Peer-to-peer mental health: a community evaluation case study

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Abstract

Purpose – The purpose of this paper is to report the findings of a third-sector community review into peer-to-peer best practices in mental health service provision in Sussex. This community initiative was funded by the Big Lottery to explore the benefits of the peer-led approach on individual and public health outcomes and identify avenues for partnership working.

Design/methodology/approach – A total of 131 participants who had engaged with peer-to-peer services both as receivers and providers of support were invited to share knowledge and best-practice expertise via a survey, focus groups and a public consultation day.

Findings – This case study review suggests peer-to-peer support services as an innovative approach to reducing suicide, self-harm, reliance on public health services (GPs, hospital stays, etc.) and engaging with drugs, alcohol and criminal activity. In addition to offering a holistic and social approach to mental health, it further identifies that engagement in peer-to-peer activities potentially provide long-term benefits by reducing the stigma associated with mental health conditions and treatment. This review highlights the importance of third-sector groups in providing peer-to-peer mental health support services. It recommends a network of Peer-to-Peer services to share best practices and improve partnership working.

Originality/value – Conducted by and for people with personal or family experiences with mental health challenges, this review captures the often inaccessible ideas of a highly marginalised group. It communicates how they would prefer to work in partnership with academic institutions, public and statutory service to improve individual and community health outcomes.

Keywords Community partnerships, Mental health, Peer support, Public health, Peer-to-peer, PPI

Paper type Case study

Introduction

The Organisation for Economic Co-operation and Development (2014) claims mental health costs the UK over £70 billion per annum (p. 15). Those with mental health challenges are more likely to experience physical ailments yet less likely to receive timely diagnoses or have treatments properly managed (Mutsatsa, 2015). In addition to health and economic disadvantages, those with severe mental health challenges are less likely to have access to resources through social connections (Secker, 2009; Webber et al., 2015). Involving those with personal or family experiences in mental health in providing services for their peers has increasingly been suggested to improve service and support health outcomes (Repper and Carter, 2011; Ockwell, 2012; Mead et al., 2001).

Formally or informally engaging those with lived experience in service provision can be achieved, for example via support groups, friendship services, peer mentoring or by organisations that employ board members or staff with similar experiences to members. “Peer-to-peer” is an umbrella term to describe the diverse range of practices that provide systems of support where people with shared experiences can aid each other in wellness.
This case study explores a community evaluation of peer-to-peer Sussex service provision undertaken by three third-sector groups from Brighton and Hove:

Mothers Uncovered – a creative support network for mothers (part of the Brighton charity Livestock). It runs arts groups, performances and events led by mothers who have participated in the programme (www.mothersuncovered.com).

Grassroots Suicide Prevention – a Brighton-based charity that supports communities to prevent suicide through training, education, strategy and consultancy (www.preventsuicide.org.uk/).

Synergy Creative Community – a not-for-profit community organisation led and run by people with an interest in and experience of mental health care. The mission is to develop a community network of peer support and creative exchange (www.synergycreative.org.uk).

Each organisation involved those with personal or family experiences in different ways, yet they had all observed benefits to their members and organisations. They recognised the theory behind the approach did not match the diverse extent that these services were being provided within their community.

Seeking to work collectively with peer-to-peer groups, service users, providers, third-sector support organisations and statutory services, a total of 131 participants who had engaged with peer-to-peer services both as receivers and providers of support were invited to share knowledge and best-practice expertise. Funded by The Big Lottery, the aim of the evaluation was to suggest how peer-to-peer support could improve individual and public health outcomes, map the prevalence of the approach in the region and provide best practice recommendations.

What the literature says

This evaluation began with a review of publications and practice examples. These were collectively reviewed to guide the line of enquiry.

Evidence of need

Referencing the Office for National Statistics Psychiatric Morbidity report (2001), the Mental Health Foundation states 25 per cent of adults in Britain will experience a diagnosable mental health condition at some time during the course of a year (Mental Health Foundation, 2015). When compared to national averages, the Community Mental Health Profiles indicate the levels of mental health and illnesses are higher in east and west Sussex with both areas showing statistical increase in cases of dementia, learning difficulties and depression (CMHPa, 2013, CMHPb, 2013).

The need to engage those with lived experiences in mental health service provision has been well documented (Department of Health & Department for Work and Pensions, 2006; Department of Health, 2010; Secker, 2009). Increased research into peer-based approaches and a greater understanding as to the extent these services are provided has further been suggested (Repper and Carter, 2011). Recent publications have commonly identify peer-to-peer sector support needs to include an increase in training and development support programmes (Biggs et al., 2012a, b; Chakkalackal, 2013; Faulkner et al., 2013).

Is peer-to-peer a valid approach for public health?

In 2010, the Royal College of Psychiatrists reported that general wellbeing for all people is improved by social inclusion and meaningful physical and mental engagement activities (Royal College of Psychiatrists, 2010). That same year, the NHS’s goal to put “patients at the heart of everything we do” (Department of Health, 2010, p. 1), has resulted in the creation of new structures to strengthen patient and public involvement. In addition to improving mental health services, involving those with lived experiences has been reported to increase their skills and employment opportunities (Department of Health & Department for Work and Pensions, 2006, p. 6). Referencing an analysis of six studies which suggested a cost-benefit when employing peer support mental health workers (Trachtenberg et al., 2013), the Centre for Mental Health calculated that £4.76 would be saved for every £1 invested in peer support (Knapp et al., 2014, p. 19).
Are peer-to-peer services known to improve individual health outcomes?

Suggesting peer-led services could be an effective approach to improve mental health outcomes, Repper and Carter (2011) analysed seven randomised control trials (including Clarke et al., 2000; Davidson et al., 2004; Dumont and Jones, 2002; O'Donnell et al., 1999; Rogers et al., 2007; Sells et al., 2006; Solomon and Draine, 1995). They uncovered that the inclusion of peer service provision was proven to be as effective in maintaining readmission rates as traditional services and in some cases, significantly reduced hospital rates. For example, research from (Chinman et al., 2001) shows a 50 per cent reduction rate in re-admissions to hospitals, studies by Lawn et al. (2008) demonstrated that over 300 bed days were saved over a three-month period when peer support workers were employed. A three-year study by Min et al. (2007) highlights the longer-term benefits of peer support in reducing hospital admissions. Benefits of involving peer support workers are noted to provide something traditional services may lack such as increased hope, social connections and improved self-esteem (Repper and Carter, 2011).

In stark contrast to treatment models based on provider/user approaches, peer-to-peer support has been argued to provide equal benefits to both parties (Mead et al., 2001; Biggs et al., 2012a, b; Chakkalackal, 2013; Faulkner et al., 2013). It has also been suggested as a more effective long-term solution by reducing stigma and aiding in ongoing recovery (Ockwell, 2012; Slade, 2009).

What opportunities exist for peer-to-peer services to work together?

Public, private and third-sector peer-to-peer service providers were identified via the review of academic literature, general internet searches and through participant responses. Many of those identified were provided by third-sector groups. Involving the third-sector in service provision has been suggested to be an effective approach in addressing health inequalities (Belle-Isle, 2014). This has further been exemplified locally through a description of a recovery college pilot in Hastings (Meddings et al., 2014).

A number of collaborative peer-to-peer initiatives have recently been initiated within the UK. “Together” offer accredited training for peer leaders and have partnered with the National Survivor User Network (NSUN) to map peer-to-peer service provision in relation to mental health across England (Together, 2015; NSUN, 2014). The Peer Led Peer Support Collaboration (2014) is a UK network of nearly 17,000 peer-led mental health support initiatives to increase promotion and improve service provision. The Scottish Recovery Network is currently mapping peer-to-peer service delivery in Scotland and developed the Professional Development Award in Mental Health Peer Support in partnership with the Scottish Qualifications Authority (Scottish Qualifications Authority (SQA), 2015).

Individual charities were also identified. MIND charity provides a directory of peer-to-peer services and run several peer participation services including their wellbeing service and The Lighthouse recovery support service for people with personality disorders (Mind, 2015). The CAPITAL Project Trust is dedicated to reducing mental health stigma through accredited training and the promotion of peer support and service-user involvement (CAPITAL, 2014). Education which values “lived experiences” as a complement to mental health treatment, is also apparent within England’s Recovery Colleges (see e.g. Meddings et al., 2015).

More locally, Southdown Housing Association developed the Peer2Peer service in 2007 in partnership with Brighton Housing Trust (BHT) providing peer-led services within Brighton and Hove (Southdown Housing Association, 2014). Sussex Partnership Trust has developed resources and training surrounding peer-to-peer services in mental health; promoting the inclusions of social firms, social enterprises and other “vocational rehabilitation” (Sussex Partnership Trust, 2014). Recovery Partners, is “100 per cent user-led and run” and offers services such as free one-to-one and peer group sessions for people facing mental health challenges run by those with personal experience (Recovery Partners, 2014).

Internationally, innovative practice examples suggest creative ways to provide sector support to peer-to-peer services. For example, in Vancouver Canada “Peer Network BC” offers a physical space for peer-to-peer groups and provides collective training and access to shared equipment (Peer Network BC, 2014). The National Peer Support Collaborative Learning Network in America...
collectively champions peer-based approaches to address both physical and mental illnesses (NPSCLN, 2014). In Australia, The Centre of Excellence in Peer Support (2014) provides an online clearing house of peer-to-peer resources. Indicating an increased interest in the peer-based approaches, The European Commission has recently supported multi country research on peer-led addiction services (e.g. Correlation Network, 2013).

Peer-to-peer community evaluation

This community review was informed by and later compared to the aforementioned literature to identify links between theory, policy and practice.

What we did?

A mixed method approach was chosen to allow people to participate in the way they felt most comfortable, resulting in 97 people offering opinions via a survey, 16 people participating in focus groups and 18 people participating via a public consultation day.

The project partners collectively agreed project aims, method selection, information sheets, consent forms survey and focus group questioning and project design. Two contractors were employed to assist with the evaluation; with both having personal experience in engaging with peer-to-peer supports independently of the partnering organisations. Full disclosure of aims and intentions was embedded into every area of the project.

All participants were self-selecting. Providing opportunities for wider participation, the survey and public consultation day were advertised via public posters and community web forums. Posters and survey information were e-mailed to organisations identified via literature and initial participant responses. These groups were invited to share the invitation across their networks.

Survey. In all, 97 people responded to a survey. In addition to print copies, an internet survey was selected as it: allowed for wider distribution; allowed participants to participate from their home should they have social or mobility concerns; and provided additional time to review the online information sheet/directly contact the project partners for more information.

In total, 31 per cent of survey respondents noted they both received and provide peer-to-peer services, 46 per cent self-identified as service users and the remainder managed and provided administration support for peer-to-peer services. The majority of respondents were from East Sussex (76 per cent), 10 per cent from West Sussex and 14 per cent from other areas. Totally, 70 per cent stated they accessed peer-to-peer services through a third-sector organisation, 10 per cent through the public sector, 6 per cent through the private sector and 9 per cent were not sure what type of organisation provided the services they received. The most common form of peer-to-peer support cited was support groups led by a peer facilitator (66 per cent), 31 per cent were accessing charity services run by people with shared experiences and 28 per cent accessed support clubs run by a peer collective. Peer mentoring and leadership programmes were accessed by 21 per cent of respondents.

The ten question survey consisted of open and close-ended questions. Two open-ended questions asked participants to suggest names of peer support organisations and identify concerns associated with the approach. The remaining eight were close ended and either multiple-choice or scale. Each included a "not applicable" option. In addition to querying why and in what ways people engage in peer-to-peer services, participants were asked to identify areas where they had avoided engaging in unhealthy activities such as drug/alcohol use or criminal behaviour and areas they estimated their use of statutory services had been reduced over the last year. To assess benefits and best practice recommendations, participants were asked to select from recommendations previously identified via the literature. An "other" option with space was further provided that participants could contribute new ideas.

Focus groups. Three focus groups involved a total of 16 people. Participants were members of each of the partnering organisations; ensuring that all participants had currently engaged with the peer-to-peer approach. Approximately one-third reported to both receive and provide peer-to-peer support, with the majority receiving support.
Focus groups were conducted based on guidelines collectively designed by the project partners and co-facilitated with an independent contractor and the group’s peer leader. Participants were guided to: identify the qualities, traits and attributes of a positive peer-to-peer leader; complete a Strength Weakness Opportunity Threat analysis on peer-to-peer service provision; identify risks and challenges of the approach and possible solutions; identify training and development needs of peer-to-peer leaders; and share any other thoughts on peer-to-peer service provision.

Later echoed in the consultation day, the partnering agencies wished that focus group participants could communicate ideas without being able to be identified, while equally wishing they be recognised as individuals. Participants were provided with labels and their ideas were captured in their own handwriting and displayed on consultation day and at the final presentation. The questions were discussed as a group and participants were asked to note ideas they agreed with in their own words on the provided labels. This later assisted with analysis as it captured the strength of collective feeling. Participants were told that, should they have any concerns about their handwriting being displayed that the facilitator would rewrite their answers. This eliminated the need for audio-recording.

Public consultation day. The evaluation concluded with a public consultation day to co-validate initial results with the community. A total of 18 participants, comprised of service providers and service users attended the public consultation day and represented peer support groups from both third-sector and statutory service providers. Approximately one-third indicated they had both provided and received peer-to-peer support. Some identified as service users, the remainder were involved in peer-to-peer training or service management.

Attendees participated in three open discussions: what training and development do peer-to-peer leaders need? How can employers best support peer-to-peer workers within their organisation? How can peer-to-peer services benefit from, complement and work with existing services?

Notes of the discussions were taken on a flip chart and agreed by participants. Hard copies of select resources were made available and participants were invited to list additional resources and peer-to-peer service providers.

Methods of analysis

Taking a problem solving approach, analysis sought to identify key ideas that emerged from the collective response across all data collection channels. Analysis was done concurrently as well as post-project. Mirroring the review of literature, results were considered and reported in relation to the following questions; What is the evidence of need? Is peer-to-peer a valid approach to public health? What opportunities exist for peer-to-peer to peer services to work collectively? Are peer-to-peer services known to improve individual health outcomes?

Survey. SurveyMonkey was used to collect and generate statistical data in relation to the prevalence and impact of peer-to-peer support. It further aided the identification of peer-to-peer services in Sussex.

Focus groups. The hand-written focus group responses were physically mounted on display papers according to each question to identify key themes. Responses were also entered into an excel spreadsheet to confirm identified themes were frequently prevalent. Responses were displayed during the public consultation day and provided an “open survey” (where participants could add their own responses to the display boards). These could then be compared to focus group responses to ensure they did not vary greatly from those that engaged in peer-to-peer support via other providers.

Public consultation day. Open discussions were designed to validate and further explore initial results. The draft report was sent in advance to consultation day attendants to ensure conclusions were reflective of the community.

What we found

Evidence of need

Collective responses identified clear sector support needs including increased guidance for those that both receive and provide peer-to-peer service. One-third of all participants across all data
collection channels indicated that they filled both roles. Suggesting that those providing peer-to-peer services require support for the approach to improve individual health, the term “compassion fatigue” was frequently mentioned by participants. This term is usually used in connection to care-givers working in environments with people who have experienced significant trauma and where they are presented with regular emotional challenge (Compassion Fatigue Awareness Project, 2014).

If given the right support, the majority of focus group participants noted that many people with lived experiences possessed characteristics that would enable their involvement. The most commonly cited qualities of a positive peer leader included being “supportive” and “respectful” and displaying “empathy” and “humour”. Longer answers focused around alertness, ability to manage boundaries, assertiveness, commitment to equality and non-discrimination. Additional skills such as creative ability, group organisation, promotion skills and acknowledging the need for breaks were also highlighted. The collective approach appeared to enable ongoing engagement with one participant who accessed and provided services saying, “the good thing is the variety of people- and the person who is best able to support you steps forward to help- cause not everyone is depressed at the same time!”.

Limited funding and a heavy reliance on volunteers was repeatedly cited to weaken the effectiveness of the peer-to-peer approach by limiting capacity and access to training. In total, 82 per cent of survey respondents felt specific peer-to-peer training would help peer services to be more effective. The need for training was strongly expressed by focus group and public consultation day attendees with one participant saying, “There is a difference between professional and nonprofessional services – it works because it is unconventional but we do not have the professional capacity or the training which puts the group at risk of being shut down”. The most frequently suggested training topics included: professional boundaries; facilitation skills (funding, administration and signposting); how to create legal documents to enable agreed boundaries and group agreements; peer leader skills (self-care and emotional resilience) and mental health awareness (responding to crisis, social isolation and suicide intervention skills).

Participants expressed a need for further research into the peer-to-peer approach and wished to be part of this process with one focus group participant saying, “It would be helpful if we could do our own research– maybe the Uni teaching us and other groups how to do that”. Those consulted through the focus groups and the public consultation day recommended research should aim to include peer-to-peer groups that provide support not specifically related to mental health to give a broader understanding. Longer time frames for data collection were also suggested to enable volunteers and those with fluctuating health needs to participate.

*Is peer-to-peer a valid approach for public health?*

The results of the review suggest the peer-to-peer approach may benefit public health by reducing both need and demand for services. Survey results suggest a reduction in GP visits with 22 per cent claiming they reduced the numbers of visits they made to the GP by one to three times per year (8 per cent reduced visits to their GP by four to nine visits). Survey respondents felt accessing peer-to-peer services had reduced their self-harm/suicide attempts (12 per cent reduced by one to three times, 6 per cent reduced by four to nine times), counselling visits (7 per cent reduced by one to three visits, 7 per cent reduced by four to nine visits), 111 calls (6 per cent reduced by one to three calls), sick days (9 per cent reduced by one to three days, 9 per cent reduced by four to nine days, 4 per cent reduced by over 20 days), A&E visits (9 per cent reduced by one to three visits) and overnight hospitalisation (3 per cent reduced by one to three nights, 3 per cent reduced by four to nine nights). Survey respondents stated the approach had additionally helped them to avoid unhealthy lifestyles (15 per cent said it reduced their use of alcohol, 17 per cent claimed it reduced drug use and, 15 per cent stated it reduced their involvement in criminal activity).

When asked to compare their experience with peer-to-peer support vs statutory services, 81 per cent of survey respondents stated they felt a peer approach was more beneficial than statutory services and 16 per cent stated it was as effective. Only 3 per cent felt the approach was less effective. Focus group responses provided further understanding as to why some people find the
peer-to-peer approach more beneficial. Communicated concerns in accessing public services were noted included perceived stigma, “You can be scared your baby may be taken or someone may be called in when actually that person just needs to talk and know they are safe and are supported and it won’t be a mountain out of a molehill situation. Peer-to-Peer can offer this”.

Participants also shared concerns surrounding drug-based treatments within statutory service provision:

The first thing they (doctors) do is offer you drugs, but some drugs are addictive so it’s like a domino effect.

The medical profession needs to realise there is more than one way to help someone. It is not all about medicines. (There are) people out there who want to help, who can listen, support, care etc. and this should be taken up.

Delays in accessing treatment were also noted with one participant saying, “I tried to get referred to a counselling group, but I was on the waiting list and then I just never heard back – here I could get help right away and now if my referral happened, I wouldn’t need it anymore”. Lack of trust in traditional treatment was also uncovered, “The thought of going into a hospital to get well is such a foreign concept – you go there when you’re a hassle to society”.

Some participants stated they engaged with peer-to-peer services as an alternative to traditional treatment. However, most participants communicated that statutory services are essential with one peer leader noting:

An example of a worst case scenario would be to send someone in need of hospitalization for six weeks to us instead, expecting our peer-to-peer support to deal with someone in crisis. We are not trained professionals. Supportive friendships IN NO WAY WHATSOEVER can replace the need for professional support.

**Are peer-to-peer services known to improve individual health outcomes?**

The majority of survey participants stated they sought out the peer-to-peer approach for emotional support (70 per cent), dealing with a life change (51 per cent), 45 per cent were seeking support for loneliness and isolation (45 per cent), 41 per cent for mental health concerns and 22 per cent for support with feeling suicidal. Of the 97 people surveyed, 84 per cent of respondents stated it reduced anxiety and depression, 90 per cent claimed their health and wellbeing had improved and 40 per cent said it had “literally saved their lives”. Results from the focus group echoed these findings:

90% of the things I do every week are seeing people from the group. For me, this is family.

If this group didn’t exist, I would have lost my marriage, I would have had my child taken away from me and been suicidal. This group showed me I was normal. I’m now very happily married with three beautiful children, and have my whole life in front of me.

If I didn’t have this group, I would have no one to come visit me when I was in hospital and nowhere to turn when I come out.

When I’m suicidal, this group puts a stop to the idea.

Engaging in social activities with personal meaning to people appeared to help build confidence, increase self-esteem and assist participants to feel “normal”. One peer-to-peer service user said, “Through talking it is like you had gone through a traumatic experience not that there was something wrong with you”. A participant that both received and provided services suggested their involvement in service provision made it easier to relate to wider society saying, “When people say “what do you do?” I can say “I run an art group” – I don’t have to say that I am a lady that lunches”.

**What opportunities exist locally for peer-to-peer services to work collectively?**

Participants at the public consultation day and within focus groups felt a network comprised of peer-to-peer support organisations would address concerns such as limited access to training while providing the flexibility to adapt to the changing needs of the sector. In total, 78 per cent of
survey respondents also expressed a desire for a local network or forum of peer-to-peer services. The majority felt a network would promote best practice through the creation of a platform to discuss standards and assist with signposting.

It was felt a network would reduce pressures on peer-to-peer providers by making it easier for commissioners, health professionals and academic institutions to contact the sector. Public consultation day discussions explored what this network would look like, including the suggestion of four meetings per year, employing a rolling chair and shared access to resources. It was suggested the network dedicate one meeting per year to research initiatives to improve the scope of future surveys and enquiries.

Through the course of the evaluation, the majority of participants suggested collective approaches such as the development of a central online source to house shared peer resources and templates, a physical peer-to-peer space for room rental and knowledge sharing between groups, a “helpers helpline”, a mentoring or “buddy system” for peer-to-peer leaders and a community garden for peer groups to help lower costs. As a number of organisations were identified that provide training locally and nationally, public consultation day participants suggested a network could potentially provide organisations with developed training with the resources to support smaller less formal groups.

Discussion and limitations

This community evaluation was conducted on behalf of organisations and individuals with experience in engaging with peer-to-peer services as providers, service users or both. Despite efforts to widen participation, responses were gathered from a pooled sample and cannot be attributed to the wider population. They also, however, represent the views of a marginalised minority that is largely inaccessible to evaluations led by statutory or academic frameworks.

The first aim of the evaluation was to suggest how peer-to-peer support could improve individual and public health outcomes. Consistent with the literature review, reported benefits include improved individual health and wellbeing and a reduction in accessing statutory services. This evaluation further suggests that the reduced burden on statutory services is not limited to the reduced use of specific individual services and evidence of improved wellbeing should be considered holistically. The use of a control group and the application of an academic framework to the analysis would have strengthened these findings. While information as to how people engage with services was considered, a comparison between approaches was beyond the scope of this review. Individual case studies would be better able to consider additional factors such as length of time engaged, components of service and the specific health needs of participants before and after engagement.

The second aim was to map the prevalence of the approach in the region. The evaluation identified 23 peer-to-peer service providers within the region, however, gathering knowledge from charity, third-sector and informal groups posed unique challenges to data collection and validation. Participants identified “lack of promotion” as a weakness of the peer-to-peer approach and this made it more difficult to identify and engage these services. A heavy reliance on volunteers made it more challenging to keep informed of sector and organisational changes. That this aim may later be achieved in full, a local network has since been initiated and connections made to the national mapping initiative (Together, 2015; The National Survivor User Network, 2014).

The third aim was to provide best practice recommendations. Participants noted they engaged in peer-to-peer services in a variety of ways. However, the majority of participants across all data collection channels felt a network would improve best practices by increasing opportunities through shared resources and training, increased promotion and by providing a central point of contact. The development of such network therefore could potentially minimise the challenges associated with mapping the approach in future.

Conclusion

In the spirit of the peer-to-peer approach, this community evaluation was completed by our community for our community. As a case study, it examples the capacity of peer-to-peer service
providers/users to work collectively, the willingness to share knowledge and the desire of those with lived experiences to develop peer-to-peer sector support.

Guided by their collective experience and existing literature, third-sector groups Mothers Uncovered (Project Lead), Grassroots Suicide Prevention and Synergy Creative Community consulted 131 participants through surveys, focus groups and a public consultation day to map service provision and uncover best-practices. The project team and the majority of participants had direct experience in engaging with peer-to-peer services. While this poses challenges in that the results cannot be generalised to the wider population, they do have an added value in that they express the views of a minority that is statistically marginalised and hard to engage (Department of Health & Department for Work and Pensions, 2006; Secker, 2009).

The results of the evaluation uncover the potential for the peer-to-peer approach to holistically reduce pressures on statutory services such as demands on A&E, GPs, counsellors, 111 calls and in patient care. They also appear to improve a person’s overall wellbeing with participants stating that it improved their skills and confidence. Some survey participants also stated it reduced their use of alcohol and drugs and steered them away from engaging in criminal activity. This review strongly suggested those engaging with peer-to-peer services felt they were more beneficial than statutory services. It seems to be a favoured approach for some because it enables supportive friendships and reduces the perceived stigma associated with mental health issues. However, it was collectively felt that it was not an appropriate approach for those in crisis and that peer-to-peer services should be provided in addition to traditional services. Participants suggested a network or forum of peer-to-peer services could provide a platform to work more collaboratively with public health services through signposting and knowledge sharing.

This review uncovered that much of the local work into peer-to-peer service appears to have been undertaken by volunteers, community groups and third-sector organisations. It was felt a network model would facilitate partnership working including improving access to resources and training and increase the scope of future reviews by enabling partnerships between peer-to-peer groups, health providers, commissioners and academic institutions. The focus group and consultation day participants stressed that those who engage with peer-to-peer services should play an active role in undertaking any further reviews or research into the approach. While the results of the evaluation can only be claimed to be true for those consulted, it is hoped to highlight areas where research could be first directed.

References


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Further reading

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