Evidence for Peer Support
May 2019

The Case for Peer Support

Peer support is an evidence-based practice for individuals with mental health conditions or challenges. Both quantitative and qualitative evidence indicate that peer support lowers the overall cost of mental health services by reducing re-hospitalization rates and days spent in inpatient services, increasing the use of outpatient services. Peer support improves quality of life, increases and improves engagement with services, and increases whole health and self-management. This document identifies key outcomes of per support services over a range of studies differentiated by program, geographic location, and year. Though many of the studies and programs listed below have some major programmatic differences, one thing is the same – they all demonstrate the value of peer support.

The Evidence

Reduced re-hospitalization rates
- Recovery Innovations in Arizona saw a 56% reduction in hospital readmission rates[i]
- Pierce County Washington reduced involuntary hospitalization by 32% by using certified peer specialists offering respite services, leading to a savings of 1.99 million dollars in one year[ii]
- Optum Pierce Peer Bridger programs served 125 people; 100% of consumers had been hospitalized prior to having peer coach, but only 3.4% were hospitalized after getting a coach [iii]
- A study of 76 individuals who had been admitted to Yale-New Haven Psychiatric Hospital (all who had at least two psychiatric hospitalizations in the previous 18 months) compared the outcomes of those who had been assigned a peer mentor with the outcomes of those who received standard post-discharge services. The individuals in the peer mentor group had double the average time to psychiatric rehospitalization than those receiving standard care – 270 days compared to 135 days.[iv]

Reduced days inpatient
- Participants assigned a peer mentor had significantly fewer hospital days (10.08 verses 19.08) & re-hospitalizations (average .89 verses 1.53) over 9 months[v]
- TN PeerLink program: significant decrease of 90% in average number of acute inpatient days per month[vi]
- WI PeerLink Program showed 71% decrease in number of acute inpatient days per month[vii]
- In two of their managed care contracts, Optum saw an 80.5% average reduction of inpatient days for individuals who had at least two hospitalizations on average per year[viii]

Lowered overall cost of services

- A study of Medicaid claims and enrollment data in New York City found that in the month of peer-staffed crisis respite use and the following 11 months, Medicaid expenditures averaged $2,138 less per Medicaid-enrolled month.[ix]
- A Federally Qualified Health Center in Denver (FQHC) that used peer support had an ROI of $2.28 for every $1 spent.[x]
- An effort to reduce depression/anxiety disorders in India demonstrated a 30% decrease in prevalence, 36% decrease in suicide attempts, and 4.43 fewer days of no work/reduced work in the previous 30 days, which was both cost-effective & cost-saving[xi]
- The Georgia Department of Behavioral Health & Developmental Disabilities found that consumers using certified peer specialists as a part of their treatment verses consumers who received typical services in day treatment cost the state $997 per year on average verses an average cost of $6,491 in day treatment, providing an average cost savings of $5,494 per person per year.[xii]
- Optum Pierce's Peer Bridger programs provided $550,215 in savings due to their 79.2% reduction in hospital admissions year over year.[xiii]
- A 2013 review of determined that the financial benefits of peer support exceed the costs, in some cases substantially.[xiv]
- In a 2013 study, 28.7% of respondents were not employed or had transitional/sheltered employment before CPS training. As a result of their work as CPS, 60% of respondents transitioned off or reduced public assistance and reduced their use of mental health care services. Changes in the respondents' mental health service use are outlined below: [xv]

> **Changes in Mental Health Service Use**
>
> Of the 122 who reported using outpatient therapy prior to CPS training, 71 reported a change in their service use. Twenty-nine (40.9%) reported an increase, and 42 (59.1%) reported a decrease, which was not significantly different, $\chi^2(1) = 2.38$, $p = .123$. Fifty-five of 93 respondents reported a change in use of case management services: More individuals reported a decrease ($n = 38$, 69.1%) rather than increase ($n = 17$, 30.9%), $\chi^2(1) = 8.02$, $p = .005$. Forty-nine of 89 individuals who had gone to an emergency room or crisis response center reported a change in frequency. Significantly more of these reported a decrease ($n = 41$, 83.7%) rather than an increase ($n = 8$, 16.3%), $\chi^2(1) = 22.22$, $p < .0001$. Finally, 37 of the 103 who had been hospitalized prior to CPS training reported a change: A significantly greater proportion of individuals ($n = 55$, 83.3%) reported a decrease versus 11 (16.7%) who reported an increase, $\chi^2(1) = 29.3$, $p < .0001$.

Increased use of outpatient services
- The following are data indicating the effectiveness of the Peer Bridger model created by the New York Association of Psychiatric Rehabilitation Services (NYAPRS).

Decrease in number of people who use inpatient services	Percentage
New York*	47.9%
Wisconsin	38.6%
Decrease in number of inpatient days	
New York*	62.5%

Wisconsin	29.7%
Increase in number of outpatient visits	
New York*	28.0%
Wisconsin	22.9%
Decrease in total Behavioral Health Costs	
New York*	47.1%
Wisconsin	24.3%

* The New York-based outcomes were achieved via the application of the Peer Bridger model.[xvi]

- 90% of PEOPLe Inc's Rose House crisis respite program (Orange County, NY) participants did not return to hospital in the following two years, 2010 program evaluation data[xvii]
- Mental Health Peer Connection's Life Coaches helped 53% of individuals with employment goals to successfully return to work in the Buffalo, NY area, 2010 program evaluation data.[xviii]
- Western NY's Housing Options Made Easy helped 70% of residents to successfully stay out of hospital in the following year, 2011 program evaluation data.[xix]
- A Mental Health America and Kaiser Permanente Pilot Study showed an increase in supports for individuals as they transitioned from inpatient settings and increased connection with behavioral health team.[xx]

Increased quality of life outcomes
- Instillation of hope through positive self-disclosure, role modeling self-care of one's illness, empathy & conditional regard may lead to higher demands/expectations for clients[xxi]
- A meta-analysis showed peer support is superior to usual care in reducing depressive symptoms.[xxii]
- Individuals receiving peer support are more likely to have employment.[xxiii]
- Peer support improves symptoms of depression more than care as usual.[xxiv]
- A Mental Health America and Kaiser Permanente Pilot Study showed an increased ability to meet participants' social needs with interventions in the community and improved ability to address gaps following inpatient services like housing and access to medications.[xxv]
- Veterans in a peer-to-peer program had significantly higher senses of empowerment and confidence.[xxvi]
- A metasynthesis showed that those receiving peer support services had increased social networks.[xxvii]

- The following table demonstrates the results of a survey regarding the impacts of CPS

Table 1
Recovery and Work Impacts of Certified Peer Specialist (CPS) Training

Statement	Score[a]		Strongly agree/agree	
	n	Mean ± SD	n	%
Your CPS training . . .				
Made you develop skills that are applicable to your life and recovery	151	4.54 ± 0.59	146	96.69
Made you more hopeful about your own future	151	4.42 ± 0.71	134	88.74
Gave you more confidence you can do things to further your recovery	150	4.38 ± 0.77	132	88.00
Gave you more confidence to seek employment	151	4.15 ± 0.98	113	74.83
Working as a CPS, you feel that . . .				
You have an ability to impact the agency where you work	148	4.36 ± 0.8	133	89.86
The work gives you an opportunity to give back to others	146	4.8 ± 0.42	145	99.32
Your confidence and sense that you can help yourself and others has increased	145	4.67 ± 0.58	139	95.86
The work facilitates and allows you to practice your own recovery	145	4.67 ± 0.59	138	95.17
Your job allows you to learn from your peers	145	4.69 ± 0.58	138	95.17
You have opportunities for personal development at agency	148	4.29 ± 0.87	126	85.14

[a] 1 = *strongly disagree*; 2 = *disagree*; 3 = *neither agree nor disagree*; 4 = *agree*; and 5 = *strongly agree* to the statements.

training.[xxviii]

- The following table outlines the outcomes of a variety of peer support programs.[xxix]

Table 2. Program Description and Outcomes of Peer Support

Study	Program Description	Study Participants	Outcome
Peer Employees (Employed Consumers)			
Solomon & Draine 1994; 1995 [20-22]	A randomized trial of a team of case managers who are mental health consumers compared to a team of non-consumers.	Recipients of case management (n=94)	Case management services delivered by consumers were as effective as those provided by non-consumers (symptomatology; QOL; social contacts; medication compliance; alliances with clients). Clients served by a consumer team were less satisfied with mental health treatment.
Felton *et al.* 1995 [23]	An intensive case-management program with peer specialists.	Recipients of case management (n=104)	Clients served by teams with peer specialists demonstrated greater gains in several areas of QOL and an overall reduction in the number of major life problems experienced.
Rivera *et al.* 2007 [26]	Consumer-assisted case management with standard clinic-based care.	Recipients of case management or clinic-based care (n=203)	There were no significant differences between the consumer-assisted program and other programs in terms of symptoms, satisfaction, subjective QOL, objective ratings of contacts with family or friends, and objective ratings of activi- ties and finances.
Lawn *et al.* 2008 [27]	Early discharge and hospital avoidance support program provided by peers.	Recipients of peer support (n=49)	300 bed days and costs were saved by the peer service.
Sells *et al.* 2006; 2008 [18, 19]	Intensive case-management teams that included peer providers.	Recipients of case management (n=137)	Participants who received peer-based services felt that their providers communicated in ways that were more validating and reported more positive provider relationship qualities compared with participants in the control condition.
Griswold *et al.* 2010 [25]	Trained peers employed by a local community organization provide a variety of services, including connections to social and rehabilitation services, by arranging appointments and providing transport.	Recipients of psychiatric emergency care (n=175)	Participants with peer support were significantly more likely to make connections to primary medical care.
Peer-Led (Peer-Run) Programs			

Chinman *et al.* 2001 [15]	An outreach and engagement program developed, staffed, and managed entirely by mental health consumers.	Recipients of consumer-run service or outpatient service (n=158)	Re-hospitalization rate. (No difference between the intervention group and the control group.)
Yanos *et al.* 2001 [28]	Programs that are staffed and operated completely by self-described mental health consumers provide services such as self-help, activity groups, and drop-in groups.	Recipients of mental health services (n=60)	Involvement in self-help services was associated with better community adjustment, the use of more coping strategies, and a greater proportion of problem-centered coping strategies.
Corrigan 2006 [29]	Consumer-operated services.	People with psychiatric disability (n=1824)	Participation in peer support was positively correlated with recovery or empowerment factors.
Nelson *et al.* 2007 [30]	Consumer / survivor initiatives run by and for people with mental illness.	Participants of peer-run organization (n=102)	Continuously active participants scored significantly higher on a measure of community integration than the non-active group.
Mutual Help Groups			
Galanter 1988 [31]	Self-help program designed by a psychiatrist to help participants cope with general psychiatric disorders.	Participants in self-help group (n=356)	A decline was found in both symptoms and concomitant psychiatric treatment after subjects joined the self-help group.
Wilson *et al.* 1999 [32]	Peer group work, including welcoming members, check-in, group discussion, planning a recreational outing and check-out	Participants in peer support groups (n=165)	Maintained independent or semi-independent living, an increase in the use of community resources and an increase in the size of the social support
Segal & Silver-man 2002 [33]	Self-help agencies that offer mutual support groups, drop-in space, and direct services, including case management, peer counseling, housing, financial benefits, job counseling	Long-term users of self-help agencies (n=255)	The participants showed significant improve- ment in personal empowerment, a significant decrease in assisted social functioning, and no
Bracke *et al.* 2008 [34]	Peer groups of clients of day-activity programs of rehabilitation centers for persons with chronic men- tal health problems.	Users of vocational and psychiatric rehabilitation centers (n=628)	The effects on self-esteem and self-efficacy of the balance between providing and receiving support in the peer groups were evaluated. The results showed that providing peer support is
Castelein *et al.* 2008 [14]	A closed peer-support group discussing daily life experiences. The group has 16 90-minute sessions biweekly over 8 months.	Users of healthcare centers (n=106)	Peer support groups had a positive effect on social network and social support compared with the control condition.

Increased engagement rates

- Peer support led to improved relationships with providers & social supports, increased satisfaction with the treatment experience overall, reduced rates of relapse, increased retention in treatment.[xxx]
- Programs like WRAP increase self-advocacy with providers.[xxxi]
- Individuals working with peers felt more empowered to be outspoken about pursuing their goals.[xxxii]
- HARP participants had significantly greater improvement in patient activation than those in usual care.[xxxiii]
- When trained peers employed by a local community organization provide a variety of services, including connections to social and rehabilitation services, arranging appointments and providing transport, participants with peer support are significantly more likely to make connections to primary medical care.[xxxiv]
- Participants who received peer-based services felt that their providers communicated in ways that were more validating and reported more positive provider relationship qualities compared with participants in the control condition.[xxxv]

- A Mental Health America and Kaiser Permanente Peer Support Pilot Study showed participants who received peer support had increased trust in services and increased team collaboration.[xxxvi]

Increased whole health
- The preliminary study findings of the Peer Support Whole Health and Resiliency (PSWHR) randomized controlled trial demonstrated the following results: [xxxvii]
  - 100% self-reported reaching whole health goal
    - Sample goals: eat five healthy meals per week, jog 20 minutes twice a week, eat seven servings of fruits and vegetables a week, etc.
  - Significant decreases in bodily pain, significant increases in hopefulness
  - Participants reported an average of 3.8 health conditions
  - 100% liked getting peer support
  - 78% of PSWHR participants were very satisfied
  - 100% strongly liked listening to other people's challenges & successes
  - 100% strongly liked the chance to form a meaningful relationship with PSWHR teachers
  - 100% strongly liked the focus on setting simple, achievable health goals
  - 89% self-reported improvement in whole health since starting PSWHR
- Individuals receiving peer support show a significant decrease in substance use.[xxxviii]

Existing State-Level Standards for Certification
- Based on the research done by the Texas Institute for Excellence in Mental Health, The following statements indicate the differences in peer support standards.[xxxix]
  - Extent of work/professional experience
  - Extent of involvement as a peer leader or doing peer support
  - Differences in the number of hours before taking the exams
  - Differences in recertification/continuing education requirements
  - Individuals must self-identify as a peer vs. provide documentation of diagnosis/treatment in the mental health care system
  - Criminal background check required by some but not most
  - Substance use disorder as co-occurring vs. primary
  - Length of time in recovery differs (range if specified: 6 months – 2 years)
  - Exam requirement (e.g. Wyoming has no exam, only requires that certain documents be provided showing training)
- As of May 2018, 45 states and the District of Columbia have established or are developing programs to train and certify peer specialists. Five states had no certification and no process or plan to develop or implement one.[xl]
  - States with certification include: Alabama, Arizona, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming
  - States planning certification include: Arkansas, Colorado, Mississippi, Nevada, New Hampshire, Vermont

- o States without certification include: Alaska, California, Montana, North Dakota, South Dakota
- As of January 2017, States reimbursing peer support through Medicaid:[xli]
  - o Alaska, Arizona, California, Colorado, Connecticut, DC, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Virginia, Utah, Washington, Wisconsin, Wyoming

National Certification
- As of March 2017, Mental Health America (MHA) launched the first national, advanced peer support specialist certification.[xlii] The MHA National Certified Peer Specialist (NCPS) certification has the following requirements:
  - o Hold current state certification with a minimum training requirement of 40 hours **OR** hold a certificate of completion of an MHA approved training program;
  - o 3,000 hours verifiable work and/or volunteer experience providing peer support services in the with the last six years
  - o One supervisory letter of recommendation for certification
  - o One professional letter of recommendation for certification
  - o High School Diploma or General Equivalency Degree
  - o 10 hours per year of Continuing Education Units (20 CEUS per two-year renewal period)
- Individuals with the MHA NCPS certification must pass a 125-qusetion examination across the following six domains of practice:
  - o Foundations of Peer Support
  - o Foundations of Healthcare Systems
  - o Mentoring, Shared Learning and Relationship Building
  - o Activation and Self-Management
  - o Advocacy
  - o Professional and Ethical Responsibilities

[i] Recovery Innovations of Arizona Programs. (n.d.). Retrieved May 28, 2015, from
http://www.recoveryinnovations.org/pdf/RIA Programs and Outcomes.pdf
[ii] Bergeson, S. (2011). Cost Effectiveness of Using Peers as Providers. Retrieved from http://www.nyaprs.org/e-news-bulletins/index.cfm?do=headlines&mn=2&yr=2011&article=77D2D51A082A461FC195477449A38681
[iii] Ibid.

iv O'Connell, M., Sledge, W., Staeheli, M., Sells, D., Costa, M., Wieland, M., Davidson, L. (2018). Outcomes of a peer mentor intervention for persons with recurrent psychiatric hospitalization. Psychiatric Services, 69(7), 760-767.

v Global Evidence for Peer Support: Humanizing Health Care. (2014). Retrieved from http://peersforprogress.org/wp-content/uploads/2014/09/140911-global-evidence-for-peer-support-humanizing-health-care.pdf ~~Sledge, W., Lawless, M., Sells, D., Wieland, M., O'Connell, M., & Davidson, L. (2011). Effectiveness of Peer Support in Reducing Readmissions of Persons With Multiple Psychiatric Hospitalizations. Psychiatric Services, 62(5), 541-544. Retrieved May 28, 2015, from http://ps.psychiatryonline.org/doi/10.1176/ps.62.5.pss6205_0541#~~

vi Bergeson 2011.

vii Ibid.

viii Ibid.

ix Bouchery, E., Barna, M., Babalola, E., Friend, D., Brown, J., Blyler, C., Ireys, H. (2018).The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization. Psychiatric Services, 69(10), 1069-1074

x Global Evidence for Peer Support: Humanizing Health Care. (2014). Retrieved from http://peersforprogress.org/wp-content/uploads/2014/09/140911-global-evidence-for-peer-support-humanizing-health-care.pdf

xi Ibid.

xii Bergeson 2011.

xiii Ibid.

xiv Trachtenberg T, Parsonage M, Shepherd G, Boardman J. (2013) Peer Support in mental health: Is it good value for money? London: Centre for Mental Health

xv Salzer, M., Darr, N., Calhoun, G., Boyer, W., Loss, R., Goessel, J. Brusilovskiy, E. (2013). Benefits of working as a certified peer specialist: Results from a statewide survey. Psychiatric Rehabilitation Journal, 36(3), 219-221. doi:10.1037/prj0000016

xvi Bergeson 2011.

xvii Ibid.

xviii Ibid.

xix Ibid.

xx Kaiser Permanente Care Management Institute. Behavioral Health Peer Support Specialist Pilot. (February 2016)

xxi Davidson, L., Bellamy, C., Guy, K. and Miller, R. (2012), Peer support among persons with severe mental illnesses: a review of evidence and experience. World Psychiatry, 11: 123–128. doi: 10.1016/j.wpsyc.2012.05.009

xxii Pfeiffer, P., Heisler, M., Piette, J., Rogers, M., & Valenstein, M. (2010). Efficacy of peer support interventions for depression: A meta-analysis. General Hospital Psychiatry, 33(1), 29-36.

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

xxiv Pfeiffer, P. N., Heisler, M., Piette, J. D., Rogers, M. A. M., & Valenstein, M. (2011). Efficacy of Peer Support Interventions for Depression: A Meta-Analysis. *General Hospital Psychiatry*, *33*(1), 29–36. http://doi.org/10.1016/j.genhosppsych.2010.10.002.

xxv Kaiser Permanente Care Management Institute. Behavioral Health Peer Support Specialist Pilot. (February 2016)

xxvi Resnick, S, G. & Rosenheck, R. A. (2008). Integrating peer---provided services: a quasi-experimental study of recovery orientation, confidence, and empowerment. Psychiatric Services, 59(11), 1307---1317.

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

xxviii Salzer et al, 2013

xxix Miyamoto, Y., & Sono, T. (2012). Lessons from Peer Support Among Individuals with Mental Health Difficulties: A Review of the Literature. *Clinical Practice and Epidemiology in Mental Health : CP & EMH*, *8*, 22–29. doi:10.2174/1745017901208010022

xxx Reif 2014, cited in Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention. (2014). Retrieved from http://www.nasmhpd.org/docs/TAC Assessment PDF Report/Assessment 1 - Enhancing the Peer Provider Workforce_9-15-14.pdf

xxxi Jones, N., Corrigan, P., James, D., Parker, J., & Larson, N. (2013). Peer support, self-determination, and treatment engagement: A qualitative investigation. Psychiatric Rehabilitation Journal, 36(3), 209-214.

xxxii Chinman M, Lucksted A, Gresen R, *et al.* Early experiences of employing consumer-providers in the VA. Psychiatr Serv 2008; 59(11): 1315-21, cited in Miyamoto, Y., & Sono, T. (2012). Lessons from Peer Support

Among Individuals with Mental Health Difficulties: A Review of the Literature. *Clinical Practice and Epidemiology in Mental Health : CP & EMH*, *8*, 22–29. doi:10.2174/1745017901208010022

xxxiii Druss, B., Zhao, L., Esenwein, S., Bona, J., Fricks, L., Jenkins-Tucker, S. Lorig, K. (2010). The Health and Recovery Peer (HARP) Program: A peer-led intervention to improve medical self-management for persons with serious mental illness. Schizophrenia Research, 118(1-3), 264-270.

xxxiv Griswold, K. S., Pastore, P. A., Homish, G. G., & Leonard, K. E. (2010). A randomized trial: Are care navigators effective in connecting patients to primary care after psychiatric crisis? Community Mental Health Journal, 46, 398–402.

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

xxxvi Kaiser Permanente Care Management Institute. Behavioral Health Peer Support Specialist Pilot. (February 2016)

xxxvii Cook, J. A. (Director) (2014, January 1). Randomized Controlled Trial Study of Peer Support Whole Health & Resiliency (PSWHR). Lecture conducted from University of Illinois at Chicago Center on Psychiatric Disability & Co-Occurring Medical Conditions.

xxxviii Davidson, et al. 2012.

xxxix Kaufman, L., Brooks, W., Bellinger, J., Steinley-Bumgarner, M., & Stevens-Manser, S. 2017. Peer Specialist Training and Certification Programs: National Overview 2016. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin

xl Doors to Wellbeing Peer Specialist Database, Accessed May 22, 2018 https://copelandcenter.com/peer-specialists

xli Kaufman (2017)

xlii www.NationalPeerSpecialist.org