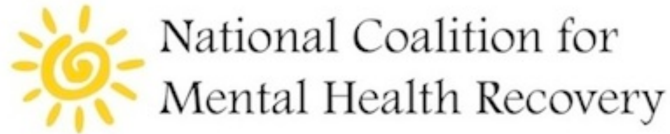

Peer Support: Why it Works

Introduction: Peer Specialists are persons with mental health conditions who have completed specific training that enables them to enhance a person's wellness and recovery by providing peer support. Peer Specialists work in a variety of locations, such as peer support centers, crisis stabilization units, respite programs, psychosocial rehabilitation programs, and in psychiatric hospitals. Peer support can be a one-on-one experience or a group of people sharing together. In a groundbreaking letter to Medicaid directors in 2007, Dennis G. Smith, director of the Centers for Medicare and Medicaid Services, explained peer support as an "evidence-based mental health model of care that consists of a qualified peer support provider who assists individuals with their recovery from mental illness and substance use disorders."

The following abstracts summarize some of this research on the effectiveness of peer support. For more information on these citations or on the issue of violence and people with mental health diagnoses, contact media@ncmhr.org.

Bergeson, S. (n.d.) Cost effectiveness of using peer providers. Retrieved from: http://bit.ly/1lbypF7

> Conclusion: Prestigious and important organizations such as CMS, SAMSHA, the Institute of Medicine, among many others, have identified peer delivered services offered through a certified peer specialists as being valuable services. In addition, research is showing that while increasing consumer wellness, the use of peer specialists is decreasing costs.

Bologna, M. J., & Pulice, R.T. (2011). Evaluation of a peer-run hospital diversion program: A descriptive study. *American Journal of Psychiatric Rehabilitation, 14*(4): 272-286.

> Abstract: Few studies have explored how peer-run hospital diversion services can contribute to consumers' perceptions of care and recovery. The purpose of this study was to evaluate the impact of a peer-run hospital diversion program (PRHDP) on mental health consumers' recovery; to compare the consumers' experience of environment, services, and staff with a non-peer-run acute inpatient program (NPRIP); to understand the clients' beliefs about PRHDP; and to assess their evaluation of services received in both settings. A purposive sample of 39 mental health consumers rated the quality and type of services they received in a PRHDP versus a NPRIP, and their beliefs about the impact of these services on their recovery and life satisfaction. The Quality of Life Index and items developed by focus groups were used. The results indicate that services at the PRHDP were more client-centered and less restrictive than at NPRIPs. PRHDP staff were viewed as more respectful. Respondents reported feeling decreased stigma due to mental illness after receiving services from the PRHDP, as well as good life satisfaction and

social involvement levels. **PRHDPs** that provide case management and treatment planning, along with peer support, **should be considered as an alternative to non-peer-run programs.**

Bouchard, L., Montreuil, M., & Gros, C. (2010). Peer support among inpatients in an adult mental health setting. *Issues in Mental Health Nursing, 31*:589–598. DOI: 10.3109/01612841003793049.

Abstract: Existing literature indicates peer support is beneficial for people with mental illnesses and plays an important role in recovery. While many studies in the mental health field have focused on formalized peer support within the community, none have explored the experience of peer support among hospitalized patients. The purpose of the current study was to explore the perceptions and experiences of naturally occurring peer support among adult mental health inpatients. In-depth interviews were conducted with ten inpatients across four mental health units, two acute and two long-term. Interviews were transcribed verbatim and analyzed using a qualitative descriptive design. The data show that peer support among inpatients is extensive and beneficial, and occurs independently of staff involvement. The findings illustrate that **peer support is a thoughtful process that involves observing, reflecting, taking action, and evaluating outcomes**. Supportive actions include helping with activities of daily living, sharing material goods, providing information and advice, sharing a social life, and offering emotional support. **This leads to various positive outcomes for providers and recipients of peer support, such as improved mental health outcomes and quality of life.** Attempts to provide supportive interactions occur within a particular context, which can hinder or facilitate peer support. The new insights from this study could provide health professionals with an increased recognition of peer support and an appreciation for the unique role patients play in their own and in their peers' recovery. **These findings have important implications for establishing collaborative working partnerships with mental health inpatients.**

Cook, J. A., Copeland, M. E., Corey, L., Buffington, E., Jonikas, J. A., Curtis, L. C., Grey, D. D., & Nichols, W. H. (2010). Developing the evidence base for peer-led services: Changes among participants following Wellness Recovery Action Planning (WRAP) education in two statewide initiatives. *Psychiatric Rehabilitation Journal*, *34*(2): 113–120.

Abstract
Objective: The purpose of this analysis was to evaluate the outcomes of two statewide initiatives in Vermont and Minnesota, in which self-management of mental illness was taught by peers to people in mental health recovery using Wellness Recovery Action Planning (WRAP).
Methods: Pre-post comparisons were made of reports from 381 participants (147 in Vermont and 234 in Minnesota) on a survey instrument that assessed three dimensions of self-management: 1) attitudes, such as hope for recovery and responsibility for one's own wellness; 2) knowledge, regarding topics such as early warning signs of decompensation and symptom triggers; and 3) skills, such as identification of a social support network and use of wellness tools.

Results: **Significant positive changes in self-management attitudes, skills and behaviors were observed on 76% of items completed by Vermont participants (13 of 17 survey items), and 85% of items completed by Minnesota participants (11 of 13 items).** In both states, participants reported significant increases in: 1) their hopefulness for their own recovery; 2) awareness of their own early warning signs of decompensation; 3) use of wellness tools in their daily routine; 4) awareness of their own symptom triggers; 5) having a crisis plan in place; 6) having a plan for dealing with symptoms; 7) having a social support system; and 8) ability to take responsibility for their own wellness.
Conclusions: Given the rapid growth of this intervention in the U.S. and internationally, these results contribute to the evidence base for peer-led services, and suggest that more rigorous investigations are warranted in the future.

Corrigan, P. (2006). Impact of consumer-operated services on empowerment & recovery of people with psychiatric disabilities. *Psychiatric Services, 57*(10): 1493-1496.

Abstract
Objective: Although the professional literature is replete with descriptions of consumer-operated services, empirical examination of these services has been relatively limited. In this study, the cross-sectional relationship between participation in consumer-operated services and measures of recovery and empowerment is examined.
Methods: A total of 1,824 people with psychiatric disability indicated whether they had participated in a peer support program (the proxy of consumer-operated services) during the past four months. They also were administered two five-factor measures of recovery and of empowerment.
Results: **Participation in peer support was associated with nine of ten factors generated by the recovery and empowerment instruments.** These associations remained significant when commensurate demographic variables were controlled for.
Conclusions: **Participation in peer support showed a significant association with multiple outcome and recovery subscales, but the magnitude of the effect was small**. The associative nature of the data precludes stating that peer support caused the observed improvement.

Davidson L., Bellamy C., Guy, K., & Miller R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11*(2): 123-128.

Abstract: Peer support is largely considered to represent a recent advance in community mental health, introduced in the 1990s as part of the mental health service user movement. Actually, peer support has its roots in the moral treatment era inaugurated by Pussin and Pinel in France at the end of the 18th century, and has re-emerged at different times throughout the history of psychiatry. In its more recent form, peer support is rapidly expanding in a number of countries and, as a result, has become the focus of considerable research. Thus far, **there is evidence that peer staff providing conventional mental health services can be effective in engaging people into care, reducing the use of emergency rooms and hospitals, and reducing substance use among persons with co-**

occurring substance use disorders. When providing peer support that involves positive self-disclosure, role modeling, and conditional regard, peer staff have also been found to increase participants' sense of hope, control, and ability to effect changes in their lives; increase their self-care, sense of community belonging, and satisfaction with various life domains; and decrease participants' level of depression and psychosis.

Davidson L., Chinman M., Sells, D., & Rowe M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophr Bull, 32*(3):443–450.

Abstract: Peer support is based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations. While this belief is well accepted for many conditions, such as addiction, trauma, or cancer, stigma and stereotypes about mental illness have impeded attempts on the part of people in recovery to offer such supports within the mental health system. Beginning in the early 1990s with programs that deployed people with mental illness to provide conventional services such as case management, opportunities for the provision and receipt of peer support within the mental health system have proliferated rapidly across the country as part of the emerging recovery movement. **This article defines peer support as a form of mental health care and reviews data from 4 randomized controlled trials, which demonstrated few differences between the outcomes of conventional care when provided by peers versus non-peers**. We then consider what, if any, unique contributions can be made by virtue of a person's history of serious mental illness and recovery and review beginning efforts to identify and evaluate these potential valued-added components of care. We conclude by suggesting that peer support is still early in its development as a form of mental health service provision and encourage further exploration and evaluation of this promising, if yet unproven, practice.

Gillard, S. G., Edwards, C., Gibson, S. L., Owen, K., & Wright, C. (2013). Introducing peer worker roles into UK mental health service teams: A qualitative analysis of the organisational benefits and challenges. *BMC Health Services Research, 13*(188). doi: http://www.biomedcentral.com/1472-6963/13/188

Abstract

Background: The provision of peer support as a component of mental health care, including the employment of Peer Workers (consumer-providers) by mental health service organisations, is increasingly common internationally. Peer support is strongly advocated as a strategy in a number of UK health and social care policies. Approaches to employing Peer Workers are proliferating. There is evidence to suggest that Peer Worker-based interventions reduce psychiatric inpatient admission and increase service user (consumer) empowerment. In this paper we seek to address a gap in the empirical literature in understanding the organisational challenges and benefits of introducing Peer Worker roles into mental health service teams.

Methods: We report the secondary analysis of qualitative interview data from service users, Peer Workers, non-peer staff and managers of three innovative interventions in a study about mental health self-care. Relevant data was extracted from interviews with 41

participants and subjected to analysis using Grounded Theory techniques. Organisational research literature on role adoption framed the analysis.
Results: Peer Workers were highly valued by mental health teams and service users. Non-peer team members and managers worked hard to introduce Peer Workers into teams. Our cases were projects in development and there was learning from the evolutionary process: in the absence of formal recruitment processes for Peer Workers, differences in expectations of the Peer Worker role can emerge at the selection stage; flexible working arrangements for Peer Workers can have the unintended effect of perpetuating hierarchies within teams; the maintenance of protective practice boundaries through supervision and training can militate against the emergence of a distinctive body of peer practice; lack of consensus around what constitutes peer practice can result in feelings for Peer Workers of inequality, disempowerment, uncertainty about identity and of being under-supported.
Conclusions: This research is indicative **of potential benefits for mental health service teams of introducing Peer Worker roles**. Analysis also suggests that **if the emergence of a distinctive body of peer practice is not adequately considered and supported, as integral to the development of new Peer Worker roles, there is a risk that the potential impact of any emerging role will be constrained and diluted**.

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*(1): 135-144.
Abstract: This experiment compared the effectiveness of an unlocked, mental health consumer-managed, crisis residential program (CRP) to a locked, inpatient psychiatric facility (LIPF) for adults civilly committed for severe psychiatric problems. Following screening and informed consent, participants (n = 393) were randomized to the CRP or the LIPF and interviewed at baseline and at 30-day, 6-month, and 1-year post admission. Outcomes were costs, level of functioning, psychiatric symptoms, self-esteem, enrichment, and service satisfaction. Treatment outcomes were compared using hierarchical linear models. **Participants in the CRP experienced significantly greater improvement on interviewer-rated and self-reported psychopathology than did participants in the LIPF condition; service satisfaction was dramatically higher in the CRP condition. CRP-style facilities are a viable alternative to psychiatric hospitalization for many individuals facing civil commitment**.

Lawn S., Smith A., & Hunter K. (2008). Mental health peer support for hospital avoidance and early discharge: an Australian example of consumer driven and operated service. *J Ment Health 2008, 17*(5):498–508.

Abstract
Background: An international trend towards greater involvement of mental health consumers to support fellow consumers is part of the shift towards more recovery-based services.
Aims: Evaluation of the first 3 months of operation of an Australian mental health peer support service providing hospital avoidance and early discharge support to consumers of adult mental health services.

Method: Key performance indicators such as bed days saved, crisis service contact, ED presentations, and readmission rates were gathered, along with feedback from various stakeholders including consumers, carers, mental health staff, GPs, and peer support workers via phone questionnaires and focus groups.
Results: In the first 3 months of operation 49 support packages were provided with 300 bed days saved, equating to $93,150 AUS saved after project set up, delivery and administration costs of approximately $19,850. Feedback from all stakeholders was overwhelmingly positive.
Conclusions: **Using peers to provide support to consumers at this stage of their recovery seems highly effective as an adjunct to mainstream mental health services.** It has personal benefit to consumers and peers, substantial savings to systems, as well as much potential for encouraging mental health service culture and practice towards a greater recovery focus and improved collaboration with GPs.

McDiarmid, D., Rapp, C., & Ratzlaff, S. (2005). Design and initial results from a supported education initiative: The Kansas consumer as provider program. *Psychiatric Rehabilitation Journal, 29*(1): 3-9.

Abstract: Despite increased attention to consumer-providers, there remains a lack of models that prepare, support, and sustain consumers in provider roles. This article describes the Consumer as Provider (CAP) Training program at the University of Kansas School of Social Welfare, which creates opportunities for individuals with severe psychiatric disabilities to develop knowledge and skills to be effective as human service providers. CAP fosters a partnership between colleges and community mental health centers where students experience classroom and internship activities. **Outcome from a 2-year longitudinal study on CAP graduates indicates increased employability, especially in social services field, and higher post-secondary educational involvement**.

Migdole S., Tondora J., Silvia, M. A., Barry, A. D., Milligan J. C., Mattison, E., Rutledge, W., & Powsner, S. (2011). Exploring new frontiers: Recovery-oriented peer support programming in a psychiatric ED. *American Journal of Psychiatric Rehabilitation, 14*(1): 1-12.
Abstract: Enhancing the diversity of roles for paid peer-support specialists is a topic of increasing interest throughout the country. **Peer specialist positions promote a renewed sense of hope for the possibility of recovery, while also offering unique and valuable competitive employment options for mental health consumers**. As we strive toward local and national recovery-oriented systems of care, we must continue to explore practical program applications and their associated benefits and challenges. The authors describe the development and implementation of a recovery-oriented peer support team within the psychiatric service of an emergency department (psychiatric ED) located at an academic medical center in a northeastern state.

Nelson, G., Ochocka, J., Janzen, R., Trainor, J., Goering, P., & Lomotey, J. (2007). A longitudinal study of mental health consumer/survivor initiatives: Part V – Outcomes at

3-year follow-up. *Journal of Community Psychology, 35*(5): 655-665.

Abstract: The objective of this study was to evaluate the impacts of participation in mental health Consumer/Survivor Initiatives (CSIs), organizations run by and for people with mental illness. A nonequivalent comparison group design was used to compare three groups of participants: (a) those who were continually active in CSIs over a 36-month period (n = 25); (b) those who had been active in CSIs at 9- and 18-month follow-up periods, but who were no longer active at 36 months (n = 35); and (c) a comparison group of participants who were never active in CSIs (n = 42). Data were gathered at baseline, 9-, 18-, and 36-month follow-ups. The three groups were comparable at baseline on a wide range of demographic variables, self-reported psychiatric diagnosis, service use, and outcome measures. **At 36 months, the continually active participants scored significantly higher than the other two groups of participants on community integration, quality of life (daily living activities), and instrumental role involvement, and significantly lower on symptom distress**. No differences between the groups were found on other outcome measures. **Improvements in 36-month outcomes for people with mental illness who participated in CSIs suggest the potential value of these peer support organizations.** Further research is needed to determine the replicability of these positive findings.

Ostrow, L., & Leaf, P. (2014). Improving capacity to monitor and support sustainability of mental health peer-run organizations. *Psychiatric Services, 65*(2): 239-241.

Abstract: Peer-run mental health organizations are managed and staffed by people with lived experience of the mental health system. These understudied organizations are increasingly recognized as an important component of the behavioral health care and social support systems. This Open Forum describes the National Survey of Peer-Run Organizations, which was conducted in 2012 to gather information about peer-run organizations and programs, organizational operations, policy perspectives, and service systems. A total of 895 entities were identified and contacted as potential peer-run organizations. Information was obtained for 715 (80%) entities, and 380 of the 715 responding entities met the criteria for a peer-run organization. Implementation of the Affordable Care Act may entail benefits and unintended consequences for peer-run organizations. It is essential that we understand this population of organizations and continue to monitor changes associated with policies intended to provide better access to care that promotes wellness and recovery.

Pitt, V., Lowe, D., Hill, S., Prictor, M., Hetrick, S.E., Ryan, R., & Berends, L. (2013). Consumer-providers of care for adult clients of statutory mental health services (Review). John Wiley & Sons, Ltd. DOI: 10.1002/14651858.CD004807.pub2

Authors' Conclusions: **Involving consumer-providers in mental health teams results in psychosocial, mental health symptom and service use outcomes for clients that were no better or worse than those achieved by professionals employed in similar roles, particularly for case management services.** There is low quality evidence that involving consumer-providers in mental health teams results in a small reduction in

clients' use of crisis or emergency services. The nature of the consumer-providers' involvement differs compared to professionals, as do the resources required to support their involvement. The overall quality of the evidence is moderate to low. There is no evidence of harm associated with involving consumer-providers in mental health teams. Future randomised controlled trials of consumer-providers in mental health services should minimise bias through the use of adequate randomisation and concealment of allocation, blinding of outcome assessment where possible, the comprehensive reporting of outcome data, and the avoidance of contamination between treatment groups. Researchers should adhere to SPIRIT and CONSORT reporting standards for clinical trials. Future trials should further evaluate standardised measures of clients' mental health, adverse outcomes for clients, the potential benefits and harms to the consumer-providers themselves (including need to return to treatment), and the financial costs of the intervention. They should utilise consistent, validated measurement tools and include a clear description of the consumer-provider role (e.g. specific tasks, responsibilities and expected deliverables of the role) and relevant training for the role so that it can be readily implemented. The weight of evidence being strongly based in the United States, future research should be located in diverse settings including in low- and middle-income countries.

Repper J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *J Ment Health, 20*(4):392–411.

Abstract:
Background: Although mutual support and self-help groups based on shared experience play a large part in recovery, the employment of peer support workers (PSWs) in mental health services is a recent development. However, peer support has been implemented outside the UK and is showing great promise in facilitating recovery.
Aims: This article aims to review the literature on PSWs employed in mental health services to provide a description of the development, impact and challenges presented by the employment of PSWs and to inform implementation in the UK.
Method: An inclusive search of published and grey literature was undertaken to identify all studies of intentional peer support in mental health services. Articles were summarised and findings analysed.
Results: The literature demonstrates that **PSWs can lead to a reduction in admissions among those with whom they work**. Additionally, associated improvements have been reported on numerous issues that can impact on the lives of people with mental health problems.
Conclusion: **PSWs have the potential to drive through recovery-focused changes in services**. However, many challenges are involved in the development of peer support. Careful training, supervision and management of all involved are required.

Resnick, S. & Rosenheck, R.A. (2008). Integrating peer-provided services: A quasi-experimental study of recovery orientation, confidence, and empowerment. *Psychiatric Services, 59*(11): 1307-1314.

Abstract

Objective: Peer-provided mental health services have become increasingly prominent in recent years, despite a lack of evidence of beneficial impact. The study presented here compared the effectiveness of the Vet-to-Vet program, a peer education and support program, and standard care without peer support on measures of recovery orientation, confidence, and empowerment.
Methods: Participants were recruited in two consecutive cohorts between 2002 and 2006, one before the implementation of the Vet-to-Vet program in June 2002 (cohort 1; N=78) and one after (cohort 2; N=218). Follow-up interviews were conducted at one, three, and nine months. There were few baseline differences between the cohorts. Intention-to-treat analyses compared cohorts on changes over time on measures of recovery orientation, confidence, and empowerment. A third cohort (cohort 2-V) was constructed that consisted of the subset of participants from the second cohort who directly participated in more than ten Vet-to-Vet sessions since the last research interview (N=102). Comparisons between this cohort and the first cohort constitute as-treated analyses.
Results: In the intention-to-treat analyses, the Vet-to-Vet cohort scored significantly higher on measures of empowerment. In the as-treated analyses, significant differences favoring the Vet-to-Vet cohort were observed on both empowerment and confidence. Secondary analyses of clinical measures showed significant differences favoring the cohorts 2 and 2-V on measures of functioning and on alcohol use.
Conclusions: **These data suggest that participation in peer support may enhance personal well-being, as measured by both recovery-oriented and more traditional clinical measures.**

Rogers, E. S., Teague, G. B., Lichenstein, C., Campbell, J., Lyas, A., Chen, R., & Banks, S. (2007). Effects of participation in consumer-operated service programs on both personal and organizationally mediated empowerment: Results of multisite study. *Journal of Rehabilitation Research & Development, 44*(6): 785-800.

Abstract: The number of empowerment-oriented consumer-operated service programs (COSPs) in mental health has increased dramatically over the past decade; however, little empirical evidence exists about the effects of such programs on their intended outcomes. This study examined the effects of COSPs on various aspects of empowerment within the context of a multisite, federally funded, randomized clinical trial of COSPs. **Results suggest that the individuals who received the consumer-operated services perceived higher levels of personal empowerment than those in the control intervention**; overall, effect sizes were very modest when all sites were examined together in intent-to-treat analyses. However, we noted variations in outcomes by intensity of COSP use and also by study site, which suggest that specific programs had significant effects, while others did not. The implications of these results for the mental health field and for service providers and policy makers are discussed.

Sells, D., Davidson, L., Jewell, C., Falzer, P., & Rowe, M. (2006). The treatment relationship in peer-based and regular case management for clients with severe mental illness. *Psychiatr Serv 2006, 57*(8):1179–1184.

Abstract:

Objective: This study compared the quality of treatment relationships and engagement in peer-based and regular case management. It also assessed the value of positive relationship qualities in predicting motivation for and use of community-based services for persons with severe mental illness.
Methods: One hundred thirty-seven adults with severe mental illness participated in a 2x2 prospective longitudinal randomized clinical trial with two levels of case management intervention (peer and regular) and two interviews (six and 12 months). Self-report questionnaires assessed treatment relationships, motivation, and service use, and providers rated participants' initial engagement and monthly attendance in treatment.
Results: Participants perceived higher positive regard, understanding, and acceptance from peer providers rather than from regular providers at six months only, with initially unengaged clients showing more contacts with case managers in the peer condition and decreasing contacts in the regular condition. Six-month positive regard and understanding positively predicted 12-month treatment motivation for psychiatric, alcohol, and drug use problems and attendance at Alcoholics and Narcotics Anonymous meetings.
Conclusions: Early in treatment, peer providers may possess distinctive skills in communicating positive regard, understanding, and acceptance to clients and a facility for increasing treatment participation among the most disengaged, leading to greater motivation for further treatment and use of peer-based community services. **Findings strongly suggest that peer providers serve a valued role in quickly forging therapeutic connections with persons typically considered to be among the most alienated from the health care service system.**

Shatell, M. M., et al. (2014). A recovery-oriented alternative to hospital emergency departments for persons in emotional distress: "The living room." *Issues Ment Health Nurs., 35*(1):4-12.

Abstract: Persons with severe mental illness experience episodic crises, resulting in frequent visits to hospital emergency departments (EDs). EDs, however, are not the most effective treatment environments for these individuals who might better be served elsewhere in an environment based on recovery-oriented framework. The purpose of this study is to describe the lived experience of guests (persons in emotional distress) and staff (counselors, psychiatric nurses, and peer counselors) of a community, recovery-oriented, alternative crisis intervention environment—The Living Room (TLR). The total sample is comprised of 18 participants. An existential phenomenological approach was used for this qualitative, descriptive, study. Through non-directive in-depth interviews, participants were asked to describe what stands out to them about The Living Room. Interviews were audio-recorded, transcribed verbatim, and systematically analyzed using descriptive phenomenological methods of analysis by an interdisciplinary and community-based participatory research team. Participants' experiences in hospital EDs and inpatient psychiatric units contextualized the phenomenological experience of TLR environment. The final thematic structure of the experience of TLR included the following predominant themes: A Safe Harbor, At Home with Uncomfortable Feelings, and It's a Helping, No Judging Zone. Findings from this qualitative study of a recovery-based alternative to hospital EDs for persons in emotional distress are supported by

anecdotal and empirical evidence that suggests **that non-clinical care settings are perceived as helpful.**

Simpson, A., et al. (2014). Results of a pilot randomised controlled trial to measure the clinical and cost effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. *BMC Psychiatry, 14*(30). doi:10.1186/1471-244X-14-303

Abstract
Background
Mental health patients can feel anxious about losing the support of staff and patients when discharged from hospital and often discontinue treatment, experience relapse and readmission to hospital, and sometimes attempt suicide. The benefits of peer support in mental health services have been identified in a number of studies with some suggesting clinical and economic gains in patients being discharged.
Methods
This pilot randomised controlled trial with economic evaluation aimed to explore whether peer support in addition to usual aftercare for patients during the transition from hospital to home would increase hope, reduce loneliness, improve quality of life and show cost effectiveness compared with patients receiving usual aftercare only, with follow-up at one and three-months post-discharge.
Results
A total of 46 service users were recruited to the study; 23 receiving peer support and 23 in the care-as-usual arm. While this pilot trial found no statistically significant benefits for peer support on the primary or secondary outcome measures, there is an indication that hope may be further increased in those in receipt of peer support. The total cost per case for the peer support arm of the study was £2154 compared to £1922 for the control arm. The mean difference between costs was minimal and not statistically significant. However, further analyses demonstrated **that peer support has a reasonably high probability of being more cost effective for a modest positive change in the measure of hopelessness**. Challenges faced in recruitment and follow-up are explored alongside limitations in the delivery of peer support.
Conclusions
The findings suggest there is merit in conducting further research on peer support in the transition from hospital to home consideration should be applied to the nature of the patient population to whom support is offered; the length and frequency of support provided; and the contact between peer supporters and mental health staff. There is no conclusive evidence to support the cost effectiveness of providing peer support, but neither was it proven a costly intervention to deliver. The findings support an argument for a larger scale trial of peer support as an adjunct to existing services.

Sledge, W. H., Lawless, M., Sells, D., Wieland, M., O'Connell, M., & Davidson, L. (2011). Effectiveness of peer support in reducing readmissions among people with multiple psychiatric hospitalizations. *Psychiatric Services, 62*(5): 541-544.

Abstract

Objective: The study examined the feasibility and effectiveness of using peer support to reduce recurrent psychiatric hospitalizations.
Methods: A randomized controlled design was used, with follow-up at nine months after an index discharge from an academically affiliated psychiatric hospital. Patients were 18 years or older with major mental illness and had been hospitalized three or more times in the prior 18 months. Seventy-four patients were recruited, randomly assigned to usual care (N=36) or to a peer mentor plus usual care (N=38), and assessed at nine months.
Results: Participants who were assigned a peer mentor had significantly fewer rehospitalizations (.89 ± 1.35 versus 1.53 ± 1.54; $p=.042$ [one-tailed]) and fewer hospital days (10.08 ± 17.31 versus 19.08 ± 21.63 days; $p<.03$, [one tailed]).
Conclusions: Despite the study's limitations, findings suggest **that use of peer mentors is a promising intervention for reducing recurrent psychiatric hospitalizations for patients at risk of readmission.**

Spirito Dalgin, R., Maline, S., & Driscoll, P. (2011). Sustaining recovery through the night: Impact of a peer-run warm line. *Psychiatric Rehabilitation Journal* *35*(1): 65–68.

Abstract
Objective: This exploratory study describes the impact of a peer-run warm line on the lives of individuals with psychiatric disabilities.
Methods: Phone surveys were completed with 480 warm line callers over four years.
Results: **Warm line callers reported a reduction in the use of crisis services and a reduction of feelings of isolation**.
Conclusions and Implications for Practice: The results indicate that peer-run warm lines can fill an important void in the lives of individuals living with mental illnesses. Although warm lines at any time of day are helpful, keeping warm lines running after 5pm and throughout the night provides support services not typically available after office hours and can assist with loneliness, symptom management, and the process of recovery. Warm lines staffed with appropriately trained, clinically supervised, compensated peer specialists can help round out mental health services in rural and urban communities. Future research should focus on the various implementation and funding options of this unique peer support service.

Walker, G., & Bryant, W. (2013). Peer support in adult mental health services: A metasynthesis of qualitative findings. *Psychiatric Rehabilitation Journal, 36*(1): 28-34.

Abstract
Objectives: Peer support involves people in recovery from psychiatric disability offering support to others in the same situation. It is based on the belief that people who have endured and overcome a psychiatric disability can offer useful support, encouragement, and hope to their peers. Although several quantitative reviews on the effectiveness of peer support have been conducted, qualitative studies were excluded. This study aimed to synthesize findings from these studies.
Method: A qualitative metasynthesis was conducted, involving examination, critical comparison, and synthesis of 27 published studies. The experiences of peer support

workers, their non-peer colleagues, and the recipients of peer support services were investigated.
Results: Peer support workers experiences included non-peer staff discrimination and prejudice, low pay and hours, and difficulty managing the transition from "patient" to peer support worker. Positive experiences included collegial relationships with non-peer staff, and other peers; and increased wellness secondary to working. **Recipients of peer support services experienced increased social networks and wellness.**
Conclusions and Implications for Practice: The findings highlight training, supervision, pay, non-peer staff/peer staff relationships, as important factors for statutory mental health peer support programs.