Peer-STOC was very confusing for people in general and that's the feedback I got from other local health districts who would ring me and say 'well how are you doing it at yours' like uhm I think those were the challenges actually labelling it a different program because I used to sit on some of the state-wide … like when I sat on the state-wide I used to get quite confused hearing how – some of them didn't even sound like peer work and it sounded more like a bit between peer work and an in between clinician and peer work. If you didn't already have an established peer workforce and your head around peer work philosophy and what it was all about uhm I think that was some of the challenges, that's the challenge I observed at a state level. There were some programs that were very prescriptive. It wasn't really a peer worker position and I've been doing peer work for many years and I've struggled to get my head around what they were saying, what they were reporting on.* (OW21)

As mentioned above, some peer workers were recruited into the role only to find themselves responsible for the implementation of Peer-STOC, which was not part of the position description. In some cases, where no-one had taken responsibility for implementation, individuals would take it upon themselves to lead the implementation and develop the program. These individuals felt the need to put in place a range of processes that had not been thought out in full:

> *…the Peer-STOC model that was written didn't actually identify what the support services could be offered, and we wanted them to be actually really clear like, so we've been writing the care plan and we developed a template, templates for their care plan like what sort of support are you going to provide, advocacy, connection to resources, experiential sharing, connection to community, relationship building, social support? Those sorts of things that they needed to engage prior and had that already before they go, rather than they're discharged and then they're having to chase them up.* (OW24)

Models of care did not generally outline who was responsible for implementation and maintenance of the program at the local level.

iii Senior peer workers

Of the LHDs and SHNs represented in the interview data, interviewees from approximately 5 LHDs/SHNs reported the presence of a senior peer worker (there may be more LHDs/SHNs with a senior peer worker, but this was not raised in interviews). Seven individuals were interviewed for this evaluation who were either a) senior peer workers or b) other mental health workers with lived experience in leadership roles. Some of those senior peer workers were directly engaged in Peer-STOC with consumers, and thus interviewed as 'Peer-STOC peer workers', while others were involved in supervising a range of peer worker programs, and self-identified as 'other mental health workers'.

The vital importance of senior peer worker roles was a strong theme emerging from the interview process for this evaluation. Senior peer workers were characterised by one interviewee as 'midwives' to the implementation of Peer-STOC:

It seems like it is a newly born baby coming into the world, the health world...they're midwives, we've got [senior peer workers] who have been amazing midwives in that experience. (PW2)

It was described as a broad and multi-layered role, encompassing engagement with consumers, peer work staff supervision and training, clinician engagement, advocacy, and workforce development:

I'm the senior peer support worker in my district so that is a lived experience position which means that I use my experience with mental illness and recovery to support others in their recovery as well as providing support to the peer workforce within my district, so supporting them through the provision of professional practice supervision and professional development and also supporting service-wide development and quality improvement, so that's my sort of role broadly. More specifically around Peer-STOC, where I provide regular supervision to the Peer-STOC workers, I do like a weekly team meeting with the peer workers, I provide support around seeking referrals, around service promotion within the local teams, inpatient and community and I helped to develop the Model of Care for the Peer-STOC service and also take part in the Peer-STOC steering committee, the state-wide steering committee. (OW10)

The breadth and sheer amount of work required for the role was described by some interviewees as overwhelming, suggesting the job could be spread over more positions, or recognised more appropriately through salary and job description:

I think if I could have anything I want the other senior peer worker I think would be really good. I think another person that's dedicated just to education for consumers. Like a recovery college type thing or like, what else would be good? Someone who just does consumer participation. 'Cause I do all consumer participation plus supervision, workforce development, da, da, da, da, da for the whole peer workforce…Yeah, like in [name of hospital], like the actual hospital, there's another lady. She gets paid more than me and her job is consumer participation. That's it…And I think … 'your job looks more boring than mine, but it is, it is paid more for less'. That's what it seems like to me, there's not parity. You know what I mean? (PW2)

One interview participant stated that they believed every LHD and SHN should have at least one senior peer worker, who could provide leadership for the growing lived experience workforce, feeling that Peer-STOC was implemented more smoothly in those location that already had a senior peer worker:

I think that's also benefitted those peer workers coming on board where they had other peer workers around them who had already been employed in the LHD and, you know, a majority of the LHDs had a senior peer worker or similar role in place to be able to support them in terms of entering the service as well. (OW33)

Senior peer workers stated feeling they also required appropriate supervision and access to leadership training and mentorship:

There's a lot of things I had to learn. I did a diploma in management as well, and so I could learn more, but I also had to learn, make sure that I had, I think I shifted again like in, I've gone to find external peer work supervisors that are seniors as well. Which is hard to find, but it was very important, to keep fidelity like, to the idea of being a peer worker,

but then being a senior peer worker, it's almost like an oxymoron. How do you have a position of authority when the idea of your role is just sort of undermine authority? (PW2)

Of all the recommendations of this report, having a greater number of senior peer worker positions would perhaps have the greatest positive impact. It would improve a range of areas of concern raised in this evaluation, including: enhanced supervision and support for Peer-STOC peer workers; peer worker self-efficacy and sense of representation and higher levels of decision making; staff training (both for peer workers and clinicians); on-the-ground development and support for implementation; and career pathways and recognition for Peer-STOC peer workers.

d) Evaluation of Peer-STOC

This final theme is developed to discuss ways in which aspects of Peer-STOC can be evaluated, including the gathering of relevant data as well as feedback from key stakeholders.

i Challenges to data collection, due to lack of uniformity across LHDs

One of the key challenges of gathering statistical data lies in one of Peer-STOC's strengths: it's adaptability and flexibility.

In terms of ascertaining the impact of the Peer-STOC model on consumers, interviewees participating in this evaluation described a number of examples of Peer-STOC peer workers supporting people well outside of the 'classic' inpatient-to-community six-week transfer of care. Deciding who is a participant within the Peer-STOC model thus becomes challenging.

The other issue is that Peer-STOC peer workers' impact does not solely lie with those consumers who have participated in the transfer-of-care aspect of the program. There were many examples of peer workers making great strides in inpatient units with individuals who did not later participate in the full transfer-of-care, either because they were out of the peer workers' geographical remit, or because they had been transferred to a different service or chose not to participate. It was clear from many peer workers and some consumers that this aspect of engagement with consumers is vital, even if it doesn't result in a full participation in transfer-of-care.

Qualitative data and some way of capturing the nature and level of engagement Peer-STOC workers have with consumers in the inpatient ward would help to create a fuller picture of the impact of Peer-STOC beyond the 'classic' model. This is one of the reasons why the interview process was so very important for this evaluation, in order to ascertain those key aspects of impact that are difficult to quantify.

It was recommended by one peer worker in a management position that appropriate collection and use of data could help LHDs / SHNs more appropriately target resources to populations most in need of intervention and support:

…if we do what we've always done we'll get what we've always had. So, you might want to make your Peer-STOC workers focus on these target groups primarily. And the way I did that was kind of step them through their own data…And to look at teams as well, so which unit has really high rates of readmission, so maybe they're being discharged before

they're ready, or maybe the community team supporting them is stretched to capacity. So that might be where you deploy that resource. (OW34)

Support and guidance concerning the use of data for the purposes of targeting Peer-STOC resources may help LHDs/SHNs make the most of available resources for Peer-STOC.

ii Tools and processes for evaluation

Some interview participants described offering the YES (Your Experience of Service) survey to participants, as well as developing a specific YES for Peer-STOC. One peer worker described that they have developed a specific YES survey, while also describing the nature of informal feedback received from consumers:

> *So we've only recently got the YES [your experience of service] surveys up and happening individually for Peer-STOC. So we're getting good feedback from that. And I, just from the incidental information that I've had along the way, you know some people have said, you know, like now I've got hope and things like that, which is great when you get those sort of feedback…* (PW6)

In addition to YES surveys, RAS-DS was also offered to Peer-STOC participants in numerous LHDs/SHNs (described above in 'I Intervention Characteristics: a) The Peer-STOC Model: Tools and approaches.

Beyond data gathered as a standard practice within the Ministry, additional information that may support evaluation of impact may include more informal sources, such as peer newsletters or stories of consumer recovery. One peer worker described his involvement in capturing stories that illustrated the depth of impact that can occur through peer work:

> *I was part of a newsletter and we actually managed to capture some of that data because I managed to get some stories from people that I'd worked with, and I de-identified them for our newsletter. Particularly people that got lots of [support from?] peer workers. And one of those stories was from someone I supported who is now a peer worker in the service who gave her kind of story from inpatient to community and then becoming a peer worker. And that was one of the main things she brought up in her story, was that through working with a peer worker, she was able to trust her clinical team.* (PW8)

As noted above, these types of data can be valuable in capturing the unquantifiable. They can also provide meaningful information that may be helpful for peer workers to pass on to consumers, as well as educating clinicians about the impact of peer work. A way of capturing more of these positive stories may be useful as a resource for peers and consumers to access as a means of providing models of recovery.

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Appendices

Appendix 1

Table A1 Interview guides: Questions/areas of investigation (Implementation and Qualitative Outcome streams combined)

Inpatient unit staff	▪ Process of identification of potential Peer-STOC 'participants' – who /how/uptake/challenges… (I) ▪ Experience and perceptions of Peer-STOC program (I) ▪ Facilitators and barriers (I) ▪ Transfer of care — approaches that worked well and what challenges exist (in-reach etc…) (I)
Community multi-disciplinary teams	▪ Experience of Peer-STOC program and peer-worker embedded in team (I) ▪ How Peer-STOC workers were integrated into teams / connected with other peer workers in the service(I) ▪ Facilitators and barriers (I) ▪ Transfer of care — approaches that worked well and what challenges exist (in-reach etc…) (I) ▪ Highlights and lowlights (I) ▪ Exit plan and process – what does best practice look like (I) ▪ Recommendations - considering best practice, future sustainability and expansion (I)
Peer workers	▪ Experience of engagement within inpatient units/in-reach process (I) ▪ Challenges and enablers (I) ▪ Transfer of care — approaches that worked well and what challenges exist (in-reach etc…) (I) ▪ Most helpful/unhelpful aspects of Peer-STOC program and peer-worker (role and qualities) (I) ▪ Models and methods of 'embedding' Peer-STOC workers in MDTs – what does best practice look like? (I) ▪ Experience in the role – needs met/unmet (I/O) ▪ Experience of support/supervision (I/O) ▪ Highlights and lowlights (I/O) ▪ Exit plan and process – what does best practice look like (I) ▪ Recommendations - considering best practice, future sustainability and expansion (I)
Peer-STOC Consumers	▪ Experiences of in-reach (I) ▪ Experiences of Peer STOC overall (I) ▪ Highlights and lowlights (I/O) ▪ Most helpful/unhelpful aspects of Peer-STOC program and peer-worker (role and qualities) (I) ▪ Needs and expectations met/not met (O) ▪ Experience of exit plan and process (I) ▪ Recommendations - considering best practice, future sustainability and expansion (I)

Note. 1. *I = implementation stream; O = qualitative outcome stream; 2. Further outcome areas of exploration will be developed in partnership with the LEAP team.*

Appendix 2

Overall rating of Peer-STOC

In the online questionnaire, each participant was asked to rate their experience with Peer-STOC on a scale of 1 to 100. They were also asked to provide reasons for their scores. Averaged ratings of overall experience of the program for each stakeholder group is provided in Table A2 below, accompanied by a summary of the reasons people provided for their scores.

Table A2 Overall ratings of respondents' experiences with Peer-STOC

Group	Rating
Consumers	92.3
Comments: Consumer respondents commented on the value of feeling supported, being able to discuss experiences, Peer-STOC workers providing connection and communication with other mental health staff. Consumers also commented on Peer-STOC peer workers being caring, offering useful advice and supporting transition from hospital to home: *"[name of peer worker] has become a valuable person helping me resettle after everything went to Hell."* However, one consumer commented *"I felt that my Peer support person brought their personal opinions about me into it too much."*	
Peer-STOC Workers	72.5
Comments: When the Peer-STOC peer workers rated satisfaction of the program highly, they described things like: the program benefiting the consumers' recovery; loving their jobs; working in supportive teams; enjoying working with their colleagues to assist consumers; and having effective supervision. When Peer-STOC peer workers gave lower scores for satisfaction, they provided the following reasons: finding the role stressful and negatively impacting their mental health due to high workloads, working alone, or because of conflict with other health workers; feeling underpaid; feeling like colleagues didn't understand the role of the Peer-STOC worker sufficiently; lack of supervision; and that they didn't think that Peer-STOC was adequately integrated into the broader mental health service generally or discharge planning specifically	
Other Mental Health Workers	79.2
Comments; When other workers rated satisfaction of the program highly, they described things like: viewing Peer-STOC peer workers as providing effective and valuable support to consumers; that their work was beneficial in general for the treating teams both on the ward and in the community; that their lived experience meant they could relate well to the consumers' situations and could build rapport with them easily; that they were seen to work collaboratively with clinical staff; that they brought warmth and humanity to the workplace; and that they challenged the culture of the service in a positive way. When other workers gave lower scores for satisfaction, they provided the following reasons: that at times Peer-STOC peer works were difficult to work with because they held conflicting ideas on approaches to treatment options for consumer care; that the coverage of the program was too limited; that there was a need for more Peer-STOC peer workers with the capacity for them to travel longer distances to see consumers in the community; that the program could be better promoted; that the recruitment process was often long and protracted; that	

management was insufficiently supportive of the Peer-STOC peer worker role; and that sometimes other workers didn't know enough about Peer-STOC or what the Peer-STOC peer worker did.

Note. In the questionnaire, respondents also provided other, more detailed feedback about their experiences receiving, working as a part of or alongside Peer-STOC program. These comments have been integrated with interview data and are reported within the chapters above.

Appendix 3

Full results from analysis of change scores in statewide routine outcome measures

Table A3.1 Results for analysis of change over time for individuals who have complete datasets (i.e., measures at baseline and for each of the follow up periods).

	n	Baseline	3 months	6 months	12 months
K10					
Transition Support Peer-STOC Participants	6	22.6 (10.2)	20.0 (10.8)^{ns}	19.5 (6.2)^{ns}	25.5 (10.6)^{ns}
Other Support Peer-STOC Participants	5	22.4 (5.7)	22.7 (8.5)^{ns}	23 (8.1)^{ns}	23 (8.2)^{ns}
All Peer-STOC Participants	11	22.5 (8.1)	21.2 (9.5)^{ns}	21.1 (7)^{ns}	24.4 (9.2)^{ns}
Comparison group	21	19.9 (8.0)	18.8 (8.9)^{ns}	18.2 (9.0)^{ns}	17.7 (9.9)^{ns}
HoNOS					
Transition Support Peer-STOC Participants	20	8.1 (3.2)	10.3 (5.3)^{ns}	9.8 (6.0)^{ns}	9.7 (4.7)^{ns}
Other Support Peer-STOC Participants	32	7.6 (4.5)	9.8 (5.2)*	9.3 (5.7)^{ns}	9 (5.2)^{ns}
All Peer-STOC Participants	52	7.8 (4.0)	10.0 (5.2)**	9.5 (5.8)*	9.3 (5.0)^{ns}
Comparison group	77	8.8 (3.7)	10.3 (5.1)*	9.1 (6.5)^{ns}	9.4 (6.1)^{ns}
LSP					
Transition Support Peer-STOC Participants	10	13.1 (11.1)	15.0 (10.2)^{ns}	10.2 (7.6)^{ns}	8.5 (11)^{ns}
Other Support Peer-STOC Participants	27	10.4 (8.3)	11.8 (8.1)^{ns}	12 (8.4)^{ns}	12.3 (10.3)^{ns}
All Peer-STOC Participants	37	11.1 (9.0)	12.7 (8.7)^{ns}	11.5 (8.1)^{ns}	11.3 (10.4)^{ns}
Comparison group	66	11.6 (7.0)	12.9 (8.2)^{ns}	12.5 (8.5)^{ns}	12.3 (8.8)^{ns}

Notes: ns = not significantly different to the baseline measure; * $p < .05$, ** $p < .01$, *** $p < .001$ (for paired t-test comparing to baseline measure)

Table A3.2 Results for analysis of change over time for any individuals who have measures at baseline and at any of the follow up periods.

	Follow up period	**N**	**Baseline score** Mean (S.D.)	**Follow up score** Mean (S.D.)	
K10					
Transition Support Peer-STOC participants	3 months	27	27.2 (10.6)	21.8 (8.6)**	⇩
	6 months	30	26.2 (10.9)	18.5 (6.6)***	⇩
	12 months	28	24.7 (10.7)	20.9 (9.1)*	⇩
Other Support Peer-STOC participants	3 months	31	20.3 (8.6)	20 (8.6)	⇔
	6 months	27	21.3 (9.4)	21.1 (8.6)	⇔
	12 months	27	20.5 (7.7)	21.2 (8.7)	⇔
All Peer-STOC Participants	3 months	58	23.5 (10.1)	20.8 (8.6)**	⇩
	6 months	57	23.9 (10.4)	19.7 (7.7)**	⇩
	12 months	55	22.7 (9.5)	21 (8.8)	⇔
Comparison group	3 months	119	25.5 (11.1)	21.7 (10.6)***	⇩
	6 months	163	25.1 (10.7)	20.2 (9.7)***	⇩
	12 months	230	25.2 (11)	19.4 (9.5)***	⇩
HoNOS					
Transition Support Peer-STOC participants	3 months	69	9.2 (3.7)	9.2 (5.3)	⇔
	6 months	114	9.2 (4.7)	8.8 (5.4)	⇔
	12 months	101	9.7 (4.9)	8.6 (5.6)	⇔
Other Support Peer-STOC participants	3 months	103	8.6 (5.5)	9.2 (5.9)	⇔
	6 months	110	8.3 (4.8)	9.3 (6.1)	⇔
	12 months	118	8.6 (4.6)	8.2 (5.1)	⇔
All Peer-STOC Participants	3 months	172	8.8 (4.8)	9.2 (5.7)	⇔
	6 months	224	8.8 (4.7)	9 (5.7)	⇔
	12 months	219	9.1 (4.8)	8.4 (5.4)	⇔
Comparison group	3 months	342	9.5 (4.1)	9.4 (6.2)	⇔
	6 months	409	9.6 (4.1)	9.5 (6.4)	⇔
	12 months	543	9.5 (4.3)	9.1 (5.8)	⇔

	Follow up period	N	Baseline score Mean (S.D.)	Follow up score Mean (S.D.)
LSP				
Transition Support Peer-STOC participants	3 months	39	12.5 (9)	12.4 (10.5) ⇔
	6 months	52	12 (8.8)	9.7 (7.4) ⇔
	12 months	41	11.9 (9.9)	11.6 (9.3) ⇔
Other Support Peer-STOC participants	3 months	61	10.4 (8)	11.2 (7.1) ⇔
	6 months	68	10.8 (8.6)	12 (9.1) ⇔
	12 months	70	10.1 (7.8)	11.1 (8.7) ⇔
All Peer-STOC Participants	3 months	100	11.2 (8.4)	11.6 (8.6) ⇔
	6 months	120	11.3 (8.7)	11 (8.5) ⇔
	12 months	111	10.8 (8.6)	11.3 (8.9) ⇔
Comparison group	3 months	219	11.1 (8.5)	12.9 (9.6)** ⇧
	6 months	287	10.7 (8)	12.1 (8.5)** ⇧
	12 months	348	10.7 (8.6)	12.9 (8.9)*** ⇧

Notes: * $p < .05$; ** $p < .01$; *** $p < .001$; ⇩ = significant reduction in score from baseline (note that lower scores represent better health / functioning, so reductions suggest positive change); ⇔ = no significant difference in score from baseline; ⇧ = significant increase in score from baseline (note that higher scores represent poorer health / functioning, so increases suggest negative change).

Appendix 4

Image credits

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