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REVIEW

A review of the literature on peer support in mental health services

JULIE REPPER[1] & TIM CARTER[2]

[1]*School of Nursing, University of Nottingham, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA, UK and* [2]*Connolly Ward, Peter Hodgkinson Centre, Lincoln County Hospital, Greetwell Road, Lincoln LN2 5UA, UK*

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.

Keywords: *Empowerment, mental health, recovery, peer support, service users, social support*

Background

There has been exponential growth in the employment of peer support workers (PSWs) in the US, Australia and New Zealand over the past decade and more recently this expansion has spread to the UK. A search of the grey literature reveals literally thousands of descriptions of peer-led and peer-run mental health services around the world. In the US, it has been reported that services run for and by people and their families with serious mental health problems now number more than double the traditional, professionally run, mental health organisations (Goldstrom et al., 2006). In contrast, the paid employment of PSWs within mental health services has been slower to develop, possibly impeded by negative assumptions about the abilities of people with mental health problems to support others. It is

Correspondence: Julie Repper, School of Nursing, University of Nottingham, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA, UK. Tel: +0780 195 3188. E-mail: julie.repper@nottingham.ac.uk

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only recently, perhaps aided by the promotion of a recovery-focused approach across mental health services, that the value of peer support in statutory services is becoming recognised.

Davidson et al. (1999), in the first review of the evidence surrounding peer support in mental health services, describe three broad types of peer support: informal (naturally occurring) peer support, peers participating in consumer or peer-run programmes and the employment of consumers/service users as providers of services and supports within traditional services. A number of reviews of the literature concerned with self-help/mutual support (Pistrang, Barker, & Humphreys, 2008; Raiff, 1984) and peer-run services (e.g. Davidson et al., 1999; Humphreys, 1997) have been published. Other reviews have concerned themselves with all types of service user employment in evaluation, training and service delivery in mental health (e.g. Simpson & House, 2002). The current review is primarily concerned with PSWs employed in clinical posts within statutory services.

Aims and objectives

The review aims to draw on published literature to define peer support in statutory services, to look at the development of specific peer support roles, the characteristics of their relationships and some of the benefits and challenges reported in the employment of PSWs.

Various terms are used to describe people with lived experience who are employed to support others who face similar challenges: 'PSWs', 'consumer-survivors', 'consumer providers', 'peer educators', 'prosumers' and 'peer specialists'. For the purpose of clarity, this article will refer to peer activities as, 'peer support work (PSW)', and peers who work within these initiatives as PSWs.

Method

This review was driven by the pragmatic intention to employ PSWs in local mental health services. We were therefore interested in clearly defining and distinguishing peer support and in determining ways in which it could be implemented most effectively. This raised methodological questions: what type of evidence should be included (i.e. what search and selection strategy was most appropriate)? How were we defining the intervention (i.e. what inclusion and exclusion criteria would apply)? Given the breadth of the aims, a pluralistic approach was adopted to include multiple sources of evidence and types of data. Published literature in the field consists largely of qualitative studies often with small sample sizes and descriptive cross-sectional or longitudinal designs. While this may be due to the early stage of development of the intervention, it may equally be a response to the restrictions imposed by the process of random assignment in controlled trials. For peer services built on the principle of inclusion and the development of a supportive, empowering culture, randomised manipulation may change the peer service being researched (Resnick & Rosenheck, 2008). In addition, since peer support is relatively innovative and unresearched, the understanding provided by narrative, personal and qualitative accounts is as valuable as more outcome focused comparative and quantitative studies. The development of PSW in mental health services raises many questions and challenges for all concerned, and it is not only *whether* it makes a difference that is of interest, but also, in *what* circumstances, with *whom* and *how* that are, as yet uncharted.

Inclusion and exclusion criteria

Articles were included only if

- peers were offering support for people with mental health problems

- peers were working in statutory or professionally led services and
- articles were written/published between 1995 and 2010

They were excluded if

- peers were working in a consumer-led service
- peers were not offering support to others experiencing mental distress and
- peers were employed to provide training, interviewing or research
- articles were published before 1995

Search strategy

The procedure began with a broad inclusive title search of databases CINHAL, MedLine and PsycINFO using keywords including: 'mental health', 'consumer', 'survivor', 'recovery' and 'peer support'. Subsequently, the abstracts were screened for reference to 'peer support' and 'mental health'. The screening process involved reviewing abstracts and filtering out those not applicable to the aims of the review, primarily through assessing the abstracts using the inclusion and exclusion criteria. Thirty-eight articles met the inclusion criteria and were retrieved. These are included in a matrix (see Appendix) The search was strengthened by identifying relevant review articles and retrieving all additional relevant articles cited in reference lists. In addition, relevant websites were consulted.

Data analysis

The challenge of including all sources of information in one area lies in the sheer volume of articles generated. A systematic approach was therefore undertaken (a) to identify those that met the inclusion criteria and (b) to organise selected articles and extract key data. All selected articles were entered into a matrix describing study design, intervention and findings (see Appendix), this allowed for systematic critical analysis based on the nature of the article (qualitative, quantitative and comparative/trial). Findings were then categorised into a framework of themes reflecting the areas covered, these provide the structure of the review.

Findings

Definition of peer support

At its core, the peer support 'approach' assumes that people who have similar experiences can better relate and can consequently offer more authentic empathy and validation (Mead & Macneil, 2004, reflecting on peer support). Peer support is generally described as promoting a wellness model that focuses on strengths and recovery: the positive aspects of people and their ability to function effectively and supportively, rather than an illness model, which places more emphasis on symptoms and problems of individuals (Carter, 2000). Mead (2003) offers a short and all encompassing definition of peer support as, '*a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful*'.

In both mutual support groups and consumer-run programmes, the relationships that peers have with each other are valued for their reciprocity; they give an opportunity for sharing experiences, both giving and receiving support and for building up a mutual and

synergistic understanding that benefits both parties (Mead, Hilton, & Curtis, 2001). In contrast, where peers are employed to provide support in services, the peer employed in the support role is generally considered to be further along their road to recovery (Davidson, Chinman, Sells, & Rowe, 2006). Peers use their own experience of overcoming mental distress to support others who are currently in crisis or struggling. This shift in emphasis from reciprocal relationship to a less symmetrical relationship of 'giver' and 'receiver' of care appears to underpin the differing role of peer support in naturally occurring and mutual support groups and PSWs employed in mental health systems (Davidson et al., 1999). It appears therefore that the degree of reciprocity expected from PSWs varies depending on the approach being adopted. Nevertheless, it appears that whatever be the setting, reciprocity is integral to the process of 'peer–to-peer support' as distinct from 'expert worker support'. This is not to say that peer support is not an 'expert role', a point recognised in the training materials used by META, Arizona: 'Peer support is about being an expert at not being an expert and that takes a lot of expertise'. Peer support could therefore be defined as: 'social emotional support, frequently coupled with instrumental support, that is mutually offered or provided by persons having a mental health condition to others sharing a similar mental health condition to bring about a desired social or personal change' (Solomon, 2004, p. 393).

Effectiveness of peer support

Seven randomised control trials (RCTs) met the inclusion criteria for this review (Clarke et al., 2000; Davidson et al., 2004; Dummont & Jones, 2002; O'Donnell, Parker, & Proberts, 1999; Rogers et al., 2007; Sells, Davidson, Jewell, Falzer, & Rowe, 2006; Solomon & Draine, 1995). These describe a range of PSW interventions (peers employed in traditional case management roles and peers employed in new roles explicitly to use their experience; peers employed as additional to members of the team and peers employed instead of traditional members of the team; peers in community services and peers in inpatient and outpatient services), they present inconsistent findings and use varied outcome measures. Therefore, for the purpose of this review, a wider evidence base was used, including follow-up studies and naturalistic comparison studies. The aggregated results paint a more complete picture of the impact of the employment of PSWs.

Benefits for consumers

Admission rates and community tenure. RCTs comparing the employment of PSWs with care as usual or other case management conditions report either improved outcomes or no change. Solomon and Draine (1995) in a 2-year outcome study reported no differences in the impact of care provided by peers and care as usual on hospital admission rates or length of stay. Similarly, O'Donnell et al. (1999) reported no significant difference in admission rates when comparing three case management conditions; standard case management, client-focused case management and client-focused case management with the addition of peer support. It seems prudent to mention that a result of no difference demonstrates that people in recovery are able to offer support that maintains admission rates (relapse rates) at a comparable level to professionally trained staff. Interestingly, however, Clarke et al. (2000) found that when assigned to either all PSW or all non-consumer community teams that those under the care of PSWs tend to have longer community tenure before their first psychiatric hospitalisation.

The majority of the wider evidence on admission rates report positive results, suggesting that people engaging in peer support tend to show reduced admission rates and longer community tenure. Chinman, Weingarten, Stayner, and Davidson (2001) compared a peer support outpatient programme with traditional care and found a 50% reduction in rehospitalisations compared to the general outpatient population and only 15% of the outpatients with peer support were rehospitalised in its first year of operation. Similarly, Forchuk, Martin, Chan, and Jensen (2005) in an evaluation of a model of discharge involving peer support reported that peer support used as part of the discharge process significantly reduces readmission rates and increases discharge rates. In a longitudinal comparison group study, Min, Whitecraft, Rothband, and Salzer (2007) found that consumers involved in a peer support programme demonstrated longer community tenure and had significantly less rehospitalisations over a 3-year period. Finally, in an evaluation of an Australian mental health peer support service providing hospital avoidance and early discharge support to consumers of adult mental health services, Lawn, Smith, and Hunter (2008) found in the first 3 months of operation, more than 300 bed days were saved when peers were employed as supporters for people at this stage of their recovery.

Empowerment. A raised empowerment score has been reported in several studies of peer support (Corrigan, 2006; Dummont & Jones, 2002; Resnick & Rosenheck, 2008). Davidson et al. (1999) attributed improvements in empowerment to the new ways of the thinking and behaving that occur when engaging in reciprocal peer support relationships (PSR).

In a qualitative study of consumer views, Ochocka, Nelson, Janzen, and Trainor (2006) reported that participation in peer support as both a provider and recipient resulted in an increased sense of independence and empowerment. Specifically, consistent engagement in peer support increased stability in work, education and training, which will allow for a sense of empowerment. Furthermore, participants reported gaining control of their symptoms/problems by researching their illness independently, and, consequently becoming more involved in their treatment, thereby moving away from the traditional role of 'mental patient'.

Related to this, several studies state that peer support can improves self-esteem and confidence (Davidson et al., 1999; Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, 2002). This has been attributed to the mutual development of solutions, the shared exploration of 'big' feelings (Mead, 2004) and the normalisation of emotional responses that are often discouraged and seen as crises in traditional health care.

Social support and social functioning. Social isolation is often one of the most significant challenges faced by individuals with mental health problems. Other than superficial social contacts with sales assistants or cashiers, many people have little social contact that does not involve mental health staff (Davidson et al., 2004).

Mead et al. (2001) assert that engagement in a PSR allows participants to create relationships and practice a new identity (rather than that of mental patient) in a safe and supportive environment. This is supported by Yanos, Primavera, and Knight (2001) in a cross-sectional study where individuals involved in consumer-run services had improved social functioning compared to individuals involved in traditional mental health services. One explanation for such a change is that when engaging in peer support, consumers are exposed to differing perspectives and successful role models who may share problem-solving and coping skills and thereby improve social functioning (Kurtz, 1990).

In a longitudinal study, Nelson, Ochocka, Janzen, and Trainor (2006) reported that at 3-year follow-up, consumers continuously involved in peer support programmes scored significantly higher than comparison groups on a measure of 'community integration', which was assessed using the meaningful activity scale (Maton, 1990). This finding is consistent with a previous qualitative study in which members of peer support initiatives in Ontario reported enhanced community integration (Trainor, Shepherd, Boydell, Leff, & Crawford, 1997).

Ochocka et al. (2006) reported that at 9 and 18 months follow-up that consumers receiving peer support reported more friends and more social support not only within the initiatives they were involved with, but also from other settings and relationships compared with participants not receiving peer support. Similarly, Forchuk et al. (2005) found that participants who received peer support demonstrated improved social support, enhanced social skills and better social functioning.

Empathy and acceptance. An important aspect of peer support is the sense of acceptance and real empathy that the peer gains through a sharing relationship (Davidson et al., 1999). In a qualitative study exploring the PSR within mental health, Coatsworth-Puspokey, Forchuk, and Ward Griffin (2006) found that consumers believed that the experiential knowledge provided by PSWs created a 'comradery' and a 'bond', which made them feel that their challenges were better understood.

Similarly, Paulson et al. (1999) demonstrated through qualitative data that there were significant differences in the focus of consumer and non-consumer providers of assertive community treatment (ACT). Specifically, the consumer providers emphasised 'being' with the client, whereas the non-consumer providers emphasised the importance of 'doing' tasks. Moreover, both sets of providers asserted that it was the consumer providers better understanding of what the patient was going through, which was their greatest strength.

Finally, in an RCT comparing the outcomes of people receiving peer support with traditional care, Sells et al. (2006) demonstrated that individuals receiving services from PSWs reported having greater feelings of being accepted, understood and liked compared with individuals receiving traditional care by mental health providers after 6 months.

Reducing stigma. Ochocka et al. (2006) found that participants involved in peer support were less likely to identify stigma as an obstacle for getting work and were more likely to have employment. This makes sense as peers embody the possibility of acceptance and success, so that they can challenge the barriers created by self-stigmatisation: anticipation of discrimination. Indeed, Mowbray, Moxley, and Collins (1998) reported that PSWs recognised that through engaging in peer support they were altering attitudes to mental illness and as such breaking down the stigma and fostering hope in the peers they were working with.

Hope. One of the essential benefits gained from peer support is the sense of hope – a belief in a better future – created through meeting people who are recovering, people who have found ways through their difficulties and challenges (Davidson et al., 2006). The inspiration provided by successful role models is hard to overstate. So many people who have been supported by peers describe their surprise when meeting others who describe similar experiences (cf. Ratzliff et al., 2006).

Benefits for PSWs

Aiding continuing recovery. Giving peer support, like receiving it, results in increased sense of self-esteem. Salzer and Shear (2002) in a qualitative study of 14 interviews with PSWs showed that over half of respondents indicated that they benefited from the feeling of being appreciated and felt their confidence and self-esteem increased and further facilitated their recovery. Similarly, Ratzlaff, McDiarmid, Marty, and Rapp (2006) found that the self-esteem of PSWs improved.

Interestingly, Bracke, Christiaens, and Verhaeghe's (2008) results showed that providing peer support is more beneficial than receiving it in terms of self-esteem, empowerment, etc. This could be due to the importance of employment and the identity shift from consumer to provider, and therefore becoming a 'valued and contributing citizen' (Hutchinson et al., 2006).

Mowbray et al. (1998) interviewed 11 PSWs, 12 months after their employment ended. The PSWs identified money as the primary benefit of the role, followed by the structure of the job, the supervision provided and the safety of a job in which they could disclose their prior difficulties. Respondents felt that the role had allowed them to gain skills, personal growth and self-esteem through doing something worthwhile. Salzer and Shear (2002) also reported that PSWs continued their own recovery by the way of skill development and personal discovery.

Challenging issues in peer support

Boundaries. PSWs may be viewed more like friends than non-peer case managers or clinical staff, especially since they are not only allowed, but also are in fact expected, to disclose personal information and to share intimate stories from their own lives. Mowbray et al. (1998) found that there were some difficulties when PSR took on more friendship roles. Particular to the US context, this brought into question what was considered reimbursable or billable use of time. In the Nottingham project (Coleman & Campbell, 2009), questions arose about how close a PSW should get to the peers with whom they worked – particularly when they had often become friends while using services; socialising might involve drinking, dancing, travelling home together – and then it could be difficult to resume a more therapeutic relationship within a work context. However, Mead et al. (2001) suggested that egalitarian relationships provide an opportunity for both peers and PSWs to grow and create meaningful and reciprocal relationships; boundaries should be flexible and individually governed as to avoid perpetuating the power structure of traditional, formal professional relationships. Furthermore, in a series of interviews with PSWs, Macneil and Mead (2003) found that boundaries, varied from individual to individual and that the PSWs evolved professionally as they learned to reflect upon and articulate their limits.

Power. Mead et al. (2001) pointed out that formalising peer support by offering payment, training and titles will inevitably lead to power differences – even if these are minimised. Furthermore, if these power differences go unrecognised or are not worked through then it could lead to peers being less than honest and saying or not saying things through fear of retribution.

Additionally, many PSWs may have to work with professionals who have treated them in the past (Fisk, Rowe, Brooks, & Gildersleeve, 2000). This could challenge the possibility of respectful equal relationship within the team as staff may fail to treat them as professional equals (Mowbray et al., 1998) or continue to view them as 'patients' (Davidson et al., 1999).

An example of which was reported by Mowbray et al. (1998) who stated that PSWs experienced feelings on the one hand part on the team, however, always of lower status than the other professionals. These attitudes/beliefs are, in actuality, examples of discrimination and, as such, agencies hiring PSWs that do not proactively address this issue will in all likelihood fail. However, it is important to point that although discriminatory beliefs about PSWs ability exist, some research suggests that mental health professionals do view consumer-delivered services helpful [e.g. Hardiman (2007) found that 84% of professionals surveyed believed that service users could provide effective services], but less helpful than professionally delivered services. Interestingly, Dixon, Hackman, and Lehman (1997) examined attitudes towards PSWs comparing staff members who worked with 'consumer advocates' with attitudes of staff members who did not. They found significant differences in 5 of the 30 items examining attitudes and on each of these staff working with PSWs scored more positively. This suggests that PSWs are their own best advocates – changing attitudes through experience of working together. With this in mind, a suggestion presented by the author to address the discrimination issues would be to invite professionals to PSW training courses, they could therefore meet the PSWs and discuss with them the nature of their role and how they fit into the service and so on.

Stress for PSWs. Chinman, Young, Hassell, and Davidson (2006) found that providers were concerned that PSWs might be exposed to stress that could result in a reoccurrence of symptoms that may result in rehospitalisation. This would be detrimental to the PSW and the people with whom the PSW was working – due to the effect it may have on the sense of hope instilled by the perceived recovery of the PSW. Paulson et al. (1999), comparing differences in practices of consumer and non-consumer providers, found that the biggest weakness of the non-consumer teams was the lack of workforce stability due to relapse. Paulson et al. (1999) go on to suggest that an adjustment of staffing patterns is required to account for PSWs greater vulnerability. Yuen and Fossey (2003) found that PSWs emphasise that they need to monitor their own workloads and demands that placed on them, they also need to feel able to take time out when required. McLean, Biggs, Whitehead, Pratt, and Maxwell (2009) also reported that several of the 11 PSWs in the Scottish pilot study had experienced readmissions to hospitals since starting in the role. These admissions were not in the same service that the PSW was working in and that was believed to be a key factor in preserving relationships with colleagues and peers. Furthermore, the PSWs used the experience to enhance the ways in which they could apply their experience to their role.

PSWs reflecting on the benefits and limitations of their employment (Mowbray et al., 1998) stated that some of the people who they were assigned to work with, created stress because they directly affected the PSWs ability to do their job. For example, peers who were 'uncooperative', 'unmotivated', did not turn up for appointments, peers who were very troubled or in major debt, created feelings of frustration, disappointment, failure, fear and guilt. PSWs who had little training were shocked at the levels of disturbance in some clients, some wanted to separate themselves from the people they worked with; some did not feel able to admit their feelings to the staff team; some found it hard to work out what they were supposed to do. This clearly demonstrates the need for support and training.

Accountability. The PSWs in Chinman et al's (2006) study also voiced worries about accountability, especially relating to risk. Mead and Macneil's (2004) talk of a shared responsibility between PSW and peer that moves away from risk assessments towards mutually responsible relationships. This is increasingly referred to as relational risk management or negotiated safety planning wherein control, as far as possible, remains with

the person who appears to be at risk. They are asked what can be done to help them to feel safe; what they would like, where they want to be. The PSW might suggest alternatives that they themselves have found useful or that others have utilised, but ultimately the decision lies with the individual about what will make them feel most comfortable.

Maintaining PSWs' distinct role. It appears to be the case that peer support offers distinctive features that are not currently provided by professional workers: support based on experience rather than professional expertise, more reciprocal relationships and more egalitarian conversations. Questions remain about whether it is possible for professionals who have personal experience of mental health problems to offer this kind of support. Solomon (2004) states that, 'consumer provided services need to remain true to themselves and not to take on characteristics of traditional mental health services' (p. 8). However, there is the risk of PSWs becoming socialised into the 'usual ways of working' or following professional role models in a bid for respect. This is particularly likely when professionals do not value the PSWs' role (see challenges above). Mead and Macneil (2004) assert that the language of mental health plays a crucial role in separating the peer support roles from traditional mental health care. If PSWs feel the need to talk about peers in medical terms to 'fit in' with the team, they neglect the unique personal experience of the peer that they are in a position to capture. Ultimately, this undermines the potential of peer support. One way of maintaining distinctiveness and continually maintaining awareness of the peer relationship is through peer-led training and peer supervision, provided by a service user led organisation and group supervision to share insights, coping strategies and experiences.

Discussion and conclusion

This review has examined the literature and research that describes PSW in professionally led services. In doing so, it has reported on some of the benefits and challenges presented in the employment of PSWs in statutory services as well as attempting to define peer support in statutory services.

Although scarce in the literature, the few experimental trials show that at the very least, PSWs do not make any difference to mental health outcomes of people using services. When a broader range of studies are taken into account, the benefits of PSW become more apparent. What PSWs appear to be able to do more successfully than professionally qualified staff is promote hope and belief in the possibility of recovery; empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks. It is just these outcomes that people with lived experience have associated with their own recovery; indeed these have been proposed as the central tenets of recovery: hope, control/agency and opportunity (Repper & Perkins, 2003; Shepherd, Boardman, & Slade, 2008). In addition, employment as a PSW brings benefits for the PSWs themselves in every reported evaluation. The experience of valued work in a supported context, permission to disclose mental health problems – which are positively valued – all add to self-esteem, confidence and personal recovery. Employment as a peer support working also increases chances of further employment and continued recovery.

The literature also presents a number of common challenges in the employment of PSWs, notably, where PSWs accountability begins and ends, where the boundaries in PSW relationships belong, power issues, both within the peer relationships and with other professionals and the stress of the role on the PSW. Peer support is, however, in its infancy and as such challenges in its introduction are inevitable, the amalgamation of the challenges offered in the current review provide invaluable scope for future research opportunities.

The current study's limitations include the lack of a framework to critically analyse the included articles. Furthermore, due to the wide scoping aims of the review, the findings had to be on a more general level, although this allowed for a wide variety of themes to be covered, each theme in itsself (effectiveness and challenges) could be reviewed exclusively in detail.

The authors propose that future research concentrates on establishing a robust evidence base for the effectiveness of peer support in mental health services in the UK, with a focus on random controlled trials, where appropriate. Furthermore, attention is required into whether PSWs are employed in addition to the team they are working with or included in the team as a part of the numbers/staff rotation. This would provide invaluable insight into how the peer support movement is progressing.

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Appendix

Study	Nature of intervention	Study design (inc sample)	Outcomes/results
RCT			
Clarke et al. (2000)	Conditions were compared on psychiatric hospitalisation, emergency room visit, arrest and homelessness within the 2-year study period between both teams and with community care as usual	Randomised comparison of two ACT experimental conditions (staffed by consumers or non-consumers) and usual community care. Sample: 163 subjects (60.7% male, 39.3% female; mean age, 36.5) all met the Oregon definition of chronically mentally ill	First psychiatric hospitalisation occurred earlier on an average among people receiving non-consumer ACT than with consumer ACT subjects
Davidson et al. (2004)	Comparison of outcomes of symptoms, well-being, self-esteem, social functioning, employment and social support	Comparison of outcomes on three social support conditions: (1) matched with peer volunteer and given an allowance per month for recreational activities, (2) matched with non-peer and given same allowance per month for recreational activities or (3) allowance only with no matched volunteer. Sample: 260 adults receiving outpatient care at community mental health centres with a diagnosis of a serious mental illness	No significant differences were found between the conditions only when frequency of meetings with volunteer were taken into account. In condition (1) improvements were seen only when participants did not meet up with their peer. Whereas in condition (2) participants improved when meeting with their partners. Implications are discussed
Dummont and Jones (2002)	Determining if people with access to a peer-run crisis hostel would experience greater recovery and increased empowerment, lower use of crisis services and reduced total mental health treatment costs when compared to persons without access	265 Participants with a severe and enduring mental illness. Randomised, experimental design with assessment at baseline, 6 months and 12 months	At 12 months, the experimental group had better healing outcomes, greater levels of empowerment, shorter hospital stays and less hospital admissions
O'Donnell et al. (1999)	Compared outcomes between the three conditions of functioning, disability, quality of life, burden of care, service satisfaction, number of hospitalisations, crisis visits and compliance with treatment	Comparison of three case management conditions: (1) standard case management, (2) client-focused case management and (3) client-focused case management with the addition of peer support. Sample: 119 service randomly allocated to one of three conditions	No significant differences found between the three conditions

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Appendix (*Continued*).

Study	Nature of intervention	Study design (inc sample)	Outcomes/results
Rogers et al. (2007)	Examined the effects of consumer-operated service programmes (COSPs) on various aspects of empowerment within the context of a multisite, federally funded, randomised clinical trial of COSPs	Sample: 1827 Individuals from traditional mental health providers. Participants were randomised to either (1) the experimental (attendance at the COSP under study in addition to usual traditional mental health services) or (2) control group (usual traditional mental health services only)	Individuals who received the consumer-operated services perceived higher levels of personal empowerment than those in the control intervention. However, results were modest
Solomon and Draine (1995)	Looked at: symptoms, social support, hospitalisations, quality of life, satisfaction and working alliance	RCT; comparison of two case management teams comprised of (1) non-peers and (2) peers. Sample: 96 service users	No significant differences found between conditions
Sells et al. (2006)	Compared the quality of treatment relationships and engagement in peer-based and regular case management	Sample: 137 People with severe mental illness. Longitudinal randomised clinical trial with two levels of case management intervention (peer and regular) and two interviews (6 and 12 months)	Participants perceived higher positive regard, understanding and acceptance from peer providers rather than from regular providers at 6 months only. No differences observed at 12 months
Quantitative research			
Corrigan (2006)	Cross-sectional design comparing measures of recovery and empowerment on people having received peer support and those that have not. Sample: data obtained from 1824 service users with a DSM-IV diagnosis during a baseline assessment of a consumer-operated services project	To examine the relationship between receiving peer support and measures of recovery and empowerment	Participation in peer support was associated with increased levels of empowerment as measured by an empowerment scale
Forchuk et al. (2005)	Description and evaluation of a model of discharge; transitional discharge, which involves peer support		Peer support used as part of discharge process reduces readmission rates and increases discharge rates
Hardiman (2007)	Mailed survey, self-administered questionnaire and random sample; 335 mental health providers	Knowledge of consumer-run programmes, attitude towards consumer-run programmes and referral rates to consumer-run programmes	53% of respondents knew about local consumer-run services, 45% of respondents had referred to consumer-run services and 94% respondents stated that trained professionals provide 'the best' mental health services

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Study	Nature of intervention	Study design (inc sample)	Outcomes/results
Hodges et al. (2003)	Sample: 311 service users who used professional mental health services. 151 (49%) of which also used self-help services. Multiple regression analysis of scores on a client satisfaction scale (CSQ 8)	To test the hypothesis that users of mental health self-help services would be more satisfied with professional mental health services than clients who did not use self-help services	Multiple regression analysis of scores shows that being involved in self-help services encourages satisfaction with professional mental health services
Hutchinson et al. (2006)	66 Individuals participated in an evaluation of a 60-hour, 5-week long peer training programme. Participants were assessed prior to and after the training on scales to measure recovery, empowerment and self-concept	Examination of the feasibility of a structured peer provider training programme and its effect on peer providers with respect to their own personal and vocational recovery	Participants experienced gains in perceived empowerment, attitudes towards recovery and self-concept. Trainees went on to obtain peer provider positions within the mental health agency in which they received the training and 89% of those trained retained employment at 12 months
Lawn et al. (2008)	Evaluation of the first 3 months of operation of an Australian peer support service providing hospital avoidance and early discharge support	Key indicators: Bed days saved, readmission rates	Three hundred bed days saved. Peer support suggested to be highly effective as an adjunct to mainstream services
Min et al. (2007)	Longitudinal, comparison study. Sample: 106 individuals participating in the peer support programme	A comparison on 3-year rehospitalisation patterns of people participating in a peer support programme and matched individuals who had not been involved with the service	Peer support programme participants show longer community tenure. Over the 3 years, 73% in comparison group rehospitalised compared to 62% of those involved in the peer support programme
Nelson et al. (2006)	Longitudinal comparison study of (1) active participants in consumer/survivor initiatives (CSIs), (2) non-active participants. Sample: CSI participants ($n=61$), non-active participants ($n=57$)	Social support, community integration, personal empowerment, quality of life, symptom distress, days of hospitalisation and use of emergency services	At 9 months, significant reduction in use of emergency room services for active participants compared to non-active. At 18 months, significant improvement in social support, quality of life and reduction in days in hospital for active participants. No significant changes on these outcomes for non-active participants

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Study	Nature of intervention	Study design (inc sample)	Outcomes/results
Nelson et al. (2007)	Longitudinal comparison study of: (1) active participants in CSIs at 36 month follow-up ($n=25$), (2) active participants at 9 and 18 month follow-up but not at 36 months ($n=35$) and (3) non-active participants (comparison group) ($n=42$)	Social support, community integration, personal empowerment, quality of life, symptom distress, days of hospitalisation, use of emergency services and instrumental role involvement	The active participants at 36 month follow-up scored significantly higher on community integration, quality of life and instrumental role involvement and significantly lower levels of symptom distress
Paulson et al. (1999)	Comparison of practice of consumer-run ACT and non-consumer run ACT. Teams were in separate offices but shared a psychiatrist, clinical director and nurse practitioner. Each team comprised five staff and had caseloads averaging five per staff member	Practice assessed through daily activity log, case manager interviews at 6, 12 and 18 months and observations after 8 and 16 months	Practice patterns reflect normal expectations of assertive outreach model. Neither significant differences in type, amount or location of activity, nor in levels of consumer participation in care. But consumers saw more clients at office (boundaries less distinctive) and consumer service was closely aligned to recovery with relationships and clients' choice paramount. Conclude that cultures differed: being vs doing
Resnick and Rosenheck (2008)	Peer education and support vs standard care on measures of recovery orientation, confidence and empowerment, symptoms, functioning, quality of life and engagement. PSW was support by and for veterans with professional assistance only as requested by participants	Participants were recruited in two consecutive cohorts between 2002 and 2006, one before the implementation of the Vet-to-Vet (peer support) programme in June 2002 (cohort 1; $n=78$) and one after (cohort 2; $n=218$). Follow-up interviews were conducted at 1, 3 and 9 months, respectively	Significant differences in improvement for Vet-to-Vet group on empowerment, confidence and functioning
Schmidt, Gill, Pratt, and Solomon (2008)	Consumer provider on a conventional case management team serving people with a serious mental illness improves service delivery and client outcomes when compared to teams staffed only by non-consumers	Retrospective co-hort study with random assignment of consumers of mental health services to community mental health teams. The study compared client outcome measures and service delivery with teams staffed by non-consumers	Overall results show that consumer providers with significant life experience, but limited post-secondary education, can be effective members of conventional case management teams that produce comparable outcomes to teams comprised exclusively of non-consumer, professionally trained staff

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Study	Nature of intervention	Study design (inc sample)	Outcomes/results
Solomon and Draine (1996)	Determined whether a team of mental health service consumers delivered intensive case management services differently than a team of non-consumer case managers	Sample: 96 people with mental health problems randomly assigned to consumer or non-consumer case managements	Consumer case managers delivered more services face-to-face with the client and fewer services in the office and in interactions with family members or other mental health service providers
Verhaeghe, Bracke, and Bruynooghe (2008)	Structured questionnaire. Sample: 595 clients at rehabilitation centres	Self-esteem and stigmatisation	Peer support associated with less stigmatisation. However, only with clients with fewer stigmatisation experiences
Yanos et al. (2001)	60 Participants with past or present psychiatric diagnosis	Recruitment from a mental health centre and two consumer-run programmes to determine if involvement in consumer-run services is positively associated with recovery	Participants in consumer-run programmes had better social functioning than those in traditional mental health services
Qualitative research			
Bracke et al. (2008)	The effects of the reciprocity of peer support on self-esteem and self-efficacy are explored in the peer groups of clients of day-activity programmes of rehabilitation centres	A survey using structured interviews to collect data from clients at rehabilitation centres providing day-activity programmes for people with chronic mental health problems in Flanders (Belgium) Sample: 628 (396 male, 232 female, mean age = 44) users of vocational and psychiatric rehabilitation centres ($n = 51$)	Providing peer support is more beneficial than receiving it. One conclusion is that the net beneficial effects of receiving support from peers are overestimated. Support providers are also more willing to seek support from others and vice versa
Chinman et al. (2006)	Focus groups and interviews used to assess the similarity and differences in beliefs towards peer support services from patients, providers and administrators. Also strategies discussed to overcome potential challenges of peer support services	Surveys, interviews and focus groups. Sample: 110 Administrators, patients and providers at three veteran administration clinics in Southern California	Numerous concerns from providers about PSWs competence and vulnerability. Number of strategies discussed to overcome potential barriers to peer support implementation
Coatsworth-Puspoky et al. (2006)	To explore and describe the PSR	Ethonursing, interviews. Sample: 14 service users who had previously received support in PSR	PSRs develop or deteriorate in three overlapping phases

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Study	Nature of intervention	Study design (inc sample)	Outcomes/results
Dixon et al. (1997)	Semi-structured interviews and questionnaires. Sample: Staff in assertive community teams who (1) worked with consumer advocates and (2) didn't work with consumer advocates	Attitudes of staff towards service users	Staff who had experience of working with consumer advocates had a more positive attitude towards service users
Gates and Akabas (2007)	This study informs new strategies that promote integration of peer providers into the staff of social service agencies	Executive directors, human resource managers, supervisors and co-workers at 27 agencies in New York city were interviewed in-depth. Focus groups with peers were conducted	Respondents identified attitudes towards recovery, role conflict and confusion, lack of policies and practices around confidentiality, poorly defined job structure and lack of support as problems that undermined integration. Strategies to overcome these issues are discussed
Janzen, Nelson, Trainor, and Ochocka (2006)	System-level findings reported on: public education, political impacts, community planning and collaboration impacts	Quantitative and qualitative report on system-level findings of a longitudinal study of CSIs	Qualitative data suggests a number of perceived system-level outcomes. Also that the staff and members of CSIs participated actively in system-level activities
Leung and De Sousa (2002)	Interviews with stakeholders currently delivering or having had experience with peer support services to give direction to the Canadian mental health association	30-minute interviews. Sample: 15 stakeholders (consumers, consumer groups and agencies)	Conclusions made included that peer support offered adjunct to mainstream services will contribute to fulfilment and self-actualization
Macneil and Mead (2003)	Share findings that begin to identify fidelity standards of peer support	Report on ethnographic evaluation study of a peer-run crisis service	Peer support promotes critical learning, provides a sense of community, provides flexibility of support and there is a sense of mutual responsibility in the PSR
Mowbray et al. (1998)	PSWs were trained and provided with paid employment and supervision. They recognised advantages of non-stigmatising environment and the skills learnt on the job	Interviews with PSWs employed on the WINS (work incentive and needs study) for people with substance misuse problems 12 months after employment ended. Sample size ($n = 11$, 6 males and 5 females)	Benefits: source of income, rewards of work, transferable skills like coping with the routine of work, skills in getting work, assertiveness skills and confidence, personal growth – patience, anger management, normalising preparation for other employment and Friendship network. Negatives: Could be

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Study	Nature of intervention	Study design (inc sample)	Outcomes/results
			difficult working with people who would not help themselves; some of the clients did not want to engage, which was frustrating. Tough job, some were disappointed with their own performance, some always felt slightly unprepared or unsupported
Mowbray et al. (1996)	Examination of the issues created by employing consumers as peer support specialists for the project. Roles and benefits of these positions are analysed	Data evaluated from a CSP-funded research demonstration project designed to expand vocational services offered by case management teams serving people with serious mental illness	Implications for consumer role definition, supports for role effectiveness and the structuring of these types of positions are discussed
Salem, Reischl, Gallacher, and Randall (2000)	Identifying the role of referent power and expert power with schizophrenia anonymous (SA) members, SA leaders and with mental health professionals	Sample: 156 Users of SA survey	Participants reported higher levels of expert power for mental health professionals and higher levels of referent power with SA members
Salzer and Shear (2002)	Systematically examination of consumer–provider benefits	Sample: 14 Peer providers from friends connections, a peer-support programme for persons with recurring mental health and substance use disorder interviews	Responses indicate that peer providers benefit from their roles as helpers, a finding consistent with the helper-therapy principle. Implications for research and policy are discussed
Trainor et al. (1997)	The impact of consumer/survivor development initiative (CSDI) membership on the use of mental health services was examined	Over 600 consumers from the CSDI of Ontario, Canada	CSDI members used a fewer mental health services, noted an increase in community involvement and contacts, found consumer/survivor organisations to be more helpful than traditional mental health services and found other consumer/survivors as individuals to be more helpful professionals with mental health issues
Yuen and Fossey (2003)	Identifying the rewards and challenges of working as a PSW	Purposeful sampling; three PSWs interviews	Analysis of participants' views identified eight themes: (1) wanting purposeful activity, (2) the importance of work, (3) rewards of helping others, (4) re-establishing social networks, (5) gaining a sense of belonging, (6) experiencing teamwork, (7) challenges of working and (8) maintaining well-being

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Study	Nature of intervention	Study design (inc sample)	Outcomes/results
Literature/systematic reviews			
Davidson et al. (2006)		Review of four RCTs on peer support	All RCTs demonstrated very few differences between conventional care and care provided by PSWs. It is suggested that peer support requires further exploration and evaluation if it is to be considered as a form of mental health service provision
Davidson et al. (1999)	Literature review on peer support		
Kurtz (1990)	Review of self-help research		
Nelson et al. (2006)	Literature review on CSIs		
Simpson and House (2002)	Systematic review		
Woodhouse and Vincent (2006)	Literature review		