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# Peer support for employment: a review of the evidence



**Libby McEnhill,  
Karen Steadman,  
Zofia Bajorek**

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# Executive summary

**Peer support is the process through which people with similar experiences support one another, both emotionally and practically.** For those with disabilities or health conditions, peer support can be a highly beneficial component of a treatment plan, and as such it is reasonably widely used.

Peers who share experience of health conditions and disabilities can promote hope and belief in the possibility of recovery, empower individuals, increase self-esteem and self-management, as well as social networks. Whilst these outcomes have advantages on their own, they are also associated with improved employment outcomes.

Although there are significant pockets of peer support activity orientated towards employment operating across the UK and beyond, the evidence base for this form of employment support is still at an early stage. A literature review was conducted, aiming to find out what we know about how and if peer support works in supporting employment outcomes, and identifying gaps in the research.

This report focuses on summarising eleven academic studies, and 'grey' literature, focussing on studies where **shared experience of disability or long-term conditions** was emphasised.

## What do successful peer support for employment programmes look like?

Seven academic studies looked at **support group-based peer support**, either delivered as a single intervention or as part of a wider package of interventions. All studies reported that support **group-based peer support led to positive outcomes for helping service users move into work, and for job retention.** One study suggested that the benefits of group-based peer support are best sustained if service users are able to continue their engagement long term. This was supported by real-life examples of practice group-based peer support practice, in the grey literature.

Two further academic studies used **one-on-one mentoring models**, matching facilitators who had experience of disability and employment with individual service users. Again, outcomes were broadly positive, although some practical problems were reported, for example, matching mentors and mentees. One further academic study matched mentors with mentees, but also allowed for contact between different members of the group outside of these relationships.

A final academic study used a **workplace-based model**, where peer support was offered by a 'peer adviser' who was trained to help colleagues, and offer social support.

**All of the academic studies report some level of positive outcomes**, but also suggest that the optimal model of peer support is dependent on the condition(s) being addressed and the desired outcomes (for example, job retention, reducing sick leave, or supporting unemployed service users to return to work).

## What evidence is there on outcomes?

There was heterogeneity in the outcomes considered in each of the studies. **The range of 'direct' outcomes associated with peer support included: improved job retention; reduced sick leave; achieving a new job or moving into education, or supporting other recovery goals.**

Other outcomes measured included changes in participants' **confidence, self-esteem and social skills**. These were seen as potentially helping participants to be more positive about their vocational prospects and in the longer term, increasing their chances of achieving their goals. The grey literature predominantly focused on these 'indirect' outcomes.

There was also some evidence on peer support as a **preventative strategy** for reducing sick leave and enhancing wellbeing at work.

## What are the gaps in the existing research?

Several gaps in the current research were identified, including **whether peer support on its own is an effective intervention**; the effectiveness of peer support for **supporting in-work progression**, and the **relationship between 'direct' and 'indirect' outcomes**. Additionally there is currently a **lack of evidence on the costs of different forms of peer support versus their efficacy**. Further there is no clear framework or guidance for how peer support services might be run, and optimised, to achieve employment outcomes, thus inhibiting our ability to share and build upon effective practice.

Anecdotally, there are multiple reports of peer support being used in employment services across the UK and abroad. However, there is very little publically available information even within the 'grey literature'. **A more comprehensive review of the extent to which peer support is used, the method by which it is utilised and the outcomes gained by recipients of peer support is needed.**

# 1. Introduction

## Peer support for employment: key terms

In this paper the following terms are used in relation to peer support models:

**Service users:** users of peer support services, and the primary beneficiaries of support. This paper is interested in the impact of peer support services on service users' employment prospects.

**Facilitator:** a trained employee or volunteer who provides support to service users. Facilitators can work either within a support group (providing support to many service users and helping service users to support one another) or on a one-to-one basis. Peer support can be facilitated alongside traditional healthcare and employment services or on its own.

**Support group:** a group of people with lived experience of a health condition, convened for the purpose of providing social, emotional and/or practical support to one another. Support groups can be formed organically or can be attached to specific services.

**One-to-one or mentoring:** facilitators are paired with service users with a shared experience of health conditions, providing support on an individual basis. In this context, mentoring implies a more asymmetrical relationship where one side is the primary beneficiary of support, but nonetheless the relationship is usually reciprocal to some extent.

***“Peer support ... is the help and support that people with lived experience of mental or physical health conditions or disabilities are able to give to one another.”***

Peer support in this context is the help and support that people with lived experience of mental or physical health conditions or disabilities are able to give to one another. Though more commonly used in relation to treatment and recovery support, there are significant pockets of peer support initiatives which are focussed on improving employment outcomes. These can be found in recovery services, employment services that work with people with health conditions and disabilities, or even within businesses to support employees to remain in work. However, evidence on peer support for employment outcomes (whether focussing on entering/re-entering the workforce, job retention, reducing sick leave, or supporting progression in work) is limited. In this paper the existing evidence from both the academic and grey literature on peer support for employment outcomes is reviewed to identify models of peer support, highlight any evidence for peer support efficacy, and provide evidence on how and why peer support works. Finally, any identified gaps in the research evidence and what further information regarding peer support and employment outcomes is discussed.

## 2. What is peer support and why should we be interested in it in relation to employment?

- Peer support is the process of people with similar experiences supporting one another, both emotionally and practically. For those with disabilities or health conditions, peer support can be a highly beneficial component of a treatment plan, and as such, peer support is often used to improve health outcomes and promote recovery.
- Peers who share their experience of health conditions and disabilities can promote hope and belief in the possibility of recovery, to empower the individuals, increase self-esteem and self-management, as well as encouraging social networks. Whilst these are advantages on their own, they are also associated with improved employment outcomes.

Peer support approaches rely on the assumption that 'people who have similar experiences can better relate and can consequently offer more authentic empathy and validation' to one another (Repper & Carter, 2011, pg 394). This can occur naturally within social support groups founded on the basis of shared experience of disability or illness, with peers giving and receiving support to one another and thus building up a mutual, reciprocal relationship that has benefits for both parties (Mead et al., 2001). Alternatively, peer support approaches can be provided in a more formal and structured way alongside more traditional services, such as those provided by healthcare professionals. These may be provided in a group or on a one-to-one basis. In such cases, peers are employed in a support role ('facilitators' or 'peer support workers') and are 'usually considered to be further along the road to recovery' than those they are supporting ('service users') (Repper & Carter, 2011, pg395). Through their lived experience of a shared health condition or disability, facilitators are able to offer support on a range of practical, social and emotional issues to service users (Soloman, 2004).

Peer support (both support groups and one-to-one) is now reasonably widely used to improve health outcomes for people with disabilities and long-term health conditions, especially in relation to mental health conditions. Repper and Carter (2011, pg. 400) provide a comprehensive overview of the evidence for peer support for mental health outcomes. They concluded:

*What [peer support workers] appear to be able to do more successfully than professionally qualified staff is promote hope and belief in the possibility of recovery; empowerment and increased self-esteem, self-efficacy and self-management of difficulties and social inclusion, engagement and increased social networks. It is just these outcomes that people with lived experience have associated with their own recovery; indeed these have been proposed as the central tenets of recovery: hope, control/agency and opportunity. (Repper & Carter, 2011)*

Such factors are also relevant to employment, and some, such as increased self-efficacy, are directly associated with improved employment outcomes (Summers, Bajorek and Bevan, 2014). Consequently interest in peer support as a tool for improving employment outcomes including supporting people into work, job retention, and job progression has increased. Many employment support services and back-to-work programs include peer support as a method to improve support and work-related outcomes for service users. Similarly, some employers incorporate peer support in their employee health and wellbeing programmes – for example through supporting disabled employee networks.

***“Many employment support services and back-to-work programs include peer support as a method to improve support and work-related outcomes for service users”***

However, the current evidence base for peer support and employment outcomes is very limited in comparison to the much wider literature on peer support for health outcomes. This evidence review assesses the current evidence - identifying what peer support for employment looks like, what is known about employment outcomes, and what the major gaps in the existing research are.



# 3. Key points from the literature and scope of the review

- Eleven academic studies looking at peer support for employment outcomes were identified. Ten placed an **emphasis on the peer facilitators having a lived experience of disability or health conditions** that was similar to that of the service users. This emphasis was also reflected in the grey literature and in the design of relevant peer support programs.
- The value of facilitators and service users sharing experience of disability and health conditions reflects the emphasis on 'shared experience of emotional and psychological pain' (Mead, Hilton, & Curtis, 2001) as a central mechanism underpinning peer support efficacy, highlighted in the wider literature on peer support and health outcomes.
- As such this paper focuses on academic studies and grey literature where **shared experience of disability or long-term health conditions** was emphasised.

A search for relevant literature was conducted, exploring both academic and 'grey' sources. Full details of search terms and a summary of the studies used in the review are included in Appendix 1.

The evidence on peer support for employment outcomes is at an early stage. Within the academic research, eleven relevant studies were identified:

- Three used qualitative methods (Bobroff & Sax, 2010; Cameron, Walker, Hart, Sadlo, & Haslam, 2012; MacEachen, Kosny, & Ferrier, 2007),
- Three used quantitative methods (Bell, 2010; Kowlakowsky-Hayner, Wright, Shem, Medel, & Duong, 2012; Odeen et al., 2013) and
- Five used a combination of qualitative and quantitative methods, sometimes to review different aspects of the same intervention (Kaehne & Beyer, 2013; Nelson, Ochocka, Janzen, & Trainor, 2006; Ochocka, Nelson, Janzen & Trainor, 2006; Nelson, Ochocka et al., 2007; Peterson, Bergström, Samuelsson, Åsberg, & Nygren, 2008).<sup>1</sup>
- Two used randomized controlled trials (Odeen et al., 2013; Peterson et al., 2008).
- One set of three studies, on 'consumer/survivor initiatives' in Ontario, Canada (of which peer support was an integral part), used a non-equivalent control group design, with groups selected on the basis of their prior involvement and engagement level with the initiatives. This was a three year longitudinal study (Nelson et al., 2006; Ochocka et al., 2006; Nelson et al., 2007).

In general, the emphasis within qualitative research was on the *how* and *why* questions around the efficacy of peer support, while the focus of the quantitative studies varied in the levels of robustness, primarily focussed on *whether* peer support works.

Ten of the academic studies placed an emphasis on peer facilitators (i.e. those providing support) having a similar lived experience of disability and long-term health conditions to those receiving support (Bell,

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(1) Nelson et al., 2006, Ochocka et al., 2006, and Nelson et al., 2007 were all evaluations of qualitative and quantitative aspects of the same intervention.

2010; Bobroff & Sax, 2010; Cameron et al., 2012; Kowlakowsky-Hayner et al., 2012; MacEachen et al., 2007; Nelson et al., 2006; Ochocka et al., 2006; Nelson et al., 2007; Odeen et al., 2013; Peterson et al., 2008). The remaining study used a different understanding of peer facilitators, matching non-disabled facilitators with disabled service users on the basis of age and gender (Kaehne & Beyer, 2013).

Facilitators having a shared lived experience of disability or a specified health conditions is generally preferred on the basis that such individuals were better equipped to model competence and self-reliance, and can use their experience to help service users to improve self-esteem and self-worth (Kowlakowsky-Hayner et al., 2012). Such facilitators were also able to help service users navigate the specific resources that were available to them through their own experiences of these systems (Cameron et al., 2012; MacEachen et al., 2007). This reflects the emphasis on the 'shared experience of emotional and psychological pain' (Mead et al., 2001, pg 136) that is highlighted in the wider literature on peer support and health outcomes (Repper & Carter, 2011).

This idea is also reported in the design of programmes featured in the grey literature (Barnes & Mercer, 2008; Fulton, Winfield, & Paradigm, 2011; National Centre for Independent Living, 2008; Voices of eXperience, Healthy Working Lives, Light on the Path, & Scottish Development Centre for Mental Health, 2008)). As such, this review focused on studies where peer support was provided by facilitators with a lived experience of a disability or health conditions.

## 4. What do successful peer support for employment programmes look like?

- Six of the academic studies looked at **support group-based peer support**, either delivered as a single intervention or as part of a wider package of interventions. **All studies reported that group-based peer support led to positive outcomes for helping service users move into work, and for job retention.** One study suggested that the benefits of group based peer support are best sustained if service users are able to continue their engagement long term.
- Three studies used **one-on-one mentoring models**, matching facilitators who had experience of disability and employment with individual service users. Again, **outcomes were broadly positive**, although some practical problems were reported: for example, around matching mentors and mentees.
- One academic study matched mentors with mentees, but also allowed for contact between different members of the group outside of these relationships.
- One academic study used a **workplace-based model**, where peer support was offered by a 'peer adviser' who was trained to help colleagues, and offer social support.
- **All of the academic studies report some level of positive outcomes**, but also suggest that the optimal model of peer support is dependent on the condition(s) being addressed and the desired outcomes (for example, job retention, reducing sick leave, or supporting unemployed service users to return to work).
- **The grey literature focuses on group-based peer support**, with all the real-life examples operating with the group method for peer support. This suggests that the group method is the most commonly used.

Six of the academic studies used **support group models**, either as a standalone approach (MacEachen et al., 2007; Nelson et al., 2006; Ochocka et al., 2006; Nelson et al., 2007; Peterson et al., 2008), or as part of a multifaceted approach (Cameron et al., 2012). All studies reported successes in helping people with disabilities or health conditions to either retain or move into work,<sup>2</sup> suggesting that a group model can be a successful peer support intervention.

MacEachen et al., (2007) looked at the effect of **group peer support on workers who were on long-term sick leave having experienced injuries while at work.** All group members in this case were on long-term sick leave at the time of the study. The authors identified four 'dimensions' of return to work barriers, which were being explored via the group peer support process - support seeking, social support, personal advocacy, and procedural support. Firstly, injured workers felt they were often misunderstood by 'system providers' (such as workers' compensation case providers or those organising traditional back-to-work support): for example, in terms of the limitations that their injuries placed on their ability to work. The support group provided a location where injured workers felt understood and lessened their feelings of alienation. Second, the support group provided an important source of social support, within an empathetic community, which also importantly provided an atmosphere of mutual trust. Thirdly, the peer support was a source of advocacy through having 'someone with a direct experience of work injury who was "on my side"', highlighting the 'role of peer helpers as allies who cared about their situation' (2007, p. 159). Finally, the support group was a source of practical help and procedural support, including

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(2) The nature of outcomes is discussed in the following section.

## **“four ‘dimensions’ of return to work barriers, ... support seeking, social support, personal advocacy, and procedural support”**

helping injured workers to navigate the complexities of the workers compensation and healthcare systems, and to negotiate return-to-work plans. Consequently, MacEachen et al. (2007, p. 155) concluded that group-based peer support offers a ‘partial return to work solution for workers with injuries’. They did however caution that this approach was not a panacea, and that workers with disabilities will continue to encounter systemic barriers in returning to work.

Cameron et al., (2012) and Peterson et al., (2008) looked at the use of **peer support groups for employment retention**: the former for employees with mental health conditions, and the latter in relation to preventing burnout and stress in the workplace (given that stress-related conditions are one of the biggest causes of long-term sick leave). Both studies focused on employees who were not currently on sick leave, in contrast to MacEachen et al., (2007). Cameron et al., (2012) found that the

benefits of group work using peer support principles in helping those employees to retain employment were similar to the MacEachen et al., (2007) study, in that participants in the support group ‘found it an effective forum for **problem solving** and peer support by sharing experiences **reducing isolation and feelings of self blame**’ (pg 468). Similarly, Peterson et al., (2008) reported statistically significant effects related to the peer support group, in terms of **improvements in general health, participants’ perceived demands on them at work, their participation at work and personal development, and their perception of the support that they received at work**. Peterson et al., (2008) concluded that group support could be a ‘useful and comparatively inexpensive tool for alleviating work-related stress and burnout’ (pg. 506), and enabling employees to stay in work.

The evaluations of the Ontario initiative discussed the effects of group peer support on outcomes related to employment and education, including whether ‘active’ participants in peer support **moved into work, remained in work, and improved their financial situations due to working** at durations of 9 months, 18 months (Nelson et al., 2006; Ochocka et al., 2006) and 3 years (Nelson et al., 2007). Results showed that the likelihood of ‘active’ participants retaining employment or education were significant. Participants were classed as ‘active’ in the initiative if they participated for more than four hours per month over sixteen months, and ‘inactive’ if they participated for less than this over the same period, in the 9 month, 18 month and 3 year follow ups. Those ‘active’ for the purposes of their evaluation tended to invest significantly more than the minimum requirement, with the average participation over the whole evaluation period reported as 12 hours per month (Nelson et al., 2007). Those in the continually active group in the final follow-up not only participated for a longer duration, but invested much more time in the intervention. Though the study experienced a relatively high drop-out rate (27 per cent) between baseline and 18 months, the remaining participants experienced fewer, less severe mental health problems (Nelson et al., 2006). Both of these factors may have had an impact on the successful outcomes achieved by the intervention group. The studies nonetheless suggest that **extensive, consistent and on-going engagement with peer support initiatives is important in getting good results**. This becomes relevant when considering the implications for peer support in supporting a person’s ‘journey’ into work (for example, looking at issues around retention as well as transitioning into employment) since the results suggest that on-going access to support is of considerable importance in maintaining employment.

In the grey literature Reidy and Webber (2009) were interested in whether peer support could help service users’ personal and professional development, for example, supporting return to work or to education, or encouraging service users to become facilitators themselves. Their small-scale qualitative evaluation of a peer support service in Southwark, focussed on service users who had accessed crisis services due to mental health conditions and were approaching discharge but were not currently in work. A total of 38 people participated were matched to receive peer support, meaning the findings are not generalizable to a wider population, but offer some indications of service users perception of support. Though only three participants completed the service exit questionnaire, two of these suggested that the match between the mentors and themselves could have been improved – indicated the importance of shared experience between the facilitators and themselves. Reidy and Webber’s (2009) findings on matching users and

facilitators from a small focus group with service users (n=4) were mixed. Some users suggested that they wanted a closer match, whereas others felt that some similarities in interests and hobbies to give something to talk about were enough. Other users mentioned differences could be beneficial as they allowed mentors to 'perhaps observe something in you, or you could observe something in them that might be problematic' (pg 17).

Three academic studies looked at the use of **one-to-one mentoring**, with one exploring this in combination with a group approach. Kowlakowsky-Hayner et al. (2012) focused on the value of mentoring in helping participants aged 16-26 with recently acquired brain or spinal cord injuries to access post-secondary education and employment opportunities. In total 131 mentees were recruited across 17 Californian counties and 100 were successfully peer matched with mentors. Mentors were recruited from the community, and given initial training and refresher courses under the facilitation of a Rehabilitation Psychologist at a medical centre in San Jose (Shem, Medel, Wright, Kolakowsky-Hayner, & Duong, 2011). The emphasis was placed on peer mentors providing a means of improving self-esteem and self-worth, which when lacking was seen as a potential disincentive to move from benefits to work. The overall findings of the study suggested that **one-to-one mentoring could be useful in helping disabled people to achieve education and employment goals**, through functional support, helping to develop cognitive independence and community integration.

A challenge with this approach was that the process of matching mentors with mentees was quite slow as several characteristics (age, gender, location, disability type, interests) were used to make matches - meaning some mentees found work in the interim period and some lost interest in the programme. The lack of availability of mentors in rural and less-densely populated counties was also problematic. Additionally, mentors and mentees reported difficulties in meeting due to a lack of accessible meeting places and trouble co-ordinating schedules. The study suggests that **online mentoring**, or a **combination of online and face-to-face work** might be an effective solution. A study on using online methods to enable peer support between young people with health conditions (albeit not offering specific evidence on employment outcomes), concluded that this was a potentially useful approach to helping young people with disabilities reach their social, academic and career potential. However, the study cautioned that 'constraints imposed by time, distance, and disability make such relationships difficult to maintain' outside of a structured programme (Burghstahler & Cronheim, 2001, pg.72)

Bell's (2010) study assigned mentors to 49 young people with blindness from four different US states. The mentor-mentee relationship continued over two years, and during this time participants were also supported to interact with the wider group, adding a group activity dimension. The mentors were also legally blind, and had achieved academic and career success. The study focused on smoothing the transition between education and employment by improving career decision-making efficacy (ie. the mentees' self-reported confidence in their ability to make career decisions), improving both the hope that the mentees' felt for their career and academic futures, and their attitudes towards blindness and the way that it might affect their life. The study identified a range of positive outcomes related to self-belief and self-efficacy, the most important being that service users were better suited to meet employment challenges (pg. 8) and an understanding that their disability was not an impediment to success.

Bobroff and Sax (2010) worked with six students with severe emotional or learning difficulties, assigning three as mentors to the three mentees. Mentors were required to have participated in at least one real job interview, shown an interest in the position as a peer tutor, and expressed an inclination or willingness to work with peers. The aim was to coach the mentees to develop job interview skills – an important 'soft skill' for gaining employment. After monitoring the 11 week study, the authors concluded that peer mentoring could provide a useful way of teaching these skills, and that the process produced both improved confidence and improve aptitude at job interviews, for both mentors and mentees.

***“service users were better suited to meet employment challenges ... and [have] an understanding that their disability was not an impediment to success”***

Odeen et al., (2013) conducted an RCT on 3,500 public sector employees in Norway, dividing these into 135 work-based groups randomized into two intervention groups using a **workplace-based peer support**. One intervention group received 'education and peer support' (EPS) while the other received 'education, peer support and access to an outpatient clinic' (EPSOC). A third group was the control group. The study aimed to find out whether giving employees information and education on lower back pain could reduce sick leave. In this study the peer support was offered by a 'peer adviser' who was appointed by colleagues and was on hand to offer support as requested. The peer adviser was given training and was responsible for helping with work modifications and directing colleagues who expressed concerns about lower back pain to either contact their GP (if in intervention group 1 EPS) or the outpatient clinic (if in intervention group 2 EPSOC). They also offered social support and were to 'use their knowledge of the working environment to help their colleagues with staying at work, despite having pain' (pg. 213). In this study there was no requirement for the peer adviser to have experience of the condition that was being addressed. The results concluded that sick leave was reduced in both the EPS and EPSOC conditions, and both conditions also reported a reduction in beliefs in lower back pain myths. The intervention was rated as trustworthy by the users and was generally well received by both employers and employees.

Kaehne and Beyer (2013) undertook a small scale supported employment project in a local authority in England. Five families took part in the study examining whether the peer support model could be used to deliver supported employment to young people with intellectual disabilities in the work-place. The peer support worker did not work at the workplace, but accompanied the individual to work, providing one to one support in the workplace. The support model included a range of activities including: a home visit to complete a vocational profile following the family recruitment into the project; a identifying and matching suitable peer supporters to the young participants; employer search; job adaptations; commencing and monitoring of the placement and the fading support. All job placements were developed over a 12-month period. Two jobs ended after a period of 12 weeks. Three jobs continued beyond the end of our study. The length of placements differed due to the individual demands of families and the availability of placements. Although the study indicated that peer support could be a useful addition to support transitions for this particular population, and the families of the young people viewed the project positively, and welcomed the fact that the young people had enjoyed their experience of work and had improved and increased confidence and social skills it was also reported that the model was not sufficiently embedded in wider transition planning.

In the grey literature, Barclays (2008) 'This is Me' campaign took a less formal approach to workplace-based peer support, encouraging employees who have experienced mental health conditions to volunteer to talk to other employees about their own issues and how they cope with them, either in person or through internal social media. There was no formal 'support group' as such established for this purpose and those who did discuss their experiences in the initiative had no formal responsibilities with regard to providing on-going support. The scheme has, anecdotally, changed the culture surrounding mental health at the organisation, with more employees recognising that having a mental health condition does not limit their opportunities or restrict the roles they can achieve.

Other approaches using more conventional support group models can be found in the following: eXperience et al. (2008), Fulton et al., (2011), Barnes and Mercer (2008) and the National Centre for Independent Living (2008).

### Summary

The academic and grey literature identified three potential models of peer support: **support groups** and **one-to-one support**, based on peers sharing lived experience of health conditions (and which can be combined), and **workplace-based support** which is based on a common understanding of the working environment and, in some cases, the adviser's knowledge of available support services. All of the studies showed some level of positive outcomes, but concerns regarding the quality of findings as a result of the research methodologies and sample sizes used, need to be taken into account when considering the generalisability of the findings. The research suggests that the optimal form of peer support services will depend both on the condition(s) being addressed and the desired outcomes, however more research is required to determine what works most effectively for which conditions. The research evidence also raises questions about delivery methods; notably, the idea of online peer support (either on its own, or combined with more traditional methods) could be a useful avenue to explore.

# 5. What evidence is there on outcomes?

- There was heterogeneity in the outcomes across the academic studies. The range of 'direct' outcomes associated with peer support included: improved **job retention**; reduced **sick leave**; starting a **new job or moving into education**, or **supporting other recovery goals**.
- Other outcomes measured included changes in participants' **confidence, self-esteem and social skills**. These were seen as potentially helping participants to be more positive about their vocational prospects and in the longer term, increasing their chances of achieving their goals. The grey literature predominantly focused on these 'indirect' outcomes.
- The studies reported various positive direct and indirect outcomes.
- There was also some evidence on peer support as a **preventative strategy** for reducing sick leave and enhancing wellbeing at work.

The following provides a summary of the user groups for each reviewed study, and the outcomes reported.

- Two studies focused on young people who were in education (Bobroff and Sax, 2010) or around the transition age between education and employment (Bell, 2010), who had emotional or learning difficulties or who were legally blind, respectively.
- One study (Kowlakowsky-Hayner et al., 2012) looked at outcomes for service users with physical health conditions who were not in employment or education.
- One study (MacEachen et al., 2007), examined peer support for individuals who were employed but on long-term sick leave due to physical injuries acquired while working, investigating the effects on their experience of being off sick, including their capacity to negotiate a return to work.
- The three Ontario evaluations (Ochocka et al., 2006; Nelson et al., 2006; Nelson et al., 2007) looked at the effect of peer support on the employment status of people with mental health conditions, taking into account changes in employment status over a three year period, with follow ups at 9 and 18 months, and 3 years.
- Three studies (Odeen et al., 2013; Peterson et al., 2008; Cameron et al., 2012) examined the effects of peer support on job retention and an individual's ability to cope with their health conditions at work .
- One study (Kaehne and Beyer 2013) looked at the benefits of peer support as an addition to traditional supported employment for young people with learning disabilities.
- Further, in the grey literature, Reidy and Webber (2009) looked at the effect of peer support for people exiting a mental health crisis services on intention to move into paid employment, voluntary work or education.

Bell (2010) obtained complete data for 49 young people who had participated in a peer support intervention for two years, seeking to identify positive changes in knowledge and career development. The results of the study suggested that peer mentoring was a broadly successful means of achieving this. They discovered a **large magnitude of effect in relation to career decision self-efficacy, finding a significant difference between self-report pre-intervention and post-intervention scores**. They also found a strong effect related to the intervention on participants' 'social responsibility towards blindness' (ie. the extent to which they identified with their condition and viewed it in a positive light), which the author suggests is

**associated with greater self-belief and self-empowerment.** The participants' **level of hope regarding their future careers also increased, but not significantly so.** As with Reidy and Webber (2009), the author recognised factors such as increased hope and ability to make decisions do not translate directly into improved employment outcomes. As the average age of the participants was only 21 years, the authors commented that it would take several more years to see whether or not the intervention had a significant impact on employment and career outcomes. However, the design of the study meant that it is impossible to accurately isolate the effect of the peer support intervention for participant's outcomes.

Bobroff and Sax (2010) investigated the effect of a very small scale mentoring programme (n=6) designed to improve the interview skills of young people with emotional and learning difficulties. The study concluded that all tutors and tutees (three of each) **improved their skills in answering interview questions effectively;** however, how this affected actual interview performance was unknown. It was suggested that peer interviewing can offer an effective means of teaching vocational skills, but more research is required to understand how this works and in what the optimal situations for mentoring would be.

Kowlakowsky-Hayner et al., (2012) asked participants about their employment and educational goals at the outset of their peer support intervention, and collected data on whether the goals were achieved, either by attending post-secondary education or moving into employment. It was not uncommon for participants to alter their goals along the way. Out of 100 successfully matched participants in the study:

- 53 stated post-secondary education as a goal: 23 out of 53 achieved this and a further 7 out of 53 achieved an employment goal instead.
- Twelve had an initial employment goal: 5 out of 12 achieved this, and a further 1 out of 12 achieved an educational goal.
- Twelve stated a combined education and employment goal: 5 out of 12 achieved an education goal and 1 out of 12 achieved an employment goal.

This meant that **54% of the participants achieved their employment or education goals.** These findings are encouraging as they look at actual (rather than intended) moves into employment. However, the design of the study meant it was **not possible to isolate the effect of peer support:** the lack of a control group means we have no way of inferring how many might have moved into work or employment anyway. MacEachen et al., (2007) assessed peer support intervention outcomes primarily in terms of the capacity of peer support to help workers on sick leave due to work-related injury cope with their situation. The outcomes included self-advocacy in meetings with employers or compensation scheme representatives, participating in putting together suitable return-to-work plans with their employers, and accessing the resources that were available to help them; measures that can be broadly termed as 'empowerment'. Qualitative findings suggested that **participants found peer support valuable,** indicating that it can be an important coping resource. However, the authors did not examine how many of the participants actually moved back into work as a result of the peer support. They also cautioned that the effectiveness of peer support as a coping strategy may mitigate against the broader need at an organisational policy level to address the systemic problems that injured workers face in returning to work, or engage in prevention strategies.

The Ontario evaluations placed participants in groups depending on their activity level during the evaluation period, and the stage of the evaluation. A large group of 118 participants, split into active (n=61) and non-active (n=57) groups were used for the 9 and 18 month quantitative follow-up (Nelson et al., 2006). A smaller sub group (n=27), with active (n=15) and non-active (n=12) participants was used for the qualitative research 9 and 18 month follow-up (Ochocka et al., 2006). At three years, the groups comprised those who had been active at 9 and 18 months but were no longer active at 36 months (n=35); those who had been continually active throughout (n=25); and those who had never been active (n=42) (Nelson et al., 2007).



In the initial qualitative follow up, participants were interviewed about their employment status, whether they felt they had sufficient income, and whether they were in employment or training.

- At the baseline measure, 9 out of 16 active group participants and 8 out of 12 non-active reported positively.
- At 9 months, 10 out of 14 active and 6 out of 12 non-active participants reported positive outcomes to the questions, and
- At 18 months 11 out of 15 active and 4 out of 12 non-active reported positively

There was therefore a significant divergence between the active and non-active groups in reported employment participation, and **the changes suggested that peer support is associated with retaining employment and engagement with education, and moving into work or education.** Active than participants were more likely to report experiencing positive changes in their financial situation, and were more likely to be in paid work in comparison to their non-active peers. However, the coding devised by the researchers does not consistently distinguish between education and employment.

The initial quantitative follow-up (Nelson et al., 2006) **found little difference between active and non-active participants over 9 months, however more differences were found over 18 months.** The quantitative findings mirrored those of the qualitative research, suggesting that engagement with peer support in the longer-term was associated with greater involvement in education and employment, and with retaining work. There was no specific evidence offered on progression in work; nor does the quantitative evaluation distinguish between work and education status. At the three year follow-up (Nelson et al., 2007), there was a significant difference in 'instrumental role involvement' (ie. participation in education or employment, or both) between the continuously active group, and the other two groups combined (which did not differ significantly from one another). Only the group that participated continuously and extensively showed a sustained benefit in engagement with employment and education.

The Odeen et al., (2013) and Peterson et al., (2008) studies explored the value of peer support as a preventative strategy to reduce absence levels and lessen the impact of ill-health on employment. Both were randomized controlled trials, and both produced evidence of efficacy. Both of the peer support interventions trialled in the Odeen et al., (2013) paper resulted in reduced sick leave - the group that received Education and Peer Support (EPS) saw sick leave reduced by 7 per cent, while the group that received Education, Peer Support and access to an outpatient clinic (EPSOC) reduced sick leave by 4 per cent. In the control group, sick leave increased by 7 per cent.

***“peer support interventions trialled ... resulted in reduced sick leave”***

Peterson et al., (2008) examined **peer support as means of preventing stress and burnout in physicians.** Healthcare workers who had reported high levels of stress (151 in total) (measured using the 'exhaustion dimension' of the Oldenburg Burnout Inventory<sup>3</sup>) participated in the study. The authors found statistically significant positive effects within the intervention group for general health (for example exhaustion, depression and anxiety). Longer term outcomes were also positive, where higher proportions of the intervention group experienced increased professional development opportunities and increased participation at work seven months on from the intervention (results were statistically significant at the  $p < 0.05$  level). Twelve months later, significant positive effects were found for perceived participation and control at work. From the results it can be inferred that peer support can aid with progression in work (which development opportunities, participation and control are all part of), but further research is needed to support this.

The qualitative dimension of Peterson et al.'s, (2008) study also indicated several mechanisms that participants felt contributed to the identified outcomes, including the value of talking to others in similar situations; developing a sense of belonging and community; the structure introduced by the programme itself; the relief from symptoms associated with stress and burnout (for example. poor sleep quality); the positive behavioural changes that they made and increased levels of self-confidence (including, for example, the ability to say 'no' to additional tasks).

[3] <https://web2.bma.org.uk/drs4drsurn.nsf/question?OpenForm>

Cameron et al., (2012) looked at the role of vocational guidance peer support for people with mental health conditions and job retention. They drew on literature suggesting that many of the problems that such individuals face around retention are situational (for example, related to workload, working conditions and work pressures) rather than person- or condition-centred. The study aimed to **understand the experiences and perspectives of workers with mental health conditions as they sought to retain their employment**. Feelings of guilt and self-blame related to mental health conditions in the workplace constituted a major barrier to staying in work. The participants who attended a peer support group found **it an effective forum for reducing unhelpful feelings of isolation and self-blame, and it helped them to cope more effectively with work** (e.g. improved confidence, communication skills and a new approach to problem solving). Importantly, the improved communication skills meant that employees could **help their line managers understand their mental health condition, so they could offer more effective support**. The findings are very similar to those of MacEachen et al., (2007), suggesting that this peer support approach may be suitable for obtaining positive outcomes for both mental and physical conditions, and for workers who are both in work, or on sick leave.

Finally, the Kaehne and Beyer (2013) study on supported employment for young people with intellectual disabilities found that key to the study was finding a job placement that matched the aspirations of the young person and their family, but also the practical requirements of the job. The parents of the young people **generally had positive comments about the young person's experience at work, and noted that their behaviour had improved in terms of improved and increased confidence**. They also mentioned that the **social skills of the young people had markedly developed throughout the work experience**. Employers also reported a willingness to employ young people with intellectual disabilities through the scheme in the future and **felt the scheme had a positive impact on the organisation's culture and diversity**. However, there were concerns relating to the implementation of the programme, such as difficulties in reconciling the needs and routines between the young person, family and support worker, and how the scheme would help in the transition to full-time employment, and if the current routine was reflective of the challenges of actual working life. Employers also voiced some concerns about what the implications of the scheme for the productivity of existing staff, and for customer satisfaction.

The grey literature offers further insight into the features of peer support that help unemployed people with health conditions to return to or move into work. These predominantly relate to building the confidence, skills and motivation of service users.

Reidy and Webber (2009) assessed participants intentions towards work through conducting an entrance and exit questionnaire. Of the eight participants who answered an exit question on whether peer support had helped them to achieve their vocational or educational goals, four said 'yes' and four said no. The main reason provided for not achieving goals was that no vocational or educational goals had been set; rather, most participants had focused simply on getting well. Participants were also asked about their plans on finishing the peer support programme and out of nine respondents, five planned to return to

**“eight out of ten respondents said that peer support had made them feel better about themselves”**

employment, two planned to complete voluntary work and one sought further education. One had no plans, and two were aiming towards something else (not specified). When considering the reported effects of the programme on participants' self-esteem: eight out of ten respondents said that peer support had made them feel better about themselves and none said it had made them feel worse, therefore it is possible that the peer support intervention helped the participants to feel more positive about their vocational prospects. The authors note that intention is not the same as action, and the study did not measure how many participants achieved their goals. However, given the design of the study, it would not be possible to directly attribute any successes seen to peer support.

Voices of eXperience et al's., (2008) review of its programmes suggested that peer support is valuable because **it helps users to regain employment-related confidence and skills to either seek employment or undertake their current duties, and because seeing how others with the same or similar conditions**

**have moved on is motivating in itself** (in addition to receiving the support from others). In regards to moving into work, the flexibility of peer support and hence its capacity to be tailored to individual service users and the particular challenges that they experience was identified as an important positive, as well as being easily transferrable to a wide range of work environments. Although Voices of eXperience et al., (2008) looked at back to work support, we can infer that similar features might also apply to in-work, job retention and progression support. The report provided a checklist of recommendations which included employers considering a buddy/supporter arrangement which could bring about great value in the workplace, in terms of understanding, knowledge and employee skills.

An analysis of peer support networks in Yorkshire and the Humber region reported that **service users 'overwhelmingly' felt they received the best advice from peer facilitators compared to other sources** (including charities and councils), due to the peer's superior understanding of their conditions and their recognition of the importance of emotional well-being (Fulton et al., 2011). Similarly, a review of disability organisations found that **user-led organisations and peer support groups were far more responsive to disabled people's needs**, and some were significantly better at meeting these needs when providing employment and education related training and advice (Barnes and Mercer, 2003), compared to services offered by councils (for example, generalised employment training and advice given by a council employee).

A report for the Department of Health by the National Centre for Independent Living (2008) described a peer support scheme in Derbyshire that helped those with physical disabilities who wished to go into education or training. At the first meeting, the peer supporter made a plan of action with the service user, followed by the individual attending monthly meetings with their disabled peers to discuss progress and any issues of concern. The participants reported increased self-esteem and self-belief, which are important when seeking employment or education opportunities.

## Summary

Overall, the current evidence suggests that peer support can lead to a number of positive education and/or employment outcomes. These include both **'direct' outcomes (aiding with job retention, helping people move back into work, or reducing sick leave)** and **'indirect' outcomes (improving self-esteem or confidence, and providing a source of advice and support)**. Success in a variety of different settings points to the potentially broad utility of peer support as an intervention for people with a range of disabilities or long-term health conditions, and in a variety of different employment situations. Despite this, significant gaps remain in the research, which are discussed in the following section.

## 6. What are the gaps in the existing research?

- There are several gaps in the current research. These include **whether peer support on its own is an effective intervention**; the effectiveness of peer support for **supporting in-work progression**, and the **relationship between 'direct' and 'indirect' outcomes**.
- Crucially for a policy audience, there is currently **a lack of evidence on the costs of different forms of peer support versus their efficacy**.
- Anecdotally, there are multiple reports of peer support being used in employment services across the UK and abroad. However, there is very little publically available information, even within the 'grey literature'. **A more comprehensive review of the extent to which peer support is used, the method by which it is utilised and the outcomes gained by recipients of peer support is needed.**

*“[there are] a number of gaps and a series of further questions about how peer support can be developed and optimised to improve employment outcomes”*

There are a number of academic studies on the value of peer support for achieving various employment-related outcomes. The grey literature offers some further insights, largely focussed on how and why peer support may work in this area. From reviewing the existing literature collectively there is potential for using peer support as a mechanism to support people with health conditions and disabilities back into employment and to help them stay and progress in employment. However, the paucity of research (both in terms of available literature and the methodological quality of the literature reviewed) on this topic gives rise to a number of gaps and a series of further questions about how peer support can be developed and optimised to improve employment outcomes.

In order to produce a strong basis for expanding peer support, there is need for stronger, clearer evidence to demonstrate that peer support itself is an effective intervention for achieving employment outcomes. The two RCTs discussed in this paper (Peterson et al., 2013; Odeen et al., 2008) provide good evidence for peer support and employment outcomes, but the sample only provided evidence on efficacy for specific groups of workers in specific situations. The small sample

size also meant that limited statistical analysis could be undertaken, and the study relied predominantly on self-reported measures. The Ontario evaluations strongly suggested that the intervention (of which peer support was an integral part) led to beneficial employment outcomes for participants with mental health conditions. However, the studies do not clearly distinguish between employment and education outcomes, and still only provide efficacy on a comparatively small samples (in which there was also a high drop-out rate). Further the authors recognised that the quasi-experimental design could have had an effect on internal validity. Nelson et al., (2007) also reported that participants were involved with other mental health services and it was unknown what added value to the outcomes this gave. **There was no evidence of studies using control groups (either randomised or not) focusing on unemployed disabled people and the effect of peer support to help them back into work.** The evidence base for peer support in this area is still developing and therefore it is not surprising that we find a larger number of exploratory

qualitative studies exploring how peer support works. Again, these studies were often very small and can only be seen as indicative (Kaehne & Beyer 2013; Bobrof & Sax; 2010). **Obtaining more robust evidence on efficacy is important.** Filling this will require consideration of ethical issues such as the challenges around providing a potentially beneficial intervention to one group but not another.

There is also a gap in the evidence demonstrating how peer support might contribute to **the entire journey of a person with a long-term health condition or disability in work**; focusing not just on whether service users become employed, but if they subsequently stay in employment, and whether they progress in work. The only studies identified in this review that took a longitudinal approach were the Ontario evaluations, and these did not specifically address progression (we might surmise that staying in work can be conducive to progression, but this is far from certain in many jobs). This is particularly important because of the tendency for people with disabilities to remain in low-paid, entry-level work for much of their careers (Kowlakowsky-Hayner et al., 2012). The current literature is largely split between studies that look at the benefits of peer support in supporting users into employment, and those that look at retention, less commonly combining this with some measure of progression. **More longitudinal research is needed into the implications of peer support for employment outcomes.**

Examples of studies that look at both 'indirect' outcomes (for example, increased confidence or self-esteem) and 'direct' outcomes (for example, moving into work or keeping a job) were included in this review. These are very limited however and most of the existing literature tends to look at either direct or indirect outcomes. Both are valid and important components of improving peer support interventions to help the employability and employment rates of people with disabilities but it would be useful to understand how they interact. It may be that achieving different outcomes requires slightly different strategies – for example, different methods of matching mentors with mentees, or facilitating group discussions – but the lack of research comparing these issues makes this difficult to ascertain. **Therefore more evidence is required to understand what peer support method is most appropriate to reach desired outcomes.**

It would also be useful to know **what types of peer support are most effective in terms of balancing cost with efficacy.** There was no evidence of any relevant research looking at the costs of providing various models of support. Group-based support is likely to be significantly cheaper than providing one-to-one mentoring (though costs may be reduced if provided online), and compared to the cost of professionally run services (Nelson et al., (2006) suggest that it can provide beneficial outcomes for a fraction of the cost). Support such as that discussed by Kaehne & Beyer (2013) would likely be quite expensive, and an evaluation of the longer term cost benefits of using this model of supported employment and peer support jointly is cost effective.

## Summary

Though we know that peer support is being used in employment services across the UK and abroad, one further important gap identified in the course of this literature review is the lack of publically available information on these initiatives. Further there is no clear framework or guidance for how peer support services might be run, and optimised, to achieve employment outcomes, thus inhibiting our ability to share and build upon effective practice.

Although there are significant gaps in the published research, the initial findings support the anecdotal evidence around the potential for peer support in improving employment outcomes. It is likely that activities already underway within both employment support services and individual businesses will be able to shed some light on the topics raised thus far, but the very limited 'grey literature' available on this topic inhibits our ability to learn from such initiatives.

# 7. Conclusion

The effectiveness of peer support programmes in supporting health outcomes and recovery is well established. Significant pockets of peer support operating in employment services that work with people with health conditions, including within those run by disabled people themselves also exist, providing a good reason to believe that peer support is an effective means of supporting people with long-term conditions and disabilities into employment – whether as a stand alone service, or in conjunction with other support.

In this paper, the current evidence base for peer support in supporting employment outcomes has been outlined. Although still at an early stage, the initial findings are promising. Evaluations in both the academic and 'grey' literature, suggest that peer support can be a useful tool in achieving a range of employment outcomes (such as moving into work, returning to work after sick leave, and retaining a job) for individuals with a wide range of health conditions. However, significant gaps in the literature were also seen, including: the relationship between 'direct' and 'indirect' employment outcomes; the costs of providing peer support versus the benefits and understanding of the full range of activities that are currently underway.

There is still a long way to go in understanding the mechanisms through which peer support can help to address the employment gap between people with and without disabilities, which models work best for which groups, and which are cost effective. However, this review has been able to identify where some possibilities lie, and has opened up avenues for further research which can hopefully fill the gaps that have been identified.

# Appendix 1: Search terms and summary of studies

## Search strategy

For the academic studies, full-text articles were searched for using the keywords 'peer support', 'mentoring' and 'employment'. Studies were included in the review if:

1. They examined peer support as an intervention in any form (eg. one-to-one models, group-based, workplace based);
2. They focused on peer support for people with long-term conditions or disabilities;
3. They sought to explain the utility of peer support for employment outcomes (either directly or indirectly);
4. They reported results or outcomes (either qualitatively or quantitatively).

Studies were excluded if:

1. They did not focus on, or contain a significant component on peer support for employment outcomes (e.g. if they focused on peer support for general health);
2. They did not report the results of a trial (e.g. papers that simply described an intervention);
3. They did not use shared experience of disability or long-term health conditions as a component of matching peers.

The academic studies that were identified are summarised in Table 1, below.

For the grey literature studies reports and publications were identified using the keywords 'peer support', 'employment' and 'disability'. Relevant papers were identified from their executive summaries or abstracts. Studies were included if they contained an assessment of peer support groups, whether they were one-to-one, group or workplace models. The studies included had to focus on peer support groups for people with long term conditions or disabilities, and specifically relate to or discuss employment outcomes from these groups. Studies were excluded if they did not include any discussion of employment outcomes (either direct or indirect), or they did not specifically relate to peer support for disabled individuals.

The grey literature is summarised in Table 2, below.

**Table 1: Summary of academic studies**

Author and year	Mode of delivery	No. participant	Aim	Outcome measures used/results
Bell (2010)	Primarily one-to-one mentoring, some group interaction	49	Improving career aspirations and attitudes towards disability	<ul style="list-style-type: none"> <li>Identified a 'large magnitude of effect' in relation to career decision self-efficacy</li> <li>There was a 'strong effect' on participants attitudes towards blindness: the extent to which they identified positively with their condition, which may be related to improved self-esteem</li> <li>Levels of hope for their academic and career futures also increased, but not significantly so</li> <li>Both mentors and mentees showed improvements in their interview skills</li> </ul>
Bobroff and Sax (2010)	One-to-one mentoring	6	Improving interview skills	<ul style="list-style-type: none"> <li>10 participants retained employment</li> <li>3 who did not were helped to retain work aspirations</li> <li>The support group helped to reduced feelings of guilt and self-blame</li> </ul>
Cameron et al., (2012)	Support group (as part of a wider programme)	14	Job retention	<ul style="list-style-type: none"> <li>Three jobs continued beyond the end of our study</li> <li>Improved parents perception of employability</li> <li>Positive experience for employer</li> </ul>
Kaehne & Beyer (2013)	One-to-one mentoring	5	Employment retention – using peer support in addition to supported employment	<ul style="list-style-type: none"> <li>77 mentor and mentee partnerships completed the programme</li> <li>42 (54.5%) mentees were considered 'program successes', of which: <ul style="list-style-type: none"> <li>29 (69%) returned to school</li> <li>13 (31%) became employed</li> </ul> </li> <li>35 (45.5%) were considered 'program failures', of which: <ul style="list-style-type: none"> <li>20 (57.1%) dropped out voluntarily due to lack of interest</li> <li>14 (40%) were dropped from the program</li> <li>1 (3%) completed the program without reaching their goals</li> </ul> </li> </ul>
Kowlakowsky-Hayner et al., (2012)	One-to-one mentoring	131 (100 were successfully matched with mentors)	Supporting unemployed participants into work/post-secondary education	<ul style="list-style-type: none"> <li>Identified four helpful dimensions of peer support and concluded it could offer a 'partial return-to-work solution'</li> <li>Did not measure moves into work; the study was interested in understanding support mechanisms</li> </ul>
MacEachen et al., (2007)	Support group	37 across three support groups	Supporting recovery and return to work where appropriate	



Nelson et al., (2006)	Support group (Nb. These studies evaluation different aspects of the same intervention, at different points)	118	Investigating the effects of peer support on a range of employment outcomes, including whether participants moved into work, retained work, or improved their financial situation as result of work	<ul style="list-style-type: none"> <li>• Found little difference between active and non-active study participants over 9 months, but a greater difference over 18 months</li> <li>• There is no specific evidence on progression in work, and the results do not distinguish clearly between work and employment status changes</li> <li>• At the three year follow-up there was a significant difference in participation in education or employment, or both, between the continuously active group and those who activity had lapse, or who had never been active</li> <li>• Participants were interviewed about their employment status, whether they felt they had sufficient income, and whether they were in employment or training. 9/16 active group participants and 8/12 non-active reported positively on this at baseline.</li> <li>• At 9 months, 10/14 active and 6/12 non-active participants reported positively, and at 18 months 11/15 active and 4/12 non-active reported positively</li> </ul>
Nelson et al., (2007)		102		
Ochocka et al., (2006)		27		
Odeen et al., (2013)	Workplace-based: appointed peer advisors, combined with <b>either</b> education <b>or</b> access to an outpatient clinic	3,500 (divided into 135 units)	Reducing sick leave	<ul style="list-style-type: none"> <li>• Peer support and education reduced sick leave by 7% during the intervention year</li> <li>• Peer support and access to an outpatient clinic reduced sick leave by 4% in the intervention year</li> <li>• In the control group sick leave went up by 7%</li> <li>• 'Faulty beliefs' about lower back pain were reduced in both intervention groups</li> </ul>
Peterson et al., (2008)	Support group	151	Reducing sick leave	<ul style="list-style-type: none"> <li>• Found statistically significant effects in the intervention group for general health, perceptions of demands at work, participation and access to development opportunities, and perceptions of support at work</li> <li>• Also identified mechanisms that participants reported as leading to these effects.</li> </ul>

**Table 2: Summary of grey literature**

Author and year	Mode of delivery	No. participant	Aim	Outcome measures used/results
Reidy and Webber (2009)	One-to-one mentoring	38 peer matched individuals Focus group of 4	Supporting return to work/ education/volunteering, alongside health outcomes	<ul style="list-style-type: none"> <li>• Intention to return to work or employment. Out of 9 respondents (respondents were allowed to choose more than one answer):               <ul style="list-style-type: none"> <li>▫ Five planned to return to employment</li> <li>▫ Two planned to complete voluntary work</li> <li>▫ One sought further education</li> <li>▫ One had no plans</li> <li>▫ Two were aiming for 'something else'</li> </ul> </li> <li>• Eight out of ten respondents reported that peer support had improved their confidence</li> </ul>
Voices of eXperience et al., (2008)	Group and one-to-one mentoring	N/A – council wide scheme (East Renfrewshire)	Identifying reasons why peer support is helpful at getting people with long term conditions back into work.	<ul style="list-style-type: none"> <li>• Interviews with participating charities identified key reasons for peer support success:               <ul style="list-style-type: none"> <li>▫ Helps to regain confidence and skills to move back into employment</li> <li>▫ Can re-address power imbalance between service users and service providers</li> <li>▫ Is easily transferable applicable to a variety of contexts</li> <li>▫ Can change the way a service user views him/herself, focussing on assets rather than needs.</li> </ul> </li> </ul>

Barclays (2008)	Workplace based: shared experiences	N/A	Fighting stigma towards mental illness by employees sharing experiences.	<ul style="list-style-type: none"> <li>• Nine employees spoke publically about their conditions, with another 60 discussing on internal social media.</li> <li>• Report stated that these conversations helped others learn what adjustments to make to manage their conditions, and shifts the focus from the problem itself to the good work people are doing.</li> </ul>
Fulton et al., (2011)	Group peer support	N/A. Council wide (Yorkshire and the Humber)	Emotional wellbeing, confidence to achieve vocational goals.	<ul style="list-style-type: none"> <li>• Participants reported increased self esteem and self-confidence, an increased sense of wellbeing and improved motivation.</li> </ul>
Barnes and Mercer (2008)	Group peer support	N/A.	Investigation into how many disability support organisations run peer support groups, and their outcomes.	<ul style="list-style-type: none"> <li>• Review found that user-led organisations were more responsive to users needs, and better at supporting their 'soft' outcome goals.</li> </ul>
National Centre for Independent Living (2008)	One-on-one mentoring	N/A.	Evaluation of pilot schemes of peer support.	<ul style="list-style-type: none"> <li>• Action plans made between mentors and mentees to establish vocational goals. Improved self-esteem and self-belief was reported.</li> </ul>

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