Peer support:
What is it and does it work?

Summarising evidence from more than 1000 studies

Nesta

National Voices
People shaping health and social care

Key themes

What is peer support?

People, families and communities can play a key role in managing their own health and wellbeing. Peer support involves people sharing knowledge, experience or practical help with each other. Many voluntary and community groups encourage peer support. Health and social care commissioners are beginning to recognise the potential benefits.

We compiled information from more than 1000 studies to help organisations and commissioners make decisions about investing in peer support. We found that peer support can take many forms, such as informal telephone calls, group get-togethers, online forums or structured training offered by paid peers in partnership with professionals. Peer support can be classified in terms of:

- **who** is involved (such as people with specific health conditions or from certain age or ethnic groups),
- **what** type of support is offered (such as education, coaching or informal discussions),
- **how** it is provided (such as in person, online or by telephone),
- **where** it is provided (such as in hospital, primary care clinics, schools, community venues or people's homes)
- and **when** peer support is offered (such as one hour every week or month).

Does peer support work?

There is evidence that peer support can help people feel more knowledgeable, confident and happy and less isolated and alone.

Peer support may also encourage people to take more care of their health which, in the longer term, could lead to better health outcomes such as improved blood pressure or blood sugar control or less anxiety. However, evidence about these sorts of benefits, as well as the cost-effectiveness of peer support, is mixed.

Different types of peer support may have varying benefits (see Table 1). The most promising types of peer support appear to be:

- face-to-face groups run by trained peers which focus on emotional support, sharing experiences, practical activities and education
- one-to-one support offered face-to-face or by telephone
- online forums, particularly for improving knowledge and anxiety
- support offered regularly (such as weekly) for three to six months

There is much left to learn about why some types of peer support are more effective than others and what may encourage people to take part. Peer support requires organisation and may have costs. Little research has explored cost-effectiveness and this gap needs to be filled to help make good decisions about commissioning and sustaining peer support.

Table 1: Key findings about the impact of different types of peer support

Components of peer support	Improves experience	Improves health behaviour and outcomes	Improves service use and costs
Who receives support	• people with long-term health issues • people with mental health issues • carers • people from certain age and ethnic groups and those with specific experiences • parents • at risk groups	• people with long-term health issues • at risk groups	• people with long-term health issues • people with mental health issues
Who facilitates support	• untrained peers • trained peers • paid peers • lay people • peers with professionals • professionals	• trained peers • lay people • peers with professionals • professionals	• lay people
How support is delivered	• one-to-one • small groups • larger groups • face-to-face • telephone • internet	• one-to-one • larger groups • face-to-face • telephone	• face-to-face
What support is provided	• education • emotional support • social support • discussion • befriending • activity-based • peer-delivered services	• education • physical support • discussion • activity-based • peer-delivered services	*(blank cells show there is insufficient research to draw conclusions)*
Where support is provided	• own home • hospital • other services	• own home • hospital • other services	
When support is provided	• one-off • up to six months	• weekly • up to six months	

What is peer support?

What is peer support?

There is increasing recognition of the role that individuals, families and communities can play in managing their wellbeing.[1] Peer support may be one component of this.[2] Peer support involves people drawing on shared personal experience to provide knowledge, social interaction, emotional assistance or practical help to each other, often in a way that is mutually beneficial.[3] Peer support is different from other types of support because the source of support is a similar person with relevant experience.[4,5] An example is people with specific health conditions meeting to share experiences and talk about what works for them. Such support may help people to manage their physical and mental health conditions more successfully and to cope with symptoms or flare-ups.[6,7,8]

There are many different types of peer support in the UK and other parts of the world.[9,10,11,12,13,14,15,16] In line with a policy focus on person-centred care, commissioners are beginning to consider the added value of peer support. Voluntary and community groups and commissioners of statutory services need accessible and accurate information to help guide decisions about whether peer support works and which types of peer support are most useful. We reviewed research evidence to build on what is already known. The review examined:

- What types of peer support have been tested?
- Does peer support work?
- What do we need to learn more about?

Why is this important?

Peer support is of interest to UK policy makers, statutory services and the voluntary and community sector.[17,18] For example, NHS England's *Five Year Forward View* refers to peer support as one of the 'slow burn, high impact' interventions that should be seen as 'essential' to the future of the NHS.[19] However, in policy and commissioning circles there may be limited understanding of the different forms peer support can take or the infrastructure and training needed.[20] There is a need to summarise what is already known in order to build on good practice.

National Voices argues in its *Person Centred Care 2020* position statement that peer support should be made widely available for all individuals and groups who could benefit from it.[21] Much peer support is provided by the voluntary and community sector, including the national charities who are members of National Voices. Members have suggested that it is important to highlight the value of peer support and generate conversations about how to commission it. Therefore National Voices worked in partnership with the innovation charity Nesta, which has a programme exploring how to 'scale up' successful peer support, to commission a review of research evidence.

Identifying evidence

The review was undertaken by an independent organisation, The Evidence Centre. The review process followed best practice for identifying and summarising trends in research. Two reviewers searched ten bibliographic databases independently to identify studies published between January 2000 and January 2015. Research of any type was eligible, as long as it was published in English and focused on peer support in OECD countries (to allow some comparability with the UK). Research with people with long-term physical or mental health conditions or their carers was prioritised but other studies were included to illustrate how widely peer support has been used.

More than 20,000 studies were screened and 1,023 studies were identified for inclusion. In total, 524 of these studies examined the outcomes of peer support and the others described processes. The studies came from the UK (23%), Europe (27%), North America (41%) and many other parts of the world (9%). There were 27 reviews compiling findings from multiple studies and 147 randomised trials (which are thought to provide high quality evidence). The rest were lower quality non-experimental studies.

We used all 1,023 studies to develop a simple 'typology' showing the variety of initiatives that are labelled 'peer support.' We then looked at the results of the 524 outcome studies to identify which types of peer support were associated with improvements in people's experience (including knowledge and satisfaction), health behaviour and outcomes and service use and costs.

We used systematic processes to identify and analyse the material, but the review is not exhaustive. It aims to show trends in the research evidence and spark discussion rather than providing definitive answers about the most effective peer support or the findings of every study.

Types of peer support

Using 1,023 articles to classify the types of peer support available, we found that peer support differs in terms of:

Who is involved?

- Target group
- Who set up the support
- Who provides support
- Training and payment of facilitators

What type of support is provided?

- Support activities
- Support type

Why is support provided?

- Rationale

How is support provided?

- Mode of delivery
- Number of people involved

Where is support provided?

- Location

When is support provided?

- Duration
- Frequency

Table 2 provides a more detailed breakdown of these categories. This is not an exhaustive list, but seeks to demonstrate the variety of types of peer support that have been researched. Other types may also be available, but not widely written about.

Table 2: Typology of peer support components

Factor	Components	Examples of types
WHO		
Who is involved?	Target group	• People at risk (eg smoking, alcohol, poor diet) • People with long-term physical conditions • People with mental health conditions • Carers of people with physical or mental health conditions • Parents, including breastfeeding mothers • Children and young people • Students • Older people • Employees • Groups with specific experiences (eg veterans, sex workers) • Health and care professionals
Who provides support?	Set up by	• Professional group such as statutory services • Voluntary or community group • Peers themselves
	Facilitators	• Peers alone • Peers working with professionals • Professionals facilitating peer group • Lay-people (but not necessarily 'peers')
	Training	• Peers are trained • Peers are not trained
	Payment	• Peers are paid • Peers are volunteers

Component	Sub-components	Examples of types
WHAT		
What type of support is provided?	Support activities	• Discussion • Listening • Tutoring / mentoring • Coaching / motivational interviewing • Mediation • Navigation • Befriending • Activity-based (eg exercise) • Peer-delivered services (such as smoking cessation counselling)
	Support type	• Information / education provision • Emotional support • Social support • Physical support (such as help exercising) • Medication / clinical support • Practical support
WHY		
Why is support provided?	Purpose	• Specifically set up to provide peer support • Set up for other purposes (eg education, clinical appointments), with peer support occurring ad hoc
HOW		
How is support provided?	Mode of delivery	• Face-to-face • Telephone • Mobile phone • Social media (eg Facebook, Twitter, YouTube) • Other internet (eg email, websites, online forums)
	Number of people involved	• One-to-one • Small group (less than 10 people) • Larger group

Component	Sub-components	Examples of types
WHERE		
Where is support provided?	Location	• People's own home • Community venue • Hospital • Other health / social services (eg primary care) or institution such as schools
WHEN		
How often is support provided?	Duration	• One-off • Up to one month • Up to three months • Up to six months • Up to one year • Longer than one year
	Frequency	• Constantly available • Weekly • Fortnightly • Monthly • Less than once monthly • Ad hoc

Does peer support work?

This section examines the effect of various types of peer support on people's experience, behaviour and health outcomes and health service use. The impacts for peer supporters are also noted. The findings are based on 524 studies explicitly exploring the impact of peer support.

Table three summarises the overall trends. Green cells in the table indicate that many studies suggest benefits in a particular area, amber shows a moderate amount of evidence or mixed evidence and red suggests little published evidence of benefit. However, it is important to note that little published evidence does not necessarily mean that something is not effective, just that limited research is available.

In broad terms, this tells us that peer support has been found to:

- have the potential to improve experience, psycho-social outcomes, behaviour, health outcomes and service use among people with **long-term physical and mental health conditions**;
- potentially improve experience and emotional aspects for **carers**, people from certain age and ethnic groups and those at risk, though the impact on health outcomes and service use is unclear for these groups;
- be most effective for improving health outcomes when facilitated by **trained peers**, lay people (not necessarily peers) or professionals;
- be most effective for improving health outcomes when delivered **one-to-one or in groups** of more than ten people;
- work well when delivered **face-to-face, by telephone or online**;
- be most effective for improving health outcomes when it is based around specific activities (such as exercise or choirs) and focus on **education, social support and physical support**;
- work well in a **range of venues**, including people's own homes, community venues, hospitals and health services in the community.

Table 3: Summary of evidence about the benefits of different types of peer support

Components of peer support	Improves experience and emotions	Improves behaviour and health outcomes	Improves service use and costs
WHO receives support			
People with long-term health issues			
People with mental health issues			
Carers			
People from certain age, ethnic or experience groups			
Parents			
At risk groups			
WHO facilitates support			
Untrained peers			
Trained peers			
Paid peers			
Lay people			
Peers with professionals			
Professionals			
WHAT support is provided			
Education			
Emotional support			
Social support			
Physical support			
Medication / clinical support			
Practical support			
Discussion			
Listening			
Mentoring			
Coaching			
Navigation			
Befriending			
Activity-based			
Peer-delivered services			

Components of peer support	Improves experience	Improves health behaviour and outcomes	Improves service use and costs
HOW support is delivered			
One-to-one			
Small groups			
Larger groups			
Face-to-face			
Telephone			
Internet			
WHERE support is provided			
Own home			
Community venue			
Hospital			
Other services			
WHEN support is provided			
One-off			
Up to one month			
Up to six months			
Up to one year			
Longer than one year			
Constantly available			
Weekly			
Fortnightly			
Monthly			
Less than once monthly			
Ad hoc			

Note: green indicates that many studies suggest benefits, amber shows a moderate amount of evidence or mixed evidence and red suggests little published evidence of benefit. If there is little published evidence this does not necessarily mean that something is not effective, just that there is limited research available.

Who

There are many different types of peer support so we have broken down the impacts according to the people involved in peer support (who), the type of support provided (what), the method of delivery (how) and the timing and duration (when). However it is important to note that **there has been little research comparing one type of peer support to another**. This means that the results focus on the impacts of a specific type of peer support, rather than whether this is better or worse than alternatives.

Below we present tables signposting to specific studies that have found benefits or no benefits from different types of peer support. This gives a sense of where there is a lot or a little published research about a topic as well as highlighting interesting studies to explore if readers want to find out more.

Who receives support

Whilst peer support involves 'peers' (or similar people), the exact type of people involved varies widely. Some peer support focuses on people who are at risk of developing specific conditions or who may be seeking to reduce or prevent unhealthy behaviours.[22] An example is support groups for people who wish to stop smoking or want to do more physical activity. Other peer support may target people with particular physical[23,24,25,26.27,28,29] or mental health conditions[30,31,32,33,34,35,36,37,38,39,40,41,42,43,44,45,46] or their carers or family members.[47,48,49,50,51] Groups with shared experiences[52,53,54,55] such as armed forces veterans,[56,57] parents (including breastfeeding mothers),[58,59,60,61,62,63,64,65,66,,67,68,69,70,71,72,73] children and young people,[74,75,76,77,78,79] students,[80,81] older people[82] or employees of a particular company[83] may also be involved in peer support. Peer support activities have also been tested for health and social care professionals, though these are not the focus of this review.[84,85,86,87,88,89,90,91,92,93]

Table 4 illustrates studies that have explored the impacts of peer support for various target groups. It shows that a number of studies have found that **peer support can improve experience, health outcomes and health service use amongst people with long-term physical conditions and mental health issues**. However, it is also important to note that a number of studies have not found benefits for these groups. The impact on service use and costs is particularly mixed, with some studies finding benefits and others not.

For carers, research has found improved psychological or emotional wellbeing, but few studies have explored whether this impacts on carers' long-term health or ability to continue caring behaviours.

Table 4: Studies about peer support for various target groups

Target	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
People at risk / prevention	94,95,96,97,98,99,100		101,102,103,104,105,106, 107,108,109,110,111,112, 113,114,115,116,117,118, 119,120	121,122,123,124,125	126		127,128	129,130
Long-term physical conditions	131,132,133,134,135,136,137, 138,139,140,141,142,143,144, 145,146,147,148,149,150,151, 152,153,154,155,156,157,158, 159,160,161,162,163,164,165, 166	167,168,169,170,171	172,173,174,175,176,177, 178,179,180,181,182,183, 184,185,186,187,188	189,190,191,192,193, 194,195,196,197,198, 199	200,201,202,203,204,205, 206,207	208	209,210,211,212,213,214	215,216,217,218
Mental health	219,220,221,222,223,224,225, 226,227,228,229,230	231	232,233,234,235,236,237	238,239,240,241	242,243,244,245,246,247, 248	249	250,251,252,253,254,255, 256	257,258,259,260
Carers and family members	261,262,263,264,265,266,267, 268,269	270	271	272				
Parents	273,274,275,276,277,278,279, 280,281,282,283		284,285,286,287,288,289	290,291,292,293,294, 295,296,297,298,299, 300	301,302,303,304,305			306
Children, young people and students	307,308,309,310,311,312, 313,314,315,316	317,318	319,320	321,322,323,324	325,326,327			
Older people	328,329		330,331				332	
Employees			333				334	
Specific experiences	335,336,337,338,339,340, 341,342,343,344		345,346		347,348,349		350	

Note: For all of the tables, the citations show studies that have found benefits or no benefits from specific types of peer support. Usually the studies did not compare types of peer support. The citations give an indication of the number of studies available and where the gaps are. The list is not exhaustive.

Who facilitates support

There is variation in who provides support. The people providing support may include peers or laypeople alone,[351,352,353] peers working with professionals[354,355,356,357] or professionals facilitating a group of peers.

Most studies involve training peers to facilitate support.[358,359,360,361,362,363,364,365,366,367,368,369] People providing each other with more ad hoc or informal support are not usually trained,[370] though there are exceptions, such as training people in football teams or barber shops to offer ad hoc health promotion information.[371]

Whilst the terms 'peer' and 'lay person' are sometimes used interchangeably, at other times these have specific meanings.[372,373,374,375] 'Peer' generally refers to someone with similar characteristics and often refers to unpaid support, In contrast, in research a 'lay person' tends to be someone who is not a professional, but they may not always have similar characteristics or conditions to the people they are supporting.[376,377,378,379,380,381,382,383,384,385] Often studies of 'lay person support' involve paid activities[386,387,388,389,390,391,392] and the support may be more likely to be practical, educational and clinical (versus emotional / social with peer support).[393,394,395,396,397,398] Many lay health worker initiatives focus on specific population groups such as people with low incomes or those from minority ethnic groups[399] and aim to improve the uptake of activities such as cancer screening, smoking cessation, diet and exercise, safer sex or breastfeeding.[400,401,402,403]

Peer support is often unpaid, with a focus on an 'equal' relationship between peers, but there are also examples of paid peer support roles.[404,405,406,407,408,409,410,411,412,413,414]

Research suggests that **peer support facilitated by a variety of people can improve people's experience, behaviours and health outcomes** (see Table 5). Most studies do not compare peers alone versus professionals or joint peer and professional-led peer support. Those that do have found that peers are usually just as effective as professionals, particularly when the focus is on emotional or social support.

There is not enough evidence to draw conclusions about whether peers in paid roles are more effective than volunteers.

Most studies that have explored the impact of peer support on the peer supporters themselves have found benefits including increased knowledge and confidence, and in some cases improved health outcomes.

Some peer support initiatives are set up by peers themselves. Others are set up by voluntary or community groups or by professional or statutory groups, such as health or social care services.[415] Whilst the voluntary and community sector is heavily involved in peer support, most of the published research about peer support focuses on activities set up by statutory health or social care services (see Table 6). From the evidence available, it is not possible to draw conclusions about whether peer support set up by peers themselves, community groups or professionals are more or less effective than one another.

Table 5: Studies about peer support delivered by various facilitators

Facilitators	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
Peers alone, untrained and unpaid	416,417,418,419,420, 421	422	423,424,425	426,427	428			
Peers alone, trained	429,430,431,432,433, 434,435,436,437,438, 439,440		441,442,443,444,445, 446,447,448	449,450,451,452,453, 454,455,456	457,458,459		460,461	462,463
Peers alone, paid jobs	464,465,466,467,468		469		470,471,472	473	474	475
Lay people	476,477,478,479,480, 481		482,483,484,485,486, 487,488,489,490,491, 492,493,494,495,496, 497,498,499	500,501,502,503,504 505	506,507		508,509,510,511,512	513,514
Peers and professionals	515,516,517,518	519	520,521,522,523,524	525,526			527	
Professionals	528,529,530,531		532,533,534,535					

Table 6: Studies about peer support set up by various parties

Set up by	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
Peers	536							
Professional or statutory group	537,538,539,540,541, 542,543,544,545,546, 547		548,549,550,551,552,553, 554,555,556	557,558	559,560,561		562,563,564	565
Voluntary or community group	566		567,568		569			

What

A wide range of activities are offered under the remit of peer support. These may include listening to what people say, discussing ideas, mentoring,[570] coaching,[571] befriending[572] or signposting or navigating towards specific services.[573,574,575] Support focused around activities, such as exercise groups or book clubs, is common.[576] Another type of peer support involves services delivered by (paid) peers such as dietary advice or education about how to manage health conditions.[577,578]

Table 7 shows that **there is research about the benefits of activities such as discussions, activity-based support (such as choirs) and peer-delivered services**. These types of peer support have been found to improve both experience and health outcomes. Research about the benefits of navigation, coaching and mentoring is more sparse. Some types of peer support, such as befriending, have been found to improve experience and emotional outcomes, but little is known about whether this translates into improved physical health or reduced use of health services.

Just as the activities provided vary in peer support initiatives, so too do the exact types of support available. Peer support may involve information provision, emotional support, social support, physical support, support about clinical or medication issues[579] and practical support, such as inserting stair rails or helping with gardening.

Table 8 shows that **there is most research evidence about the benefits of education, emotional support and social support**. These may all improve experience and emotional outcomes. There is some evidence for impacts on health behaviours and health status too. Physical support, such as helping people with exercise, has been found to improve people's physical wellbeing.

Another way to differentiate peer support is in terms of the reason it is provided. Some activities are specifically set up to provide peer support, such as regular group get-togethers. Other activities are set up for other purposes, such as education sessions or group clinical appointments, and peer support happens in an ad hoc manner.[580,581,582,583,584,585,586,587,588,589,590,591,592,593] There is little evidence directly comparing these types of peer support so it is not possible to say whether organised and managed peer support is any more effective than more ad hoc support.

Table 7: Studies about peer support activities

Mode	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
Discussion	594,595,596,597,598, 599,600,601,602,603, 604	605,606	607,608,609,610,611	612,613,614,615,616	617		618	
Listening							619	
Mentoring	620,621,622		623,624		625,626		627	
Coaching	628,629		630,631	632				
Navigation								
Befriending	633,634,635,636,637		638		639			
Activity-based eg exercise, choirs	640,641,642,643,644	645	646,647,648,649,650,651, 652					
Peer-delivered services	653,654,655,656,657, 658,659,660		661,662,663,664,665	666			667	

Table 8: Studies about different types of peer support

Type	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
Information / education	668,669,670,671,672, 673,674,675,676,677, 678,679,680		681,682,683,684,685, 686,687,688,689	690,691,692,693,694	695		696,697,698	
Emotional support	699,700,701,702,703	704,705,706	707,708,709		710,711		712	
Social support	713,714,715,716		717	718				
Physical support		719	720,721,722,723,724					
Medication / clinical support			725				726	
Practical support	727							

How

Another way to classify peer support relates to how it is delivered.[728] Options include face-to-face sessions,[729,730,731,732,733,734] support through landlines or mobile phones,[735,736,737,738,739,740,741,742] email, and social media,[743,744,745,746] websites and other online forums.[747,748,749,750,751,752,753,754,755,756,757,758,759,760,761,762,763,764,765,766,767,768,769] Novel approaches such as video phones have also been tested.[770]

Table 9 shows that **face-to-face, telephone and internet approaches have all been found to be useful ways of encouraging peer support**, particularly in terms of improving experience and emotional wellbeing. The impacts of various delivery methods on health outcomes are less clear, with some studies suggesting benefits and others not. Higher quality studies such as systematic reviews and randomised trials were just as likely as lower quality studies to have mixed findings.

It is not possible to suggest that one mode of delivery is any more effective than others. Most studies do not directly compare face-to-face versus telephone versus internet approaches, and those that do have inconclusive findings. An increasing number of initiatives are *combining* in-person, telephone and / or online approaches, with good effect.

The number of people involved in peer support activities can range from one-to-one individualised support,[771,772,773,774] small groups (fewer than ten people)[775] or larger groups. Some studies have tested building volunteer support teams around an individual with a long-term condition.[776,777]

Table 10 illustrates that **many studies have found benefits from one-to-one, small group and larger group approaches**. It is not possible to say whether one of these approaches is more effective than others. All approaches have been found to improve experience and emotional wellbeing. The impact on physical health outcomes and health behaviours is more mixed.

There is limited evidence about whether individual or group approaches are likely to reduce health service use or costs.

Table 9: Studies about different methods of delivering peer support

Delivery	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
Face-to-face	778,779,780,781,782,783, 784,785,786,787,788,789, 790,791,792,793,794,795, 796,797	798	799,800,801,802,803, 804,805,806,807,808, 809,810,811,812,813, 814,815,816	817,818,819,820,821,822	823,824		825,826,827,828,829, 830	
Telephone	831,832,833,834,835,836, 837		838,839,840,841,842, 843,844,845,846,847	848,849,850,851,852	853		854	855
Mobile app				856				
Social media	857,858			859				
Other internet, email and technology	860,861,862,863,864,865, 866,867,868,869,870,871, 872,873,874,875,876,877, 878,879	880,881,882,883	884,885,886	887,888,889,890,891, 892,893				

Table 10: Studies about peer support for small and larger groups

Number	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
One-to one	894,895,896,897,898,899, 900,901,902,903,904,905, 906,907,908,909,910,911, 912		913,914,915,916,917,918, 919,920,921,922,923	924,925,926,927,928	929,930,931,932		933,934,935	936,937
Small group (<10)	938,939,940,941,942,943, 944,945,946,947,948		949,950,951	952			953	954
Larger group	955,956,957,958,959,960, 961,962,963,964,965	966,967	968,969,970,971,972,973, 974,975,976,977,978,979	980,981,982,983,984, 985	986		987,988,989	

Where

Peer support can be provided in people's own homes,[990] in community venues[991] such as churches[992,993,994,995] or community centres, in hospital environments[996,997,998] or on the premises of other health or social services, such as in primary care clinics.[999,1000,1001] Novel approaches such as peer-led camps for children with long-term conditions[1002] and houses set up to support people with alcohol and substance misuse issues have also been tested.[1003]

Table 11 demonstrates that there is evidence that **peer support provided in a variety of venues can improve experience and health outcomes**. Peer support visits or internet or telephone support in people's own homes have been found to improve emotional and physical wellbeing. Peer support offered in hospital is more likely to have been associated with improved experience, whereas peer support offered in other health or social care environments has been found to impact positively on both experience and health outcomes. There is evidence that peer support initiatives provided in community venues such as churches or community centres can improve health outcomes.

There is no evidence to suggest that one venue is any more effective than others. Nor is there evidence about whether specific venues are more or less likely to be cost-effective.

Table 11: Studies about peer support in various locations

Mode	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
Own home	1004,1005,1006,1007		1008,1009,1010,1011	1012			1013	
Community venue	1014,1015		1016,1017,1018,1019,1020		1021,1022		1023	
Hospital	1024,1025,1026,1027,1028 1029,1030,1031,1032,1033		1034		1035			
Other health, social services or institutional setting	1036,1037,1038,1039,1040		1041,1042,1043,1044,1045, 1046	1047,1048			1049	1050

When

Peer support differs in terms of its duration and frequency. Some peer support activities occur only once or twice. Others continue for many months or years. Some peer support is constantly available, such as through website forums, whereas other types are ad hoc or occur at regular intervals such as weekly or monthly.[1051]

The most commonly researched peer support initiatives last around six to twelve weeks. Table 12 illustrates that one-off support and **support lasting for up to six months has been found to be useful**. There is little research about peer support services that extend for longer periods. This is not to suggest that ongoing initiatives are not available or worthwhile, just that their impacts are not commonly written about.

Table 13 shows that the most commonly researched peer support occurs weekly. Whilst some studies have found weekly support, whether by telephone, internet or in-person, to be associated with improved health outcomes, other studies have not found this to be the case.

There is limited evidence about whether the duration or frequency of peer support influences health service use or costs.

Table 12: Studies about peer support of various durations

Duration	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
One-off	1052,1053,1054,1055							
Up to one month	1056		1057					
Up to six months	1058,1059,1060,1061, 1062	1063	1064,1065,1066,1067,1068, 1069,1070,1071,1072,1073, 1074,1075,1076,1077,1078	1079,1080,1081,1082,1083,1084, 1085,1086	1087			
Up to one year	1088			1089,1090			1091	
Longer than one year								

Table 13: Studies about peer support of varying frequency

Frequency	Experience and emotions		Behaviour and health outcomes		Impact on peer supporters		Health costs and service use	
	Benefits	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*	*Benefits*	*No benefits*
Constantly available	1092	1093					1094	
Weekly	1095,1096	1097	1098,1099,1100,1101,1102, 1103,1104,1105,1106	1107,1108,1109,1110	1111			1112
Fortnightly				1113				
Monthly	1114		1115	1116				
Less than once monthly								
Ad hoc	1117,1118,1119		1120,1121					

Where to from here?

What else do we need to know?

The review suggests that a great deal of work has been done to explore the potential for peer support, but there are some issues to consider.

Firstly, although a large quantity of research is available, it is not always of good quality. Systematic reviews and randomised controlled trials are often thought to provide the most robust evidence about whether activities are effective. Only 17% of the studies identified were reviews and randomised trials, and these tended to have less favourable findings than other studies.

Secondly, even where good quality evidence was available, it often did not include details about exactly how peer support was offered or what the most useful components were. Furthermore, peer support includes many varying components such as the type of participants, whether facilitators are trained or paid, the location and delivery method. Thus, even when peer support is associated with benefits, it is uncertain whether it was the location, delivery style, level of training and so on that made a difference.

Thirdly, although the review was limited to OECD countries to allow comparability with the UK context, much of the research is from North America where services and personal attitudes and attributes may be different from the UK. What works in one country cannot necessarily be transferred without adaption to another.

We also identified a number of gaps in knowledge about peer support, which current programmes could build in to their ongoing evaluations:

Participation

- What type of support do people prefer?
- What influences whether or not people participate in peer support?
- How could more people be encouraged to take part?

Implementation

- Is training needed to provide effective peer support?
- What is the best way to train people to provide peer support?
- Does the duration of peer support make a difference?

Impacts

- What are the longer-term impacts of peer support?
- How cost-effective are different types of peer support?

What influences effectiveness?

- Why are some types of peer support more effective than others?
- Does the effectiveness of specific types of peer support differ depending on the people involved (eg children versus adults, physical versus mental health, people at risk versus those diagnosed)?
- What are the fundamental characteristics needed to ensure successful peer support?
- What do peers do more effectively than professionals and what types of support may professionals provide more effectively than peers?

What should we invest in?

There is a lot left to learn, but the evidence available suggests that peer support is worth investing in, including commissioning more robust evaluations of the impacts and the reasons why peer support works better in some contexts and for some groups. Table 14 summarises the types of peer support that commissioners and groups wanting to encourage peer support might consider investing in. It is important to note that the cost-effectiveness of these initiatives remains uncertain.

Based on the totality of evidence, the top three most useful types of initiatives for improving emotional and physical well-being may be:

- face-to-face groups run by trained peers which focus on emotional support, sharing experiences, education and specific activities such as exercise or social activities. Running groups regularly, such as every week for three months, has been found to work well;

- one-to-one support offered face-to-face or by telephone. This may include a variety of information provision, emotional support, befriending and discussions. This type of one-to-one support may be more likely to result in reciprocal benefits for supporters and be more likely to involve volunteers rather than paid peer support facilitators;

- online platforms such as discussion forums. These have been found to be particularly useful for improving knowledge and reducing anxiety, though people may use them for a limited time.

Both experience and evidence suggests that peer support is valued by those who take part and that it can improve how people feel and what they do. The challenge for the voluntary and statutory sectors is how to make the case for embedding this in mainstream services without over-professionalising it and potentially losing some of the 'peer' approach.

Table 14: Summary of expected benefits from various types of peer support

Peer support	Expected return on investment
One-to-one telephone support delivered by unpaid peers	• Inexpensive to set up and manage • May have variation in quality • Difficult to reach large numbers • Likely to reduce anxiety and isolation
One-to-one telephone support delivered by paid peers	• Potentially more costly • Difficult to reach large numbers • Likely to reduce anxiety and isolation • Moderate uptake rates
One-to-one in-person support delivered by unpaid peers	• Inexpensive to set up • Some management may be needed • High uptake rates • Likely to reduce anxiety and isolation • May improve health outcomes and behaviours
One-to-one in-person support delivered by paid peers	• Some costs for set up and management • High uptake rates • Difficult to reach large numbers • Likely to reduce anxiety and isolation • May improve health outcomes and behaviours
Support groups led by trained but unpaid peers	• Some investment in organisation required • Likely to reduce anxiety and isolation • Easier to reach larger numbers
Educational groups co-led by paid peers and professionals	• Investment in organisation required • Likely to reduce anxiety and isolation • Easier to reach larger numbers • May improve health outcomes and behaviours
Online support groups / forums	• Inexpensive to set up and manage • May have lower uptake rates and high drop out • Likely to improve knowledge and reduce anxiety by helping people feel less alone

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