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Evidence Review Peer Support and Peer Delivered Service

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EVIDENCE REVIEW

Peer Support & Peer-Delivered Services:

A Brief Look at the Evidence

November 2022

CORE | Center for Outcomes Research and Education

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Evidence for Peer Support: Key Takeaways

In 2007, the Centers for Medicare and Medicaid Services (CMS) recognized peer support as an evidence-based model of care for behavioral health and approved coverage for the provision of peer-delivered services. This led to an expansion of peer-delivered services in both healthcare and community-based settings, and a wide variety of peer employee titles, program settings, models, and program goals/outcomes.

In this review we provide a brief history of peer support within the United States and the state of Oregon, a summary of outcomes and evidence pertaining to peer-delivered services that have been examined within the literature, and an overview of areas for future research. This review aims to:

- Support peer programs as they consider potential outcomes or impacts to track for peer-delivered services and programs.
- Provide accessible information that organizations can use to advocate for peer workforce development or financing.

Overall, we found that peer support and peer-delivered services are effective and produce positive outcomes within participant populations.[1–10] The studies examined included a wide diversity of peer program models, populations, study designs, and delivery settings which highlights the challenge of comparing or aggregating evidence across distinct peer programs and contexts. Despite these challenges there is a growing body of literature demonstrating strong evidence to support several clinical and social outcomes for peer delivered services.

Southern Oregon Peer Workforce Project Background

In 2022 the Center for Outcomes Research & Education (CORE) collaborated with interested parties in Southern Oregon (So. OR) on a project to develop collaborative recommendations to strengthen the peer workforce. The project aims to cultivate and support:

- Shared learning across peer programs
- Increased ability to advocate for funding and workforce improvements
- Strengthened capacity to evaluate what is working within and across peer programs

This **Evidence Review** is one of several products from this project. The others are linked below and include:

1. A full Project Report with four additional briefs highlighting promising practices related to Peer Training & Certification, Supervision & Support, Professional Development & Career Pathways, and Additional Priorities for Peer Services.
2. A PowerPoint presentation highlighting information from the project.

Key Takeaways: Outcomes & Evidence

Evidence of clinical outcomes There is strong evidence to support the impact of peer-delivered services on the following clinical outcomes:	• Reduced hospitalization/rehospitalization • Reduced substance use • Increased engagement with treatment & services
Evidence of social outcomes There is strong evidence to support the impact of peer-delivered services on the following social/psychosocial outcomes:	• Increased quality of life (QOL) • Increased hope and empowerment • Increased social support

Literature Gaps & Areas for Future Research

- Limited studies disaggregate outcomes and experiences by race/ethnicity, language, sexual orientation, and gender
- Gaps exist in the research on culturally specific peer-delivered services and models
- More attention to the specifics of implementation for peer-delivered services
- Standardize measurement and use consistent scales to measure outcomes
- Include more detailed definitions of peer-delivered services and clarify peer roles and responsibilities in interventions
- Limited research into economic outcomes related to the cost-effectiveness of peer-delivered services in varied settings

History of Peer Support

Informal peer support has been part of the recovery process for multiple behavioral health conditions for decades. However, only recently has hiring and collaborating with peers come into mainstream use.

Historically, peer support has been based on mutual aid and grassroots movements and can be tied to consumer, survivor, or ex-patient advocacy for peer services.[1] Support and advocacy for the integration of peers into primary care and behavioral health settings began in the late 1960s.[1]

However, peer-delivered services have become more formalized in recent years following CMS's acknowledgment of peer-delivered services as an evidence-based model of care for mental and behavioral health.

Within the state of Oregon, peer support has reportedly been used since the late 19th century. However, within the last ten years, the State of Oregon established the Traditional Health Worker (THW) Commission to specifically support and promote the role, engagement, and utilization of the traditional health workforce, which includes two types of peer worker types (peer support specialists and peer wellness specialists) as well as personal health navigators, community health workers, and doulas. The timeline to the right depicts a brief history of peer support in the United States (purple text) and in Oregon (green text) from the 1970s through 2020.

1970	The Insane Liberation Front founded in Oregon is often cited as the first mental health consumer-run rights group
1980-1989	Expansion of drop-in centers and other peer-run organizations helped forge formal support for peers and peer services.
1990-2000	During this period there was limited integration of peers and peer services into the mental health and behavioral health system.
2003	A strong recommendation for the development of the peer workforce was made in the President's New Freedom Commission report.
2005	The Department of Veterans Affairs began incorporating peer services into their treatment model.
2007	The Centers for Medicare and Medicaid Services (CMS) recognized peer services as an evidence-based model of care and approved coverage for the provision of peer services.
2011	Oregon Legislature passed HB 3650, mandating the development and implementation of a plan to integrate Traditional Health Workers into Oregon's Health System Transformation process.
2013	Oregon's Traditional Health Worker (THW) Commission established to promote the traditional health workforce in Oregon and provide advice and recommendations to support Oregon's Health Care System.
2018	Mental Health America releases National Certified Peer Specialist Certification for advanced peer certification.
2020	Oregon approves 21 peer support certification trainings statewide with 2,834 certified peers on the THW Registry.

What is Peer Support?

The definitions and classifications of peers vary across the literature. The Substance Abuse and Mental Health Services Administration (SAMSHA) defines peer support as "a range of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both."

Peer support offers a level of acceptance, understanding, and validation not found in many other professional relationships.[28] By sharing their own lived experience and practical guidance, peers help people to develop their own goals, create strategies for self-empowerment, and take concrete steps towards building fulfilling, self-determined lives for themselves.[29]

Peer Support: Assessing the Evidence

This evidence review includes studies related to the effectiveness of peer-delivered services in behavioral health and SUD settings. Global studies as well as studies that were conducted in the United States are included and studies span the years between 2006-2022.

Included in this review are a variety of study types (e.g., randomized control trials, systematic reviews, meta-analyses, literature reviews, and mixed methods studies). For the purposes of this summary, we defined strong evidence as:

- Statistically significant study findings related to an outcome for peer-delivered services
- An outcome evaluated as part of a high-reliability study
- Evidence from studies with low risk of bias

For studies to be considered as providing strong evidence they needed to meet at least one of the bulleted conditions above. For additional information about strength of evidence please see Appendix A- Methods.

Limitations of Assessing the Evidence via Literature Reviews

Publication bias, the widely acknowledged pattern of peer reviewed journals to be more likely to publish studies with strong or positive findings, can distort our understanding of the evidence. Additionally, there are unknown varying factors and priorities that motivate researchers and funders to choose to study certain outcomes over others. In our review, for example, we found seven total studies examining hospitalization/rehospitalization and only two studies that reviewed for self-esteem; However, we cannot use this information alone to make the comparative determination that 'peer programs have a stronger impact on hospitalization vs self-esteem' because of the unknown factors and priorities that lead to the studies and publication of these specific outcomes in the first place.

Settings, populations & perspectives within the body of literature

Settings Peer services are delivered within a range of settings, including:	• Child welfare agencies • Drug courts and other criminal justice settings • Homeless shelters • Hospital emergency departments • Permanent supportive housing programs
Populations Peer-delivered services are provided to a wide range of populations and include the following:	• Adults with PTSD • Adults and youth with serious mental illness • Formerly incarcerated individuals • Individuals in SUD recovery • LGBTQIA+ • Veterans • Young adult and adult persons experiencing homelessness • Youth and families • Various ages, races/ethnicities, and genders
Perspectives The most common outcomes found in this review are reported from:	• Participants • Peers • Clinicians, therapists, or other members of a care team • Payors • Quality regulators

Peer Support: Outcomes

Extensive research on the efficacy of peer-delivered services in mental health, behavioral health, and SUD settings has been conducted through randomized control trials, systematic reviews, meta-analyses, literature reviews, and mixed methods studies.

These studies evaluated the impacts of peer-delivered services on participants by examining outcomes such as hospitalization/rehospitalization, emergency department (ED) use, substance use, engagement with treatment and services, symptom severity (psychiatric and SUD symptoms), provider engagement, Quality of Life (QOL), hope and empowerment, social support, self-esteem, depression, employment, social functioning, housing stability, criminal justice status, loneliness, coping skills, recovery (including self-perceived recovery), and patient satisfaction. In our review of the literature on peer-delivered services, we found that reported outcomes are generally separated into two main categories: Service and clinical outcomes or social/psychosocial outcomes (see below for more information).

Outcomes defined & categories

Service & clinical outcomes These measures may be binary (yes/no), numerical (a percentage), or related to patient care/care delivery (e.g., reduced substance use; increased engagement with treatment and services) and are typically captured in claims or electronic health records data.[2,10–12]	**These outcomes focus on:** • Access to care • Care utilization • Changes in symptoms	**Most commonly examined outcomes:** • Hospitalization/hospitalization • Substance use • Engagement with treatment and services • Symptom severity (psychiatric & SUD symptoms)
Social/psychosocial outcomes These measures are more subjective and personal (e.g., increased QOL; gaining a sense of self-efficacy).[2,10–12]	**These outcomes are generally self-reported & focus on:** • Feelings of being supported • Individuals' belief in their ability to reach goals • Self esteem	**Most commonly examined outcomes:** • Hope & empowerment • QOL • Social support

Evidence Highlights: Clinical outcomes

The use of 1:1 peer support for participants experiencing serious mental illness (SMI) is well documented and shown to reduce hospitalization/rehospitalization and increase participants' engagement with treatment and services.[2,9,13,14] Other studies have evaluated the effectiveness of peer-delivered services in relation to participants with SUDs. Evidence from several studies suggests that peers are effective in helping participants reduce substance use episodes and/or relapse, increase abstinence from substance use, and significantly increase sustained engagement with treatment.[1,15–17] For more detailed information about the studies included in this review please see Appendix B.

Table #1 depicts outcomes where key strong evidence has been found to support the effectiveness of peers and peer-delivered services based on service and clinical outcomes.

TABLE #1: Studies that found strong evidence for service and clinical outcomes

Reduced hospitalization/ rehospitalization	• Recovery mentors notably reduced duration of hospital stays among participants they worked with.[14] • Participants assigned a recovery mentor had significantly fewer hospital admissions and hospital days over a nine-month period.[14] • Family-led peer support interventions significantly reduced rehospitalization rates and durations of stay.[9]
Reduced substance use	• Peers were found to reduce substance use and relapse among adult homeless participants.[1] • Participants in peer support group treatments showed higher rates of abstinence compared to treatment as usual.[17] • The sustained recovery management model can be beneficial in treating relapse and the chronic nature of addiction.[16]
Increased engagement with treatment and services	• Increased engagement in or completion of treatment in participants that engaged with peers.[6] • Participants receiving peer services were 3x as likely to engage with treatment one-year post-services.[17] • LGBTQIA+ participants that engaged with peers stated an increase in engagement in treatment.[18] • Participants engaged in a sustained recovery management model showed improved access to care and retention in care.[16]

Reduced hospitalization/rehospitalization

One study of a companion peer model in which participants self-identify goals and the peer meets the participant where they are in their recovery found that peers have a positive impact on reducing rehospitalizations among persons with SMI.[14] Participants who were assigned a peer, in addition to treatment as usual (TAU), had significantly fewer hospital admissions and hospital days over a nine-month period compared to patients that were assigned to TAU only and did not receive peer-delivered services.

Another study found that participants working with a peer changed how often they sought emergency services, instead using primary care services in place of the emergency room as their main connection to healthcare services.[13] Kelly et. al. note that peers have a direct impact on hospitalization rates because they offer guidance for participants to seek appropriate medical care, reducing psychiatric episodes and therefore can contribute to reductions in hospitalizations.[13]

Reduced substance use

Stanojlovic and Davidson found that peers are effective along the continuum of care for participants struggling with SUD.[16] Peer-delivered services provided during initial stages of recovery, when participants were just beginning to engage with treatment, helped participants improve their access to care, retention in care, and other treatment and recovery outcomes during later stages of their recovery.

Increased engagement with treatment and services

Peers have also been found to increase engagement with treatment and services among LGBTQIA+ individuals with mental distress and/or SUD.[18] Willging et al. found that that at the six-month follow-up, participants that engaged with peers stated an increase in engagement in treatment.[18] Peers increased

participants' engagement in treatment by offering information about services and treatments available that participants may not have previously known about. Additionally, they provided advocacy for their participants, making participants feel more supported when engaging with treatment and more capable to communicate needs and negotiate with providers.[18]

Evidence Highlights: Social/psychosocial outcomes

Studies show the social impact of peer-delivered services on QOL, hope and empowerment, and social support. Young adult, adult homeless populations, and low-income participants struggling with SMI that received peer-delivered services have shown increases in QOL.[1,12,19] Other studies examined peers as they engage with participants impacted by SUD. Evidence from these studies suggests peers are effective in increasing hope and empowerment and increasing social supports with various populations.[1,3,10,18]

Table #2 depicts outcomes where key strong evidence has been found to support the effectiveness of peers and peer-delivered services based on social/psychosocial outcomes.

TABLE #2: Studies that found strong evidence for social/psychosocial outcomes

Increased QOL	• Intentional peer support (IPS), a specific approach to peer services, had significant positive impact on participants upon follow-up between 3 and 12-months post baseline.[1] • Participants in a peer-run hospital diversion program reported increased satisfaction with their QOL after receiving services.[19] • Participants with SMI that received peer-delivered interventions showed positive effects upon their QOL compared to treatment as usual.[12]
Increased hope and empowerment	• One-to-one peer support can have a positive impact upon self-reported empowerment upon follow-up between 6 to 12 months.[10] • Participants in two statewide initiatives using Wellness Recovery Action Planning reported significant increases in their hopefulness for their own recovery.[3]
Increased social support	• IPS has shown to increase social supports among adult homeless participants.[1] • LGBTQIA+ participants had strengthened social networks and reduced feelings of social isolation upon 6-month follow-up post baseline.[18] • Participants that received at least 10 sessions of individual peer support reported reduced social isolation, increased social skills, widening social networks, and decreased social anxiety.[5]

Increased Quality of Life (QOL)

One study compared the quality and type of services received in a peer-run hospital diversion program (PRHDP) to a non-peer-run acute inpatient program. The study found that participants enrolled in the PRHDP were more likely to report satisfaction with their QOL compared to participants enrolled in the non-peer-run acute inpatient program.[19] Participants attributed increases in QOL to peer providing more client-centered and less restrictive services within the PRHDP, which allowed for greater flexibility in their mental health recovery.

Increased hope and empowerment

A study that evaluated the outcomes of two statewide initiatives in Vermont and Minnesota using Wellness Recovery Action Planning indicated that participants in both states reported significant increases in

hopefulness for their own recovery.[3] Peers have their own lived experience with mental health and SUD issues and can share stories about their own recovery. This can enhance participants feelings of hope and empowerment for their own recovery journey.

Increased social support

A qualitative study of adults with psychiatric conditions found that participants who had received at least 10 sessions of individual peer support reported reduced social isolation, increased social skills, widening social networks, and decreased social anxiety.[5] Peers offer the opportunity for participants to engage in recreational activities such as local walks, movies, or coffee and meals. They also provide opportunities for participants to engage with other people experiencing the same thing. This has been shown to increase social supports for participants and help them increase their supportive social networks.[5]

Literature Gaps & Areas for Future Research

There are several challenges to evaluating the strength of evidence in peer-delivered services. Addressing these gaps and areas for future research will allow for clearer assessments of outcomes, more reliable evaluations, increased ability to compare and/or aggregate data across programs, and a stronger overall evidence base for peer-delivered services.

- **Limited studies disaggregate outcomes and experiences by race/ethnicity, language, sexual orientation, and gender**
  While most studies included demographic information for participants (and often included diverse participants), few studies that we looked at explicitly disaggregated the results of peer-delivered services by race/ethnicity, language, sexual orientation, or gender. Many communities face additional challenges in their recovery journey due to racism, nativism, homophobia, and other types of systemic oppression and these show up in disparities related to access to quality treatment, program completion, recovery rates, involvement with the criminal justice system, and more. As we build the evidence for what makes effective and impactful peer services, it is critical that the evidence is grounded in the experiences of all communities.
- **Significant gaps exist in the research on culturally specific peer-delivered services and models**
  There is a significant need to evaluate the efficacy of culturally specific peer delivered services.[2,16] Black, Indigenous, and people of color communities have much lower rates of behavioral health utilization. The 2021 Coalition of Communities of Color report on behavioral health in Oregon attributes much of this to a dearth of multicultural and multilingual providers and hesitation based on previous experiences of racism, discrimination, and cultural insensitivity.[20] Culturally specific models are based on the same premise as the peer model itself- that shared life experiences and the knowledge and perspective gained from that experience provides a powerful type of support that dominant culture clinical models cannot replicate.
- **Limited research into economic outcomes related to the cost-effectiveness of peer-delivered services in varied settings**
  There has been some research into the cost-effectiveness of peer-delivered services in primary care but more research into other peer-delivered service settings, such as behavioral health and community-based settings, is necessary. Explicit studies that examine the cost effectiveness of peer services (especially in relationship to costly interventions like hospitalization) could provide more evidence to

support the expansion of peer-delivered services. Understanding the economic outcomes of peer-delivered services requires further research into the cost-effectiveness of these services in more varied settings.[7,11,12,21]

- **More attention should be made to the specifics of implementation for peer-delivered services**
  While there is significant evidence that peer-delivered services can contribute to positive outcomes for participants, much less is known about the particulars of how these programs are designed and how implementation impacts outcomes. Organizational/administrative considerations such as the types and extent of training that peers receive, retention rates of peers within a particular organization, and the quality and frequency of supervision can have significant impacts on participant outcomes. Yet in many of the studies reviewed these considerations were not well detailed.

  Addressing the varying aspects of implementation can help support peer programs and address barriers to sustaining and scaling peer delivered services. The duration of services, types of services peers provide (group, individual, advocacy, etc.), and frequency/intensity of their contact with a participant can vary widely between settings.[5,15,18] Future research that can provide actionable recommendations for peer programs and models can help advance the workforce and model.

- **Standardize measurement and use consistent scales to measure outcomes**[2,6,9]
  Future research could utilize consistent tools/scales to measure outcomes more effectively. In Oregon, peer-delivered service providers are considered "traditional health workers" along with community health workers (CHWs), and doulas. Existing efforts by the CHW Common Indicators Project to develop a set of standardized measures within CHW programs, defined by CHWs themselves, is a promising model that could potentially be replicated within the peer profession.[22]

- **Include more detailed definitions of peer-delivered services and clarify peer roles and responsibilities in interventions** [2,10,15,23]
  When studies do not include detailed definitions of peer roles and responsibilities and clarify what they mean by peer-delivered services, it makes it difficult to conduct comparative reviews of effectiveness and generalizing findings becomes more complicated.

Conclusion

In our review of the literature, we found that peer-delivered services are effective and produce positive outcomes for individuals engaging with peer services. While the strength of evidence around certain outcomes varies, most research demonstrates that peer-delivered services have a positive impact for people living with mental illness and SUD, and that the addition of peers can add to the effectiveness of services. Peers instill hope in those they work with by demonstrating that recovery is possible, offering stories via personal experience, showing people the steps they need to take towards recovery, and providing access to necessary resources to help with recovery.

With the mounting evidence about the overall effectiveness of peers we can progress from asking whether peer-delivered services work and instead, further explore the questions: Under what circumstances do peer-delivered services work best? And how do we best support peers to fully leverage their unique qualities and skills? The peer workforce is quickly growing, and researchers and organizations alike should take the time to further study the areas in which peers are most effective, which implementation practices best support peers, and which validated tools/scales should be used to measure peer-delivered service effectiveness.

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Appendix A- Methods

This review was conducted with two separate literature searches using Oregon State University's 1Search engine. 1Search queries relevant databases such as Cochrane, MEDLINE (PubMed), EMBASE, PsychInfo, CINAHL, and government websites and databases. Relevant articles related to the effectiveness of peers/peer-delivered services working in behavioral health, and SUD were included. Global studies and studies that were conducted in the United States were included. Studies that are included span the years between 2006-2022. Systematic reviews and individual articles are both included in this review.

Keywords used within the literature search include peer; peer support worker; mental health; behavioral health; substance use; addiction; impact; effectiveness; effectiveness of peer support workers; impact of peer support workers; effectiveness of mental health peers; impact of mental health peers; effectiveness of addictions peers; impact of addictions peers.

Additionally, a variety of study types (e.g., Randomized Control Trials, systematic reviews, mixed methods studies, etc.) were included in this evidence summary; therefore, the criteria for strong evidence means a few different things. For the purposes of this summary, we generally define strong evidence as:

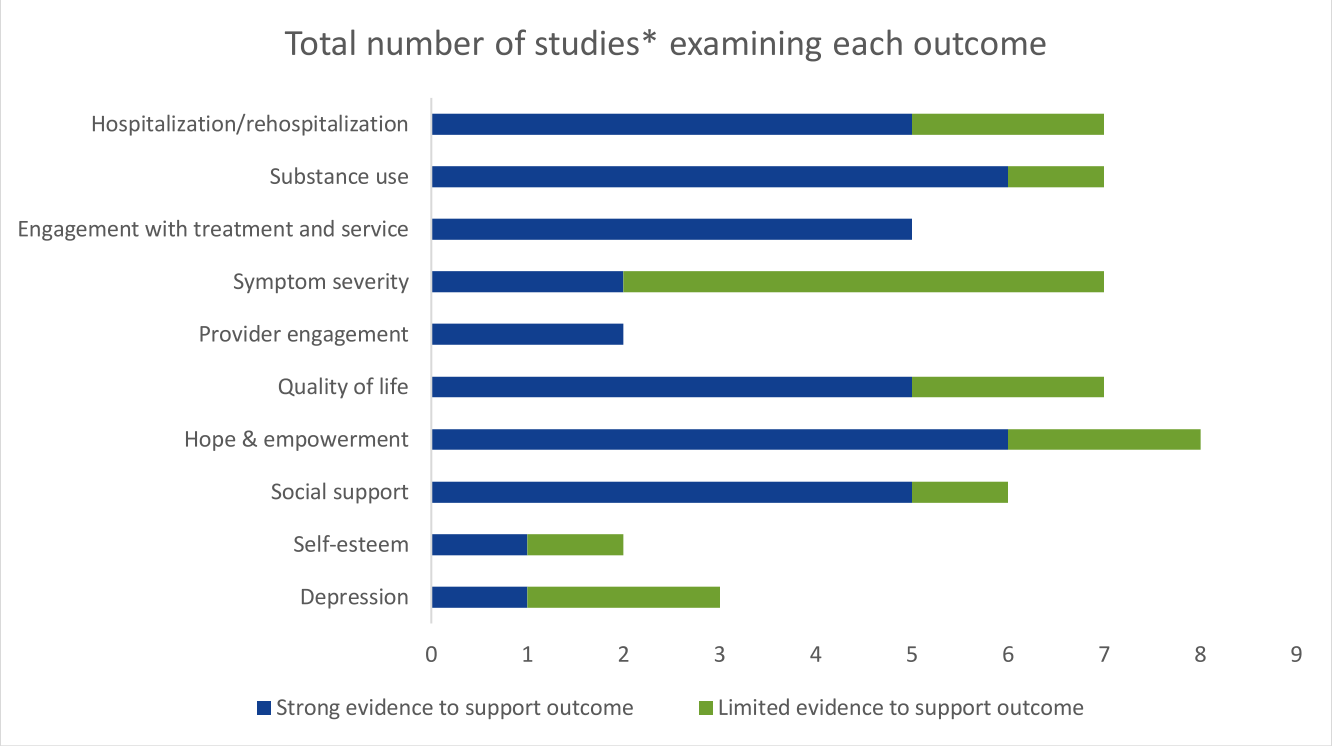
- Statistically significant study findings related to an outcome for peer-delivered services
- An outcome evaluated as part of a high-reliability study
- Evidence from studies with low risk of bias

When we report that studies found limited evidence for specific outcomes, for example symptom severity, this means a few different things including:

- The impact of the outcome was not statistically significant within the specific study
- There may have been a high risk of bias within the study
- Longer interventions may be needed to determine the impact of the outcome

Appendix B- Studies in this review

The chart and two tables below (table #3 and #4) depict information regarding the studies included in this review. The tables illustrate either service and clinical outcomes or social/psychosocial outcomes and different studies that show strong evidence (✓) or limited evidence (○) to support the effectiveness of the listed outcome.



*Total number of studies included in this report

TABLE #3: STUDIES AND FINDINGS ON SERVICE & CLINICAL OUTCOMES

	HOSPITALIZATION/ RE-HOSPITALIZATION	SUBSTANCE USE	ENGAGEMENT WITH TREATMENT & SERVICES	SYMPTOM SEVERITY (PSYCHIATRIC & SUD SYMPTOMS)	PROVIDER ENGAGEMENT
Wang et al, 2022[9]	✓				
Stanojlovic & Davidson, 2021[16]		✓		✓	
Fortuna et al, 2020[11]				✓	
White et al, 2020[10]	○			○	
Willging et al, 2018[18]		○	✓	○	
Barker & Maguire, 2017[1]		✓			

	HOSPITALIZATION/ RE-HOSPITALIZATION	SUBSTANCE USE	ENGAGEMENT WITH TREATMENT & SERVICES	SYMPTOM SEVERITY (PSYCHIATRIC & SUD SYMPTOMS)	PROVIDER ENGAGEMENT
Bassuk et al, 2016[15]		✓			
Tracy & Wallace, 2016[17]		✓	✓		
Chinman et al., 2014[2]			✓		✓
Fuhr et al, 2014[12]			✓	○	
Kelly et al, 2014[13]	✓				
Lloyd-Evans et al., 2014[24]	○			○	
Reif et al, 2014[6]		✓	✓		✓
Davidson et al, 2012[25]	✓	✓			
Sledge et al, 2011[14]	✓				
Davidson et al, 2006[26]	✓			○	

✓ indicates strong evidence; ○ indicates limited evidence

TABLE #4: STUDIES AND FINDINGS ON SOCIAL/PSYCHOSOCIAL OUTCOMES

	QUALITY OF LIFE	HOPE AND EMPOWERMENT	SOCIAL SUPPORT	SELF-ESTEEM	DEPRESSION
Wang et al, 2022[9]	○	○			
Lyons et al, 2021[23]		○			○
Kowalski, 2020[27]	○				
Shalaby & Agyapong, 2020[8]	✓				
White et al, 2020[10]		✓			
Willging et al, 2018[18]			✓		
Barker & Maguire, 2017[1]	✓		✓		
Tracy & Wallace, 2016[17]				✓	
Chinman et al, 2014[2]		✓			

	QUALITY OF LIFE	HOPE AND EMPOWERMENT	SOCIAL SUPPORT	SELF-ESTEEM	DEPRESSION
Fuhr et al, 2014[12]	✓				○
Gidugu et al, 2014[5]		✓	✓		
Lloyd-Evans et al., 2014[24]		✓			
Reif et al, 2014[6]	✓		✓		
Davidson et al, 2012[25]		✓			✓
Bologna & Pulice, 2010[19]	✓				
Cook et al, 2010[3]		✓	✓		
Davidson et al, 2006[26]			○	○	

✓ indicates strong evidence; ○ indicates limited evidence

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