



Chronic
Illness
Alliance

Peer Support for Chronic and Complex Conditions

A Literature Review

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EXECUTIVE SUMMARY

1. The objectives of this literature review were to identify effective models of peer support; which aspects of peer support are effective; outcomes of effective peer support; its sustainability and cost effectiveness; comparative effectiveness of the different models of peer support and the links between peer support and the Victorian sub-acute and primary health care system.

2. The literature review used methods related to systematic searching. Two researchers searched literature using an extensive list of key words. Due to constraints, literature was confined to randomised controlled trials and systematic reviews reported in peer reviewed journals. Following review by the researchers, 55 articles were included.

3. There are seven models of peer support:
 - a. Professionally-led groups;
 - b. Peer-led groups;
 - c. Peer coaches;
 - d. Community Health Workers;
 - e. Support groups;
 - f. Telephone based peer support;
 - g. Internet and email peer support.

4. There is a wide range of terms used to describe peer support; most articles failed to define peer support and few articles demonstrated the research was related to theory. Most articles failed to recognise there were different models of peer support or explore the implications of the different models.

5. The evidence of effectiveness of peer support in the literature reviewed demonstrated:

- a. Shortcomings in research designs and reports made it difficult to assess effectiveness in terms of health outcomes.
 - b. There was more evidence that peer-led self-management support was effective with socially disadvantaged groups. Culturally relevant peer support in diabetes programs for the UK Bangladeshi and the NZ Maori communities was associated with improved health outcomes.
 - c. Only one article reported on cost-effectiveness. This was the UK Expert Patient Program where it was found that it was a cost-effective part of the NHS.
 - d. The most common outcome of effective peer support was improved self-efficacy.
6. Systematic reviews criticise randomised controlled trials RCTs in peer support for using inappropriate research designs, not reporting all the findings including adverse ones, not explaining training programs and interventions fully. Despite these reservations authors of systematic reviews consider peer support to be effective and that improved research design and evaluation would demonstrate this. Authors of systematic reviews offer few suggestions on how research designs and evaluation can be improved.
7. The interface with the Victorian sub-acute and primary health care system shows peer support is well established in Victoria with all models of peer support represented. Many NGOs facilitate peer support models, where there are innovative models using social networking, telephone and internet support. Sub-acute and primary health care organisations have links to support groups. The Hospitals Admissions Risk Program and Living Well Program encourage and support the creation of peer support groups and peer-led self-management programs.

1. INTRODUCTION

Peer support programs have been developed and sustained by not-for-profit health foundations for many years. It is seen as a cost-effective means to care for others with chronic conditions. However, it also has the additional advantage of allowing those who have lived with a chronic condition to share their experiences with people who have been more recently diagnosed. This form of support is now recognised as being an important adjunct to professional health care.

In 2009 the Chronic Illness Alliance established the Peer Support Network. This network comprises a number of not-for profit organisations that facilitate peer support activities amongst their membership and clients as well as health professionals and others who would like to learn more about peer support and how it can assist people living with chronic conditions. The network identified the different models of peer support that each of its members has established. These include peers leading self-management programs, peers working face to face with newly diagnosed people such as in hospital visiting programs, peers who speak the same language as others, peers who undertake telephone support and peers who run support groups.

The network now provides a 'one-stop' shop in Victoria for interested people to find out more about peer support. It also means that leaders in this field are available to provide information and help to those who wish to establish a peer support program – that is, the model of peer support has been adopted by the group itself.

The Peer Support Network has identified that there are gaps in knowledge relating to peer support. These include training, evaluation and funding. These gaps largely exist because peer support is undertaken on 'a shoe string' and the available resources are needed to continue programs, with little left over for research and development. The network has shown, however, that its members operate at high standard. This group recently developed The Best Practice Framework for Peer Support and this resource is now available to community members wanting to set up a peer support model. The resource is now being utilised in Peers for Progress projects internationally (personal communication Ed Fisher August 2010).

One of the gaps that exists is the evidence base for the effectiveness and impact of the various models of peer support. This literature review undertakes to address this. Additionally, the review

offers a ‘roadmap’ on the points at which peer support can be further researched in order to strengthen it as a means by which people with chronic illnesses can seek to take back control of their health and quality of life.

2. OBJECTIVES

This literature review identifies effective models of peer support for chronic and complex conditions. Specifically, it explores literature on peer support for evidence on which aspects of peer support are effective; the outcomes of effective peer support; cost-effectiveness of peer support; the sustainability of peer support; how peer support links to sub-acute and primary healthcare and the costs and benefits of peer support.

3. METHODS

3.1 The research team:

Two researchers conducted an electronic search of the health-related databases Medline, PubMed, CINAHL, PsychInfo, and Cochrane Systematic reviews using the following MeSH terms:

Self-help	support group therapeutic
Social Support	self-help groups
Peer Group	
Social adjustment	support groups
Social facilitation	
Peer Support	Telephone, internet, on-line
Peer Leader	

Key words

Chronic, complex, peer support, cancer, asthma, arthritis, musculoskeletal, heart disease, cardiovascular, stroke, diabetes, rural/remote, homeless, social isolation

3.2 Inclusion strategy:

The strategy was to include articles from January 1990 to July 2010 written in English which include a sample of people with one or more chronic and complex conditions, who engaged in peer support activities as part of their health management. The initial search delivered 455 peer-reviewed articles.

3.3 Selection strategy:

All abstracts of the peer-reviewed literature were read independently by two researchers. They were graded according to whether they were systematic reviews and randomised controlled trials (RCTs), articles on single or small projects or marginally concerned with peer support issues. Following review and agreement between the two researchers, it was decided on the basis of the limitations of the current literature review to constrain selection criteria to systematic reviews and RCTs. This provided an initial cut of 108 articles. This number was further reduced with the removal of

duplications and articles that proved not to be relevant to peer support. The result was some 72 articles to review in full.

Complete published copies of those articles that met the inclusion criteria were obtained and read and the key attributes summarised in terms of effectiveness, outcomes, sustainability, relationship between peer support and sub-acute and primary care, costs and benefits, populations served and models of peer support. Closer review of these revealed their inappropriateness for our purposes; for example, one referred to social support in the context of family relationships and another was concerned with peer mentoring among medical practitioners. A number of others were concerned with professionally led self-management programs. After thoroughly reading these, they were again culled to 55 articles.

Grey literature has been used for the examples to illustrate models of peer support and as examples of peer support interfacing with the health system.

4. MODELS OF PEER SUPPORT

From the literature review it is possible to characterise a number of models of peer support. This is a useful start to this literature review as it provides a way of ordering the many ways in which peer support can be delivered. It also demonstrates that peer support is organic, growing and adapting to the introduction of new communication technologies. Heisler (2007) characterises peer support as seven different models. These models are:

- a. Professionally led groups
- b. Peer-led self-management programs
- c. Peer coaches
- d. Community health workers
- e. Support groups
- f. Telephone based support
- g. Internet and e-mail support

4.1 Professionally-led groups

Professionally led groups are a model of peer support where peers are brought together to share their experiences of living with a chronic illness. They discuss the challenges they face and learn from one another as well as learning from the professional facilitator. The extent to which there is strong component of group interaction and social and emotional support among peers is governed by the leadership style of the health professional which may vary along a continuum from didactic to facilitative.

Examples

The Living with Cancer Education Program of The Cancer Council of Victoria is representative of this model. Health professionals undertake the training to deliver the program which is run in two-hour sessions over 8 weeks. Participants are people with cancer and their family and friends. The program consists of informative material about cancer diagnoses and its treatment and care as well as self-management strategies. Participants are encouraged to share their emotional responses and experiences with one another. The emphasis of this sharing is to identify positive strategies to deal with the diagnosis and model these strategies in other relationships.

CHiPs (Chronic Illness Peer Support, Centre for Adolescent Health Melbourne) has group programs for young people (12-25) with chronic illnesses. The 8 week groups are led by a health professional and a trained peer leader.

4.2 Peer-Led Self-Management Programs

Similar to the previous model, these programs are run by people who themselves have a chronic illness. Peers are usually trained in the skills required to run a program such as active listening and presentation skills, drawing up action plans and goal setting, problem solving and assertiveness. The main advantage of peers as leaders is that they serve as positive role models in managing chronic disease. Lorig and associates demonstrated that peer-led programs are as effective as health professionally led programs (ref) while Heisler (2007) points out that, when programs are co-led between a peer and health professional, this may result in the health professional dominating the partnership.

Examples

Expert Patient Program is the UK variant of Chronic Disease Self-Management Program developed at Stanford University. In this program people with chronic illnesses who have attended the program undertake training to become peer leaders and deliver a highly structured program which has a strong research and evaluation component. The program has been subject to evaluation and is now an integral part of the UK National Health Service chronic disease management policy (ref Rogers).

Beyond Maturity Blues is a peer support program where older people are trained by Council on the Ageing to provide a program on helping with depression amongst older people.

Council on the Ageing (COTA) and National Prescribing Service (NPS) have partnered to present a Quality Use of Medicines Program (QUM) to seniors across Australia. Training is delivered by state branches of COTA to senior volunteers who deliver one-hour information sessions in community settings. NPS provides evidence-based and updated resources to the program.

4.3 Peer Coaches.

Heisler (2007) defines peer coaches as volunteers who are trained in skills similar to peer-leaders of self-management programs but deliver services to individuals, either visiting them in their homes or in hospitals. As people who have experienced a condition, undergone the treatments and recovered, their roles are to alleviate fears and anxieties associated a new diagnosis, commencing a new treatment or coping with a recurrence. They are required to have a level of confidence and wellness and to have developed a healthy perspective on their own lives and the role their illness has played in their own emotional development. This aspect is important as they offer a level of hope for the future and represent the good outcomes of treatment a person will be undergoing. In the US, peer coaches have roles in introducing patients to cancer treatments, organ transplants, dialysis, alleviating postpartum depression, and taking on supportive roles such as visiting people with HIV/AIDS.

An interesting tangential debate concerns the use of current injecting drug users as peer educators to teach the safe use of injecting drugs. One side of the debate suggests that current drug users are in constant contact with their peers and are more likely to be trusted than ex-users or even those who are on substitutes such as methadone. The other side of the debate explores the difficulty of employing current users by a service, including drug use during work time and lack of trust from their colleagues. One of the solutions offered in this article by the policy officer at the Australian Federation of AIDS Organisations (AFAO) is employing a mix of non-users and users in outreach services. (AFAO Discussion Paper: Employment of current IDUs www.hivpolicy.org/Library/HPP001076.pdf)

There are examples of peer coaches in Australia but they are not usually referred to as coaches since this term is associated strongly with Health Coaching which is undertaken by health professionals and also has a strong association with mentors in the educational field.

Examples

Cancer Connect, Cancer Council of Victoria links people with cancer to a volunteer who has had the same form of cancer and is of a similar age and background. The Cancer Connect volunteer has received training from the Cancer Council and remains supported by the Cancer Helpline. Their role is to offer emotional support and practical help.

Buddies in HIV/AIDS have been widely used in all HIV/AIDS programs across the world. Buddies undertake emotional support for newly diagnosed people as well as offering practical guides to dealing with HIV discrimination. In developing countries 'buddies' are likely to have a role in promoting awareness of HIV and have a prevention role, in addition to offering support and reducing the stigma communities may attach to having this condition.

The MS Society of ACT/NSW/Vic has peer support workers who provide telephone, face to face and on-line support from people with MS to people with MS. These people receive training to undertake this service.

4.4 Community Health Workers

Community health workers are associated with ethnic or geographically remote communities (Heisler 2007). Community health workers are likely to have some more formal training than volunteers receive and they are likely to be part of the paid staff. Community Health Workers are peers in the sense that they are usually members of the community they serve rather than having a relationship through an illness. Thus they share social and cultural experiences in common. This commonality can contribute to better adherence in the community because there are basic understandings of the community needs. 'Promotoras' are Hispanic community health workers who work in health promotion for the US Hispanic community.

Examples

Indigenous community health workers are employed in community controlled health organisations in remote Australia. They generally undertake Certificate III or IV training in health work with a registered training authority. Their roles can be very broad including health promotion, preventive work, education and support.

Community health workers are also commonly associated with ethnic community groups in metropolitan areas of Australia. They may be highly skilled in unrelated areas but work in health promotion and chronic disease management when the funds are available to employ them. As skilled literate members of a community they are held in high regard and have the ability to bridge the gap between health professionals and consumers by providing information in a manner that is understood. Some areas where community health workers provide benefits are immunisation programs, diabetes prevention and projects to reduce family violence.

4.5 Support Groups

Support groups are a peer support model that contributes to health systems world-wide. Often termed self-help groups, this term encapsulates that peer support is intrinsic to their structure. The Collective of Self-Help Groups (COSHG) defines self help groups as 'groups of people who get together with others "in the same boat" to support each other, share experiences and knowledge, and work together to improve their quality of life'. Groups are involved in a variety of activities, such as meetings, information, phone support, producing newsletters, social gatherings, advocacy and campaigns.

Support groups are generally associated with a single condition. They are run by the members through a committee system where office holders are elected by, and from, the members. Traditionally support groups held regular face to face meetings where information, formal presentations and sharing of experience took place. While this is still often the case, 'virtual' support groups now operate.

Support groups may be associated with hospitals, community health services or operate autonomously in the community. Not for profit organisations often have support groups associated with them and these are likely to be facilitated by peer support volunteers or by health professionals working in the not-for-profit. The extent of the association between support groups and a larger organisation may vary from the support group being seen as part of the organisational structure through to simply letting them use a room and having no further involvement.

As groups that are largely volunteer-run, they often rely on their association with larger organisations for resources such as a meeting venue, office materials and access to health professionals for advice and as speakers. Such an association also provides support groups with recruitment of newly diagnosed people. In return, organisations benefit from having a volunteer group prepared to help out with other tasks such as fundraising and a place to refer people who request peer support.

Levels of training that support group leaders receive are variable across support groups. Where the support group is part of a larger organisation it is likely that some level of training is required as this is considered to be part of organisational quality control and risk-management. Support groups that have no such association may not have trained support group leaders.

Example

There are 18 metropolitan-based arthritis self-help or support groups and 31 similar groups in rural Victoria. These are linked to Arthritis Victoria which assists them with resources and advice. The groups are otherwise independent, with their own governance structure and many have established relationships with health services in their local area. Arthritis Victoria encourages people with arthritis to establish their own group if one does not already exist close by.

4.6 Telephone-Based Peer Support

This model overlaps with the previously discussed peer coaching which may take place over the phone. It is often used in conjunction with other forms of support. For example, it might be combined with self-management courses to keep people motivated between meetings. Telephone peer support is usually undertaken within an organisational structure, where peer supporters have access to phone lines and/or are reimbursed for the calls.

Telephone-based peer support is useful in remote areas where it is difficult to access face to face services. It is also useful where anonymity and confidentiality is an issue or, as in depression, where the motivation to socialise is low.

Training of telephone peer support is similar to other forms of peer support training.

Examples

The following examples have been cited as they show innovative use of telephone-based peer support.

Depression

Researchers at the Flinders Health and Behavioural Research Unit in collaboration with researchers

from the University of York (UK) and University of Michigan (USA) are piloting an international peer-partner support program linking people in treatment with depression across national boundaries via telephone voice-over internet protocol (VOIP) and a study website.

People with depression are often awake at night or in the early hours of a morning and may be feeling anxious and out of control but unable to contact help because family, friends and telephone lines are not available to them at these times. Peer-partners operating in different time zones are able to provide support when others are not available locally.

Postnatal depression

A recent Canadian RCT tested telephone support provided by women who had recovered from postnatal depression to women at high risk of developing the same condition. The telephone supporters were provided with training and then paired with a high risk woman whom they phoned from time to time over 12 weeks. The women who received telephone counselling were 50% likely to have developed depression than those in the control group, and the chances that an individual woman would benefit from the counselling were one in eight or nine.

This RCT is cited in Peers for Progress literature as evidence of the value of telephone peer support in postnatal depression.

Author: Dennis C-L et al. Effect of peer support on prevention of postnatal depression among high risk women: multisite randomised controlled trial. URL: <http://www.bmj.com/2009;338:a3064>

(Note: this RCT not included in review as PND not part of the search protocol)

Gay and Lesbian Welfare Association Queensland

This is a telephone counselling service provided by people who are gay, lesbian, bisexual or transgender to assist with enquiries from other people who identify as having these characteristics. Calls are confidential and no names used.

Telephone counsellors receive 7 weeks training in telephone counselling skills, 'coming out', gender identity, safer sex and sexual health, discrimination and domestic violence in same sex relationships.

4.7 Web and email based programs

These programs overcome problems of distance, having contact with others who have rare conditions and problems of stigma and discrimination. Where carers who are strapped for time are concerned, these programs provide support that would otherwise not be possible to access. In the case of rare conditions it may not be possible to meet other people in the same city but it becomes possible to make international contacts. For those people who choose not to identify themselves, web-based peer support programs are helpful to gain support.

Technology means that support between peers takes place with the sharing of information and emotional responses through 'real time chat rooms' where messages may be publicly available or shared only between individuals. This is much the same as face to face meetings. More recently blogs have been added as another means of peer communication.

Web-based and email peer support may be moderated by a paid administrator as is the case with on-line forums from Cancer Councils across Australia. This is recommended for quality control and risk management. In the case where they are started by a person who is either a consumer or carer, that person may be the administrator and the moderator. The extent of control over what is posted and how others use the site will depend on the moderator's views of how the site should work for those who access it. Heisler (2007) points out that little is known about the risks and benefits of professional moderation over peer moderation or no moderation.

Evidence suggests that adding peer-support, such as chat rooms to internet based self-management programs or face to face programs, increases their effectiveness (Heisler 2007; Glasgow 2003). However, further research is needed to establish whether improvements are maintained by this means and how best to integrate use of new technologies into established services (Glasgow 2003).

Mike's World. An On-line Cancer Support Group <http://mikelizr1.com/>

What is an online cancer support group?

Wednesday, 01 December 2010 18:40 | Written by Administrator |

An online support group is a place for all people touched by Cancer, whether it is family friend patient or survivor where the best medicine is to talk with others in similar situations. There are no financial gains or miracle cures offered on these sites, just people that have been or are currently affected by cancer in some way or another.

I have personally dealt with the loss of a loved one, my daughter who bravely fought for three years....Being able to share experiences with others was something that helped me through this difficult period and no matter how bad I felt my situation was there were those out there whose predicament was worse.

So the purpose of this site is for people to get and give support and to just be there for each other. Being able to talk to strangers who can offer advice and not be emotionally involved with you and your family personally is a wonderful thing and gives you a strength that you didn't know you had.

Some people were afraid to use the site because they could not spell or write what they thought was correct and proper English, support is not about your grammatical skills or use of computers, nobody cares how good or bad your spelling is, it's not about that but about support so don't be frightened to jump in bad spelling and all. Last Updated (Wednesday, 01 December 2010 19:12)

Dementia Net <http://www.dementianet.com.au/>

Dementia Net is an Australian online information service. It allows people with dementia and their carers to interact with others via online chat rooms. These chat rooms require a person to subscribe so they are quarantined from the more public parts of the site. There is also a place to ask questions which will be publicly answered by a list moderator who is employed as such. Another part of the site allows people to keep a diary of their experiences which can be private, or shared with others. Public diaries mean that others may comment and offer advice.

The Carers Chat Room <http://www.carersnet.org.uk/chat/chat.html>

The carers chat area for the UK Carers Net was developed by The Princess Royal Trust for Carers. This chat room allows carers to communicate with one another around the UK and the world. The chat room is in 'real time'. Carers in the chat room at the same time chat together using keyboards. Carers Net advise participants they should never give out personal contact information such as telephone numbers, home address or other personal information to anyone in the chat room. This chat room has an open door policy that allows anyone to enter. However, to use the chat room participants need to register with The Princess Royal Trust for Carers via the chat area of the website and a registration code is then sent to their email address.

5. RESULTS OF LITERATURE REVIEW

5.1 Use of terminology:

The literature review demonstrated there is a wide range of terms associated with models of peer support.

'Lay-led' and 'lay-leader' are largely confined to self-management literature (see for example Newbould et al 2006; Barlow, Edwards, Turner 2008; Wilson and Mayor 2006; Griffiths, Foster, Ramsay, Eldridge and Taylor 2007; Lamb et al 2002; Griffiths, Motlib, Azad, Eldridge Feder et al 2005).

Lay community health workers are seen as a form of peer support. Diabetes New Zealand has lay community health workers who are volunteers, trained by a diabetes specialist nurse working with Maori and Pacific Islander communities near Auckland (Simmons et al 2009).

'Peer support' and 'peer provided services' are broader terms and may refer to support groups, peers working in conjunction with health professionals in a formal program or services delivered by peer with a chronic condition to others with the same condition (Solomon 2004).

'Expert patient' refers to lay leaders trained in the Expert Patient Program modelled on the Stanford Chronic Disease Self-Management Program (CDSMP) in the United Kingdom.

'Peer mentoring', 'peer support' or 'support intervention' (Riegel and Carlson 2004) refers to support by mentors to reduce isolation and allow older people to remain at home. People who share a common problem have a unique resource to offer one another.

Heisler (2007) uses the term 'peer coaches' or 'mentors' in relation to one-on-one meetings of trained peers with others with the same condition.

'Peer advisors' is used by Whitemore et al (2000) to describe support and education provided by elderly people who were given health education to support other elderly people. Peer advisors may be matched according to similar experiences or life events such as diabetes or myocardial infarct. Whitemore et al (2000) used 'peer informant' interchangeably with peer advisor.

'Peer counsellors' refers to a paraprofessional relationship that occurs between two older adults, one of whom is in a situation of authority (Crane-Okada et al 2010). The peer counsellor doesn't have to have the condition.

'Peer advisors in diabetes' (PAD) were people with type 2 diabetes trained to deliver the CDSMP on the Isle of Wight (Baksi et al 2008).

5.2 Definitions of peer support:

Most articles failed to define peer support or recognise differing models of peer support.

Elstad et al (2010) define peer support as 'social support shared among people living with a chronic condition or sharing a health need or objective'.

Heisler (2007) defines peer support as support from a person who has experiential knowledge of a specific behaviour or stressor and similar characteristic to the target population. Heilser emphasises

the mutuality of peer support (mutual exchange of experiences when people identify with one another's experiences).

Dale et al (2008) defined peer support in health in three categories: emotional support (including encouragement and attentive listening); appraisal support (including communication of information for self-evaluation, motivational encouragement and reassurance); and informational support (including provision of information relevant to problem-solving).

The WHO Peer Support Program in Diabetes (2007) defines peers as having diabetes or being affected by diabetes. They are volunteers and not employees; they do not replace professionals; they are advocates; their community needs and resources often define their role. The role develops as part of an existing health service or nongovernmental program. Similarly Dale et al (2007) defined peer supporters as people with diabetes who have a role in providing education and support.

Peer support refers to support provided or exchanged by people facing similar challenges or problems, e.g. cancer (Ieropoli et al 2010; Tilkeridis et al 2005). Hoey et al (2008) emphasise that sharing experiences is the essence of peer support in cancer.

Peer mentoring provides peer support (Riegel and Carlson 2004); this use of the term emphasises that mentoring is mutually supportive for both mentor and mentee.

Peer support has also been defined as 'the provision of emotional, appraisal and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics of the target population, to address a health-related issue of a potentially or actually stressed focal person' quoted in Paul et al 2007).

5.3 Theories relating to peer support

Most articles did not have a theoretical basis for peer support.

Hoey et al (2008) describe two theories relating to peer support: one in which there is a direct effect on health outcomes whereby peer support lowers feelings of isolation and depression, improves a sense of well-being and encourages healthier behaviours and the other where peer support is seen as a buffer to stress by improving coping skills and behaviours. The former theory was evident in Murrock et al's (2009) article where peer support was defined as 'camaraderie' and fostered attendance at the dance classes. This definition was seated within a social cognitive theory which relates to creating efficacy within a supportive social environment as the key to individual behaviour change. Simply expressed, the authors hypothesised that individual responses to diabetes would improve when people undertook an enjoyable physical activity within a supportive environment amongst their peers.

5.4 Key attributes

We examined the evidence from the literature in terms of a number of key attributes.

5.4.1 Effectiveness

Du et al conducted a literature review to explore evaluation models for self-management programs. The aim was to establish a general evaluation system in self-management. While not specifically about peer support, this review covers lay-led self-management programs.

Dale et al (2008) found that peer support telephone calls reduced depressive symptoms but overall did not show a great deal of effectiveness. Trials were generally of poor quality and Dale et al recommend better RCTs.

Riegel and Carlson (2004) tested the effectiveness of peer support for people with heart failure (HF) with regard to providing support for isolated people with HF. Peer support improved self-care amongst the intervention group though there was increased resource use because people sought help earlier; the study could not assess whether this was appropriate or not; it did not improve support; there was low enrolment and inability to maintain the participants.

Schwartz and Sendor (1999) focused on the outcomes of offering support for those who provided telephone support during a RCT. They recognised that support may be 'symbiotically beneficial'. This mutual benefit might arise when people are assigned to help people with whom they have some chance of developing a personal relationship. Supporters reported more benefits than those they helped; this was measured both quantitatively and qualitatively e.g. self-efficacy, life satisfaction, improved depression scores and physical role limitations.

Heisler (2007) discusses the benefits of volunteering to provide peer support on the health of volunteers. Heisler argues that there is good evidence for the benefits of face to face peer support programs and that peers are effective leaders of such programs. They are good role models; can run programs out of hours; maintain contact with participants. Heisler considers there is evidence for the improvements in chronic disease management when peer support is telephone based. Web and email support also can be done by peers. Evaluations of projects with Internet discussion boards and internet self-management programs have shown results similar to face to face self-management.

Taylor et al (2009) conducted a Cochrane Review and found that lay-led self-management programs led to small, short term improvement in self-efficacy, self-rated health, cognitive symptom management, and frequency of aerobic exercise. No evidence demonstrated that they improve psychological health and health related quality of life.

Kennedy et al's (2007) report on RCT of lay-led self-management program in UK concluded that they are effective in improving self-efficacy level and energy levels and are cost-effective within the UK health system where they are likely to be paid for by NHS.

Fu et al (2008) compared lay-led and professionally led self-management programs. Only changes in self-rated health differed significantly between the groups. Patients in the lay led group had significantly improved rates of fatigue while those in the professionally led group had better self-rated health scores.

Dale et al (2008) measured improved self-efficacy through peer led telephone support from peer supporters. This was an RCT where peer telephone support was compared to health professional telephone support. Those people who received peer telephone support considered it very helpful and would recommend it to others. There was a rise in self confidence related to managing diabetes and rises in adherence and exercise. There was no evidence of telephone support leading to improved outcomes whether delivered by health professionals or peer supporters.

Collela and King (2004) undertook a literature review on peer support with regard to its effectiveness in supporting patients recovering from cardiac surgery. Based on the evidence, they consider it has the potential to improve outcomes for those who have undergone cardiac surgery, assist carers and ease financial burdens on the health system. They also consider the value it has to the peer supporter in maintaining their own health following cardiac surgery.

Griffiths et al (2005) undertook a CDSMP in Bangladeshi using trained peer supporters and found that the benefits were marginal and possibly limited by poor uptake and poor attendance.

Funnell (2009) undertook a literature review of peer support and concluded that, while health professionals could fill the role of providing ongoing support and strategies to improve behaviour change, peer supporters were equipped to provide the long term support required in self-management. She concluded that, with training, peers could provide the psychosocial support needed in the long term. However, she identified that many peer based programs did not describe the behaviour strategies employed by peers and very little is known about the training required for peers to successfully implement behaviour strategies.

Simmons et al (2009) undertook a systematic review of literature relating to peer support in diabetes care in NZ. They found a range of support activities including lay community health workers, support groups, volunteers working in the community. They consider that peer to peer support has the potential to overcome emotional, self-efficacy and other barriers in relation to self-care. While peer to peer support appears to be valuable in primary prevention in NZ, the authors call for further research to evaluate the efficacy of the training of lay people in diabetes prevention.

Chambers et al (2008) report that dyadic peer support for men with prostate cancer has demonstrated reduced depression and improved self-efficacy (note this was a feasibility study). A RCT of education to men having treatment for prostate cancer found that, when peer discussions were added to health professionally provided information, 'sexual bother' was significantly alleviated. They generalise that when peer-delivered sexual counselling is added to health professional delivered information this will be effective.

Hoey et al (2008) undertook a systematic review of peer support programs in cancer. In the RCTs they reviewed there were results relating to increased social support for only three of the RCTs. Other RCTs found peer support produced no significant improvements in psychological distress or health related quality of life. Hoey et al point to the methodological problems such as small sample sizes, lack of clear measures, and lack of long term follow up measures, which related to many of the projects that were reported as well as suggesting that many of the outcome measures may not be appropriate for assessing the effectiveness of peer support. Few articles assessed reduced isolation, increased hope and shared experiences.

Griffiths et al (2009) conducted a systematic review of internet support groups and depression. It was not clear from their review if the groups were peer support or facilitated though the use of support suggests they are open-ended groups. There was little evidence of the efficacy of the groups; however, there was evidence that the users perceived them as useful.

Eysenbach et al (2004), in exploring health related virtual communities, remarked on the lack of good evidence of their effectiveness. The lack of measurable effectiveness was in sharp contrast to the popularity of such groups and researchers, they argued, would do well to assist in their evaluation in order to promote peer to peer self-help that was effective.

Social support, which includes peer support, is considered important in diabetes care (Damm et al 2005) but there have been few RCTs of this intervention. The review conducted by Damm et al (2005) concluded that it was impossible to tell which aspects of social support are most effective for enhancing self-management and outcomes for people with Type 2 diabetes.

Schwartz (1999) conducted a RCT to test the comparative effectiveness of coping skills (face to face) group and telephone peer support in people with MS. This trial found little difference between the outcomes for the groups. People with MS receiving telephone peer support were less likely to drop out than the ones in the face to face group.

5.4.2 Effectiveness of peer support in disadvantaged populations

Glazier et al (2006) found that for people with diabetes from disadvantaged groups lay-delivered sessions were more likely to be associated with good outcomes than were health professional provided didactic sessions. However the authors note that it was difficult to make judgments about the effectiveness of most interventions from the articles.

Perez-Escamilla et al (2008) undertook a systematic review of peer education and counselling on nutrition habits among US Latino populations. Despite the short-comings of many of the studies there was evidence that the use of Community Health Workers (CHWs) in diabetes is effective. RCTs in both Puerto Rican and Mexican populations have shown that CHWs are associated with improved medical adherence, lowered glucose levels and improved knowledge. CHWs have been used in a variety of ways in various projects, from providing social support to delivering diabetes education programs. Levels of training have been variable.

Dance and peer support was the subject of one RCT with African American women (Murrock et al 2009). In this RCT peer support was defined as camaraderie which fostered attendance. The dance classes were culturally relevant, being taken by an African American woman, with dance steps graded to suit those with some physical impairment to those who were fit and then danced to gospel music chosen by the women. Women in the intervention group had significant reductions in blood pressure, their weight and HbA1c compared with the control group.

Griffiths et al (2005) conducted an RCT of Bangladeshi people with chronic illnesses in East London. The Stanford Chronic Disease Self-Management program was adapted for Bangladeshi people and delivered by trained facilitators who were also Bangladeshis with chronic illnesses. The RCT reported people benefited in terms of self-efficacy from the attendance but there were few effects on use of health services. The RCT also suffered from poor attendance and poor uptake of the program.

Simmons et al (2009) conducted a systematic review of diabetes programs in New Zealand and found that peer to peer programs were useful in overcoming motivational and other psychological barriers in diabetes self-care. They were particularly of benefit where there were no professional workers available and with disadvantaged communities.

5.4.3 Cost-effectiveness

The only RCT to assess cost-effectiveness was conducted by Kennedy et al (2007) on the Expert Patients Program in the UK. The authors judged that, if a quality adjusted life year was valued at £20,000, then immediate access to a self-management program improved health related quality of life and resulted in reduced costs, thus making it a 70% probability that the program was cost-effective. There was no reduction in health service utilisation. The authors note that much of the cost was subject to estimation and hypothetical figures so that resulting figures are estimates. They based this on the 'conventional level of decision-makers' willingness to pay'.

5.4.4 Outcomes of effective peer support

Of fifteen systematic reviews the most often reported outcome (10) is improved self-efficacy or improved well-being. One reports improved social support. Systematic reviews generally note that outcomes of peer support are difficult to assess from the literature. Hoey et al (2008) noted that high levels of satisfaction were recorded by people involved in cancer support but there was poor evidence of effectiveness. Macvean et al (2008) also criticised the poor evidence of effectiveness available in literature on cancer support.

Parry et al (2010) concluded that peer support produced higher levels of self-efficacy, reduced pain and fever and reduced emergency room visits for people with heart disease but cautioned there were too many methodological problems to generalise more widely.

The Expert Patient Program provided short term benefits but the evidence showed it was difficult to estimate the relative or absolute effectiveness of the program (Newbould et al 2006). Similarly Foster et al (2009) found there were short term benefits such as self-efficacy but that most clinical improvements remained insignificant. In contrast Funnell (2009) argues that peers are best for long term management of chronic disease based on the premise that health professionals cannot sustain such long term relationships. She does, however, concede that so far there are few details of which strategies work best in the longer term.

With regard to internet support groups, telephone peer support systematic reviewers (Dale et al 2008; Griffiths et al 2007) noted they were effective in terms of social support but methodological problems made it hard to generalise.

Glazier et al (2006) argued there were key interventions for successful peer support programs in socially disadvantaged populations. These interventions related to cultural tailoring, use of peer leaders and a level of resources to sustain the programs.

Only two systematic reviews pointed out that none of the literature they reviewed had documented any adverse events arising in peer support programs or had presented results of peer support programs that had failed. However van Damm et al (2005) concluded from their review of peer support in diabetes that social support from peers may enhance diabetes care though, where men are concerned, more support may have a negative effect.

5.4.5 Summary of results

The literature demonstrates a wide range of terms involved in peer support and self-management and there is no single, widely accepted definition of peer support. Terms and definitions encompass concepts of support or education by non-health professionals who have some characteristics in common with the target population. They may not necessarily have the same health condition but they may live in the same community or speak the same language.

Most research projects were pragmatic in their intention which was largely to find effective outcomes from a peer support intervention. They were not undertaken to test theories of peer support or to develop new hypotheses of how peer support improved health outcomes.

Many of the RCTs found that peer support programs produced improvements in self-efficacy, or simply improved people's sense of well-being or provided social support. There was little evidence about how sustained these improvements were. Long-term improvements in biological health outcomes were less likely to be reported, with systematic reviews documenting that health outcomes were often only a little better in intervention groups than in the control groups.

Systematic reviews found that peer support worked well in disadvantaged populations.

RCTs were confined to single diseases and, apart from addressing depression related to these conditions, did not take into account any greater complexity.

There was only one RCT of the cost-effectiveness of lay-led self-management.

Systematic reviews were generally critical of the research design of RCTs of peer support, the lack of documentation in the articles and the inability to compare results across research projects.

6. DISCUSSION

6.1 Quality of research designs

Thirty -two RCTs were included in the literature review. Sizes of the samples included in RCTs might be small. For example Murrock et al (2009) recruited 46 women to be randomised between a dance and usual care group and Reigel and Carlson (2004) recruited 60 patients out of a possible 237 patient for a heart failure program. However Fu et al (2003) recruited 954 patients to their CDSMP in Shanghai with less than 50% of them completing the 6 month study. More than 900 people with cancer were enrolled in a study of internet peer support (Hoybe et al 2010) with a loss of approximately 25% for various reasons.

Some RCTs did not describe their randomisation methods. Taylor et al (2009) in their systematic review of self-management programs with lay-leaders are critical of the inadequate reporting of how randomisation was undertaken, how adequate was the concealment of allocation to groups and how researchers dealt with other potential sources of bias. It is worth noting RCTs are generally not good indicators of what happens in 'real-world' settings as all those in both the control and intervention groups are self-selected from those who are most interested to participate and may be self-selected from hospital-based populations which are not representative of those living in the community. .

Hoey et al (2008) conducted a systematic literature review of peer support in cancer and found that most of the studies were related to breast cancer and were descriptive, with only eight RCTs identified. Most of the articles reviewed did not provide adequate information on the design and delivery of the peer support programs so that researchers cannot assess the value of an intervention. Hoey et al rated the papers as generally 'fair' in this regard.

Paul et al (2007) argue that peer support is a complex intervention and should be evaluated according to Medical Research Council (UK) guidelines for complex interventions. This includes piloting and modelling before the implementation of a full RCT, as well as the inclusion of a qualitative process intervention and health economic analysis.

Griffiths et al (2009) conclude from their systematic review of internet support groups for depression, which also covered some support groups for other conditions, that there is need for high quality research to evaluate internet support groups for depression. The evidence was of too poor quality to inform decision-making at any level regarding their value in addressing depression.

Eysenbach et al (2004) conducted a systematic review of health related virtual communities. They found that most RCTs of virtual communities did not provide sufficient detail to determine the quality of the study; it was not possible to examine the effectiveness of the peer to peer support of virtual communities because of the study designs. They concluded that, since virtual communities and peer to peer support of this nature was so pervasive, it was necessary to undertake better designed quantitative studies.

Van Damm et al 2005 conducted a review of social support including peer support interventions in Type 2 diabetes. They considered the RCTs they reviewed were difficult to assess; for example, many of the RCTs did not employ measures of social support so it was not possible to assess the optimal

amount of social support or which components of social support are the most effective. Some of the RCT did not assess biomedical outcomes.

Macvean et al (2008) conducted a literature review on peer support in cancer programs. They were most particularly interested in one-on-one volunteer support. They arrived at 28 papers of which 19 described peer support programs, though only 10 of these papers described the volunteer role in any detail. Training of volunteers received scant attention in most of the 28 papers. Most of the papers described the peers as people who had cancer currently or had recovered from cancer. The research based papers in this review provided indications of the benefits of peer support but the evidence of the effectiveness of peer support was limited since only one was a well-designed RCT, which measured the benefits of peer support. However this RCT had a small sample size and only studied short term outcomes.

Glazier et al (2006) explored the evidence of effectiveness of programs for people with diabetes from disadvantaged populations. They found that of the 17 studies that fit socially disadvantaged populations there were only 6 RCTs that described their randomisation processes.

Perez-Escamilla et al (2008) undertook a systematic review of peer education and counselling on nutrition habits among US Latino populations. Despite the short-comings of many of the studies there was evidence that the use of Community Health Workers (CHWs) in diabetes is effective. RCTs in both Puerto Rican and Mexican populations have shown that CHWs are associated with improved medical adherence, lowered glucose levels and improved knowledge. CHWs have been used in a variety of ways in various projects, from providing social support to delivering diabetes education programs. Levels of training have been variable. The authors conclude that there is need for better research into the optimal role of CHWs and their effectiveness. Such research could be followed up by research into cost effectiveness.

The quality of the research designs is consistently criticised by systematic reviewers who argue that poor design and lack of information in articles makes it difficult to evaluate or trust the results reported. Evidence of the effectiveness of the programs is lacking. It is interesting to note that most reviewers do not condemn peer support programs because of this lack of evidence of their effectiveness but instead argue for better evaluation and better research design. Few, however, offer advice on this, with only Perez-Escamilla arguing for longitudinal randomised controlled trials of peer support in nutrition and Hoey arguing for better documentation of results.

6.2 Attributes of those who participate in peer support; attributes that make peer support attractive
There was little information on the attributes of those who participate in peer support. RCTs reported drop-out rates of up to 50%. This suggests that participants were either not engaged by the intervention or were not the most appropriate recruits. Gender does not appear to be an issue from the literature. Both men and women were prepared to be trained as peer leaders. There was some small evidence that the desire to help others and a willingness to undertake training and learn new skills were important factors in becoming a peer leader.

What makes peer support attractive to participants was not discussed to any degree. However, some RCTs reported that the social aspect of peer support was an important factor in maintaining attendance.

Lack of information in this area means that the design and delivery of peer support programs beyond an RCT is at a 'hit and miss' level.

6.3 Training

Training is recognised as an important part of peer support programs, with most organisations that auspice peer support programs offering training to peer supporters. Unfortunately, most articles do not give details of training for peer supporters. This is probably due to the word limit placed on authors and the focus of articles on results rather than the details of how the results were achieved.

Lorig and her colleagues have always maintained that a consistently delivered training program for peer facilitators is essential since it provides the basis from which to compare results across self-management programs. Lorig (2009) provides a good description of the training of peer-leaders for a community based diabetes program.

Riegel and Carlson (2004) describe training for mentors in heart failure self-management. This was undertaken by a trained cardiovascular clinical nurse. Mentors were given basic information about heart failure, diet, exercise and medication. They were taught about support and communication as opposed to assuming the role of the health professional. They were taught to model practical solutions to self-management problems and maintain boundaries in their relationship with mentees. The cardiovascular nurse held monthly meetings with mentors and was available to assist the mentors with advice.

Crotty et al (2009) included peer support calls in an RCT of self-management strategies for people with arthritis in SA but there are few details of the calls, none of the training of peer supporters and no details of the outcomes of the calls.

In their RCT of peer support in multiple sclerosis, Schwartz and Sendor (1999) briefly describe training of telephone peer supporter in non-directive and active listening based on psychotherapeutic theories. The goal was to facilitate the development of the capacity and insight to deal with problems by allowing the study participants to explore their own feelings. In this RCT one of the results was that the peer supporters reported greater benefits than the participants.

Crane –Okada et al (2010) gives good account of training for peer-counsellors.

Funnell (2009) identified that many peer based programs did not describe the behaviour strategies employed by peers and very little is known about the training required for peers to successfully implement behaviour strategies.

Baksi et al (2008) ran a small RCT (n=67) to test the value of peer advisors in running a self-management program for people with diabetes. They compared peer-led programs with professionally led programs. There were no differences in the results between peer-led and health professional led programs. Both groups improved in terms of information, adherence to medicine, nutrition and exercise. Neither group showed improved HbA1c levels, possibly due to the short time span of the project. The authors conclude that trained patients are effective in delivering training programs.

Glasgow et al (2003) ran a complex RCT of which part of the intervention was internet-based peer support. They concluded that internet-based self-management interventions appeared moderately successful especially in improving dietary behaviours. However, they concluded it was not clear how long or how actively participants need to use internet based interventions to achieve significant changes in behaviours and physiological measures.

6.4 Evaluation

One article (Du and Yuan 2010) discussed evaluation methods in full. While these evaluations were largely related to trials of self-management programs, they are also relevant to peer support. Du and

Yuan noted there was little consistency in evaluation with different standards and designs for evaluation. The authors only concentrated on indicators used in quantitative evaluation. Most trials used self-efficacy as an indicator but there was wide variation in the use of other indicators with some employing health service utilization, some using health status, some using health behaviour and quality of life indicators or psychological indicators.

6.5 Interfaces with the Victorian health system

This section relies on anecdotal evidence. Anecdotally, it is the not-for-profit organisations that have most engaged in, and developed, all models of peer support. These organisations continue to adopt new technology to work with consumers which promotes communication amongst their consumer groups and consequently peer support. On-line support groups, use of social media, Skype and internet chat groups are common with many of the not-for profit organisations.

In the recent past, attempts have been made to link not for-profit-support services to sub-acute and primary care services. In 2008 the DHS Primary Health Branch published revised guidelines for Primary Care Partnerships and primary health services which recommended referring people to peer support groups in the community in Early Intervention in Chronic Disease (EliCD) programs. As part of good management of chronic disease, it also recommended that GP Management Plans consider referring people to peer support groups. Individually, Primary Care Partnerships have made links with not for profit organisations where peer support is likely to be centred. The focus of both Hospitals Admissions Risk Programs HARP and Primary Care Partnerships has been self-management and this focus has developed programs that are both professionally led and peer led. Thus this model of peer support has become more integrated into the Victorian health system than before the HARP and Primary Care Partnerships.

Interestingly the 'Chronic Disease Action Plan for South Australia 2009-2018' incorporates referral to peer support self-management programs. It also includes peer support groups in its disease management strategy for secondary and tertiary prevention of chronic diseases. NSW Health Rehabilitation for Chronic Design also suggests that part of rehabilitation is to refer people to community based peer support groups.

Additionally the DHS Service Directory has provided the means to refer people to support groups in the community and in not-for-profits. The value of the Service Directory relies on peer support groups including their details. Barwon Health provides links to a list of community services for health professionals including local GPs and this list includes self-management and support groups which are professionally led self-management groups.

Support groups are the other major model of peer support in both sub-acute health services and primary care (largely community health services). These are generally professionally led support groups and examples are Knox Community Health Centre Weight Loss Support Group and Western Region Health Centre Mental Health Day Programs.

Peer-led support groups may begin as independent groups and then develop links with health services in either the acute sector or primary care sector. Both Rosebud and Mornington Diabetes Support Groups have links to Peninsula Health through the diabetes educator from Peninsula Health. Additionally support groups affiliated with a not-for-profit organisation may develop links with both community health services and health services. Support groups affiliated with the Cancer Council and Diabetes Australia Victoria have associations with health services. For example, the Shepparton Diabetes Support Group has an association with the local community health service, using its facilities for meetings and liaising with the diabetes educator and referring people to its services.

Another interface has occurred through HARP programs. For instance, a peer support group was developed for HARP2 clients at Ballarat Health Service. Barwon Health's HARP program offer support groups that are professionally led for the range of conditions with which they work.

Often in both sub-acute and primary care services the extent to which there are links with support groups depends on individuals who are working in these services, as well as the specific funding. Both HARP and PCP funding has fostered the staff and the projects to make these links recently.

In primary care it is far less likely that GPs will refer people to peer support groups or any other model of peer support.

Models of peer support such as internet, email and telephone models are less likely to be integrated within sub-acute or primary health care services.

Example of peer support in primary care services

CRAIGIEBURN ARTHRITIS SELF HELP GROUP
Peer Support Partnering with Community Health
"Our Success Story"

WHY WE HAVE A SELF HELP GROUP

- Power of peers
- Advocacy
- Perceived Community Needs
- Limited Resources of Health Services
- Health incorporates Social, Physical & Emotional well being

WHAT WE DO

- Self Help group meetings
- Water Exercise
- Chair Exercise
- Support Mental Health Rehabilitation programs
- Regional Presentations

COMING – GOING – GONE

- Nordic Walking
- Tai Chi
- Walking Groups
- PRIME Movers
- Better Health Self-Management

PARTNERSHIPS

- Arthritis Victoria
- Dianella Community Health Centre
- Leisure Centre
- Hume City Council

"PARTNERSHIPS OF EQUALS BUILT ON RESPECT AND TRUST"

This group has been in operation for twenty years and has expanded to several group meetings per month to meet the needs of its increased numbers. The group is associated with Arthritis Victoria and Dianella Community Health. The physiotherapist at Dianella maintains that she would not be able to meet the needs of all Dianella's clients with musculoskeletal conditions and the self-help group assists her in this respect. She attends the group and refers clients to it.

Dianella intends to evaluate the self-help group's outcomes.

Example of peer support in sub-acute care

Goulburn Valley Health Service HARP – Disease Management Team (DMT):
HARP-DMT aims to improve the quality of life for people with Chronic Heart Failure and Chronic Obstructive Pulmonary Disease by supporting them at home to manage their disease. Several support groups have been initiated by the DMT. They are regularly evaluated and have been shown to reduce hospital admissions.

The groups are evaluated in terms of process measures and consumer qualitative feedback via a survey. Regarding admission rates to hospital for heart failure/chronic lung disease, when last evaluated indicated that the support programs were effective (low re-admissions), but as both groups and home visits are offered, it cannot be determined whether one of these components is more effective than the other. Anecdotally, clients who attend the groups are more 'well' and recover more quickly/fully after exacerbations, but this could also be attributable to the characteristics of those clients who choose to attend the groups versus those who choose not to attend them.

Question 6 of their August 2010 evaluation survey was undertaken to establish how well clients understood the objectives of the group (for example, to improve/maintain physical capacity, stay out of hospital, proactively monitor health etc.) Responses indicated that clients understood why the groups had been established and what the objectives of the HARP team were. It was then interesting to note their responses to question 8 below, which gave participants the chance to state what they most liked about the group. In response: "80% of clients documented that the social interaction with others was the best feature of the group, this provided overwhelming evidence that the 'peer support' role of the group was functioning well and was the most highly valued aspect of the group."

Example of peer support in sub/acute care

Genetic Services Victoria and Genetic Support Network Victoria (GSNV) work together in the paediatric and adult genetic services area. Counsellors will refer families to GSNV for follow up support. There are 130 support groups attached to GSNV relating to individual genetic conditions, some of which are very rare. GSNV links families across Australia through 'peer-matching'. Families with the same genetic condition are linked but this linking includes matching up people's needs, interests and social conditions. For example, a family in a rural area will ideally be linked to a family in another rural area because they will face similar social issues.

7. CONCLUSIONS

- There are several models of peer support. While the most common model relates to support groups, either peer-led or facilitated by health professionals, new technology means other models are developing almost daily;
- The evidence for the effectiveness of peer support is poor. However there are a number of factors which means this statement cannot be accepted at its face value:

- poorly designed RCTs rather than the programs themselves contribute to the poor evidence base;
- articles reporting on results of RCTs lack detail of the methods and this may be related to the word limits imposed by journals rather than the RCTs themselves;
- comparisons of results between programs is difficult as many of the indicators used are not consistent;
- Despite this lack of evidence, peer support models continue to be developed and promoted in Australia by not-for-profits and by state government health departments;
- With the growing interest in peer support programs from international groups such as Peers for Progress and Stanford University, greater consistency in evaluations may be anticipated;
- There is some form of training given to most peer supporters when these models are associated with not-for-profits and sub-acute and primary care. This training is rarely described or reported on. It is likely that training programs are subject to internal evaluations though not published;
- There is a strong historical association between peer support and not-for-profit groups. Peer support groups are now associated with primary care largely in community health services and sub-acute care via HARP programs.

8. RECOMMENDATIONS

The following recommendations are based on the results of this literature review:

a: (i) That an audit of models of peer support and their connectedness to the Victorian health system be undertaken to establish which models are most used and valued by both health consumers and health professionals; where peer support sits in the Victorian health system; with which target populations peer support might be most effective; what roles peer support could play; any evaluation tools currently in use and the funding sources.

(ii) This audit include an audit of the training models and tools used to train peer supporters since this literature review identified that training is poorly described in literature. This audit of training is required to fully understand and evaluate effectiveness and cost-effectiveness of models of peer support.

b: This audit forms the basis for developing an evaluation framework for peer support. Since RCTs are expensive, complex research interventions which are not suited to measuring the effectiveness of a social intervention such as peer support, an evaluation framework that can be used across all peer support models should be developed so that consistent and comparable data are obtained.

An evaluation framework should include simple tools to allow people with few research skills to self-administer data collection and to analysis that identifies outcomes and effectiveness of peer support in specific situations as well as offering future directions for a support group and the health services with which it is associated.

c: While some data to evaluate cost-effectiveness of peer support models could be collected from a self-administered evaluation framework, this form of evaluation is highly specialised and requires it be undertaken by an expert. It is recommended that cost-effectiveness be evaluated in already established and ongoing programs that are based in real community experiences rather than in RCTs where the groups have been created for that purpose.

d: More work is required to understand which components of peer support produce the best results in terms of effectiveness and better health outcomes. Training of peer supporters is one of these components. There is also lack of data on the characteristics of those who participate in peer support. Researching these components can contribute to the design and delivery of programs that address the needs of particular populations.

e: Given that the best evidence for the effectiveness of peer support has been produced from programs run in disadvantaged communities where risks and health outcomes of chronic diseases may be greatest, it is recommended that the Department of Health concentrate any resources in these areas. Given that disadvantaged communities are resource poor, attention must be paid to providing resources such as training, education and information as well as ongoing support to peer support groups and their leaders to ensure sustainability.

f: Where disadvantaged Culturally and Linguistically Diverse (CALD) populations are encouraged to take up peer support, culturally relevant interventions with peer leaders from the community are recommended.

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