eahsn
Eastern Academic
Health Science Network

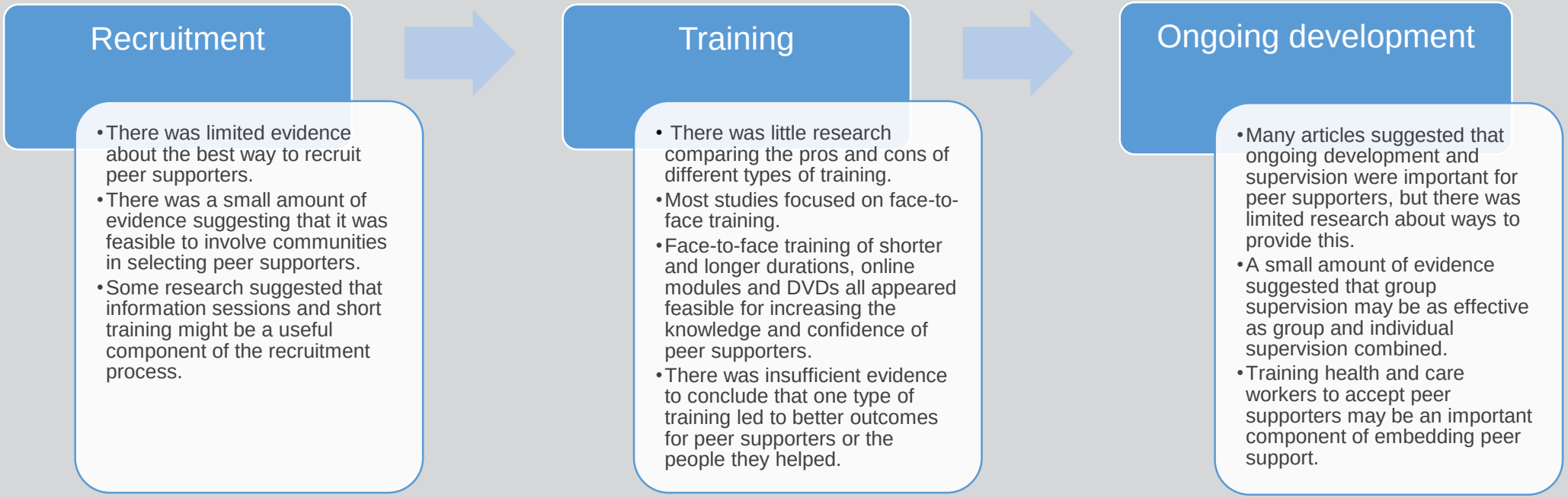
# Training peer supporters

## Rapid review of feasibility and impacts

# Key themes

Lay people and those with lived experience of conditions can provide information, support and advice to others in a paid or unpaid capacity. Whilst people generally appreciate such peer to peer support, there is mixed evidence about its impacts. One factor influencing the impact of peer support may be the type of training and development opportunities available to peer supporters.

This rapid review examined the feasibility and impact of training peer supporters in health and social care. Two reviewers independently searched ten bibliographic databases for studies published up until 31 March 2018. Ninety studies were included, most from the United States. The diagram summarises key findings.




The review identified gaps in knowledge about what works best to develop and support peer supporters. Shorter and longer face-to-face, online and DVD training was been found to be feasible, but there was little evidence that one type of training should be prioritised over others.

# Acknowledgements

*Galvanising people to advance health and wealth*

Eastern Academic Health Science Network is one of 15 Academic Health Science Networks (AHSNs) set up to spread innovation at pace and scale across the healthcare system – in order to achieve the ultimate goals of both improving health and generating economic growth.

We are the only bodies that connect all partners across sectors: NHS and academic organisations, local authorities, the third sector and industry. We are catalysts that work to create the right conditions to facilitate change across whole health and social care economies, improving outcomes for patients.

This rapid review was undertaken for the Eastern Academic Health Science Network by an independent organisation, The Evidence Centre. The review was completed in its entirety within one week so it is a rapid compilation of readily available evidence rather than a systematic review of all published research.

# Contents

# Background

## Scope

Peer support involves someone using their own life experience or knowledge to help someone else, often from their own community or with similar experiences or physical or mental health conditions to themselves.

> *"Peer support in healthcare encompasses a range of approaches through which people with similar long-term conditions or health experiences support each other in order to better understand the condition and aid recovery or self-management."*[1]

Many people may provide support to others without formally using the term 'peer support'. Lay people and those with lived experience of physical or mental health conditions can provide peer support in many ways, from informal and unpaid conversations, befriending and coffee mornings through to facilitating self-management support sessions or holding paid posts as navigators or advisors.

In recent years, peer support has gained momentum in health and care services in the UK and internationally. Many people's stories, case studies and research suggests that peer support can play a role in signposting people to health and care services, providing information and emotional support and potentially reducing inappropriate use of health services.[2,3,4,5,6,7,8,9]

Some studies have found that support or education provided by peers can be just as effective as that provided by professionals,[10,11] that peer support can reach specific cultural or sociodemographic groups appropriately[12,13,14] and that it has benefits for the people providing support too.[15]

However, research has not always found consistent benefits.[16,17,18] This may be due to the many types of peer support being compared, the varying contexts in which it is provided, the differing resources allocated to it and the skills and capacity of peer supporters themselves.[19] There is some evidence that peer supporters do not always feel well prepared for their roles. For instance, a systematic review of 24 studies found that lay people facilitating self-management education programmes for people with long-term conditions did not feel they had received enough specific training to support them to work with groups.[20] Increasing the skills and knowledge of peer supporters may thus be one of many priorities in strengthening the foundations of peer support in health and social services.[21,22,23]

This rapid review explores published research evidence about the **feasibility and impact of training and development approaches for people providing peer support**.

# Identifying research

For the purposes of the review, peer to peer support was defined as the provision of information, advice, counselling, motivational interviewing or other support by a member of the public, lay person or person with lived experience in a community, residential or primary care setting. The lay person could be paid or unpaid. Training for peer support provided in other contexts was not a focus of the review.

Studies were eligible for inclusion in the review if they:

- were about training or developing peer supporters
- focused on developed countries
- contained empirical research
- were published in a journal up to 31 March 2018
- were written in the English language
- were about training for peer support to be offered outside a hospital or specialist context i.e. in a person's home, residential care, community or primary care setting

Two reviewers independently searched ten bibliographic databases for relevant studies. The databases were CINAHL, the Cochrane Library and Controlled Trials Register, EMBASE, Global Health, Google Scholar, Health Systems Evidence, PsychInfo, Pubmed/Medline, Scopus and Web of Science. Databases were searched from their inception up until 31 March 2018.

The following key words were used in searches: education, training, teaching, app, eLearning, module, toolkit, resource, tools, manual, supervision, recruit, preparation, development, curriculum, competency framework, peer support, navigator, peer to peer, peers, experts by experience, lay, community health worker, volunteer, train the trainer, patient-led, patient mentor, peer specialist, peer provider, champions and similes.

The reviewers scanned the titles and abstracts of 4,991 studies. Of these, 119 were rated as potentially relevant and the full text was reviewed in depth. **Ninety relevant studies** were identified for inclusion in the review and data from these was independently extracted by two reviewers using a structured template. Themes were analysed based on characteristics of the training and development approaches. Findings were not broken down according to whether peer supporters were paid or unpaid or the types of support they might provide.

A number of studies focused on training for 'community health workers', 'community health advisors' or similar, particularly in the United States (US). There were many different definitions of such roles. A systematic review identified 119 papers that provided definitions of community health workers in 25 countries. Community health workers were either lay people or paraprofessionals with a primary goal to provide culturally appropriate health support to the community. The review divided community health workers into three groups: lay people with little or no formal education who underwent a few days to a few weeks of informal training and provided unpaid peer support; level 1 paraprofessionals with some form of secondary education and subsequent informal training who sometimes received an allowance or expenses, and level 2 paraprofessionals with some form of secondary education and subsequent formal training lasting a few months who often took on paid roles.[24] Studies about the training of community health workers and similar roles did not always differentiate the type of person taking part and it is important to recognise that variation was present when interpreting the findings presented overleaf.

This review was undertaken using structured processes, but it is not a systematic review. It aimed to rapidly identify key themes to give a sense of the scope and quality of research available, not to summarise the findings of each individual study.

# Identifying peer supporters

## Recruiting peer supporters

Identifying people to become peer supporters may form part of the initial development process. However **the review did not find robust evidence comparing different ways of recruiting people to act as peer supporters**. Some studies and non-empirical material described how people had been encouraged to provide peer support, but such descriptions tended to be sparse and not a focus of the documentation.

Material has variously explored how school children, university students, barbers, church members, people from certain ethnic groups, people from specific geographic regions and those with particular physical or mental health conditions can be recruited or trained as peer supporters.[25, 26,27] For example, in the US the value of recruiting hairdressers as peer supporters was tested. Fifty-two hair salons were randomised to provide clients with four sessions of basic health promotion versus education about organ donation. Hairdressers received four hours of training about organ donation. When followed up after four months, the customers that took part in the organ donation sessions with their hairdressers were almost twice as likely as the other group to say they would become an organ donor. This was confirmed via verified organ registry data.[28]

A UK study found that asking school children and teachers simple questions helped to identify children who were well regarded and had good social networks to be trained as peer supporters.[29] More than 10,000 students aged 12-13 years from 59 schools nominated peers for training. Although some students and staff expressed doubts about the suitability of some of the young people recruited as peer supporters, the peer support programme was associated with a 22% reduction in the odds of being a regular smoker compared to schools in a control group. The researchers concluded that paying attention to the way in which peer supporters are identified and involving young people in this process may be the key to increasing the effectiveness of peer education in schools.[30]

Some studies examined the characteristics that might help people provide peer support effectively. For instance, a US study explored the characteristics of African American women trained as lay health advisors to reduce health disparities in underserved communities. The researchers suggested that important characteristics included similar sociodemographic features to the communities they supported, racial pride, experiences of discrimination, psychological and physical health, health behaviours, social networks, social support, self-efficacy and leadership. In other words, capacity at the individual level, social level and organisational level were all important.[31] If generalisable, it may be useful to consider these types of characteristics when recruiting and training people as peer supporters.

In the UK ‘health trainers’ are lay people recruited to help harder-to-reach people from local communities make healthy lifestyle changes. Health trainers are usually paid for this role. A study found that health trainers in London often emphasised their similarities but underestimated significant differences to their local communities. Those based in community or voluntary groups found it easier to engage with local communities than those based in health organisations, but there remained a lack of clarity about the role. The researchers concluded that lay health trainers are not necessarily part of the marginalised communities they are expected to engage with and their ability to do so is compromised by the culture of the NHS and its approach to community engagement. This emphasises the importance of appropriate recruitment and embedding of peer support where such roles are professionalised.[32]

## Training as part of the recruitment process

A US study described how training could be used as part of the recruitment process for peer supporters. Thirty-four Spanish-speaking lay people were recruited to take part in an information session about leadership and cancer. Of these, 27 enrolled in a short training programme (79%) and 22 completed the training (81% of those who began training). Offering an information session was a component of the recruitment process, helping people consider whether a peer support role was appropriate for them.[33]

Another example of using a structured process to recruit and train peer supporters comes from a study of training Spanish-speaking (lay) community health workers in the US to support people with hearing loss. A three-phase recruitment and training process was implemented by audiologists and public health researchers. The process first included focus groups with community health workers and local residents to raise awareness about hearing loss. This was followed by a three-hour workshop to prepare 12 community health workers to identify signs of hearing loss among community members. Finally four community health workers took part in more detailed training, comprising 24 hours spread over six weeks. This training was designed to help community health workers facilitate educational and peer support groups for people with hearing loss and their family members. The process was feasible for recruiting people to provide different levels of support. The training was associated with increased knowledge and confidence amongst community health workers in effective communication strategies and skills in facilitating groups. Follow up showed that community health workers applied their learning and made referrals for hearing care.[34]

Though the evidence is sparse, overall research findings suggest that it is feasible to recruit a wide range of people as peer supporters, though there is no research to suggest that it would be more appropriate to target some people over others. There is no robust evidence that some recruitment methods are more effective.

# Training peer supporters

More research was available about ways that peer supporters had been trained or developed, whether the role was paid or unpaid. There is research about training for peer supporters in schools, prisons and those aiming to support adults in the community with particular conditions, especially screening for various types of cancer, diabetes care, heart health, depression and other long term physical or mental conditions.[35] There was research about training in community venues, churches, academic settings and primary care centres.[36]

Table 1 includes examples of the types of training researched. This is not exhaustive, but seeks to provide examples of the context of training, the types of people trained and a snapshot of the outcomes. Most of the research about training peer supporters focused on face-to-face sessions of short duration. There was very limited information about online or other forms of training. In many instances, studies would note that supporters had been trained, but not document the content or sometimes even the duration of training.

To supplement the rapid review, a search of grey literature was undertaken to identify examples of training programmes and toolkits to help develop peer supporters. More than 100 examples were identified and are included in a spreadsheet accompanying this review. The search suggested that **there are many manuals, toolkits and reports to assist with developing peer supporters, but the feasibility and impacts of these tools is not usually documented** or published.

This gap in both published and grey literature about training peer supporters has been noted by others:

> *"Researchers … tend to provide brief descriptions of training strategies and provide little discussion of the challenges and barriers to training a lay population in the delivery of technical interventions, including ensuring fidelity to the intervention protocol."* [37]

*Table 1: Examples of researched training and development approaches for peer supporters*

| Initiative | People trained | Duration | Condition focus | Country | Impact |
|---|---|---|---|---|---|
| Face-to-face training | People in prison (unpaid) | Not specified | Supporting older prisoners and those with disabilities[38] | UK | Training was associated with improved self-esteem of peer supporters, increased social support and better relationships between peers and those they supported |
| Face-to-face training | 28 mothers (unpaid) | Not specified | Supporting women to breastfeed[39] | UK | Training mothers as breastfeeding peer supporters improved their already positive attitudes towards breastfeeding and their knowledge |
| Face-to-face training | Unemployed people (paid) | 22 weeks | Diabetes education[40] | NZ | Training unemployed people as diabetes educators was feasible, helped draw in cultural skills from the community and helped people gain employment |
| Face-to-face training | 8 South Asian adults (unpaid) | Five 4-hour sessions | Diabetes self-management[41] | Canada | Training was associated with increased knowledge and skills amongst peer supporters |
| Face-to-face training | 13 people with spinal cord injury (unpaid) | Half day workshop | Increasing physical activity amongst people with spinal cord injury[42] | Canada | Training was associated with increased competence in motivational interviewing amongst peer supporters immediately after training but desire to use techniques was not maintained when followed up after one month |
| Face-to-face training | 17 lay counsellors (allowance) | 12 hours | HIV/AIDs[43] | South Africa | Training was associated with increased skills and competence amongst peer supporters immediately that remained after one year |
| Face-to-face training and practicum | 37 immigrant women (unpaid) | A weekly 2-hour session for 12 weeks followed by a 3 week practicum | Oral health for immigrant children[44] | Taiwan | Training was associated with increased knowledge and confidence and improved oral health behaviours amongst peer supporters |
| Face-to-face training | 32 lay people from a low rent housing estate (unpaid) | 4 hour workshop | Health promotion for people living in a public low rent housing estate[45] | Hong Kong | Peer supporters had improved knowledge and attitudes immediately after training and this was sustained after one year. Peer supporters ran activities for the community and those who took part reported improved communication and neighbourhood cohesion |
| Face-to-face training | People with mental health issues (paid) | Six weeks of sessions plus a 24 week paid position on a telephone helpline | Mental health[46] | Hong Kong | Training was associated with improved knowledge amongst peer supporters, who also felt it had positive impacts on their own mental health. The support they provided to others was deemed to reduce isolation and raise hope amongst service users |
| Face-to-face training | 15 rural African American men (unpaid) | Two days | Prostate cancer screening in African American men[47] | US | Training was associated with improved knowledge about cancer and confidence to support others amongst peer supporters |

| Initiative | People trained | Duration | Condition focus | Country | Impact |
|---|---|---|---|---|---|
| Face-to-face training | 8 barbers (unpaid) | Short duration, unspecified | Prostate cancer amongst urban African American men[48] | US | Training was associated with improved cancer knowledge and confidence to support others amongst peer supporters |
| Face-to-face training | African American community health workers (payment status unknown) | Short duration, unspecified | Addressing health inequalities in African American people[49] | US | There was increased community involvement, but no significant change in self-reported health status or health behaviour amongst peer supporters |
| Face-to-face training | African American peer supporters (payment status unknown) | Train the trainer, short duration | Cancer[50] | US | Training was feasible and replicable but there was limited rollout of motivational interviewing skills |
| Face-to-face training | African America women (unpaid) | Short duration, unspecified | Breast cancer survivors[51] | US | Training was associated with improved knowledge amongst peer supporters |
| Face-to-face training | African American lay people (unpaid) | Short duration, not specified | Promoting joining cancer clinical trials[52] | US | Training was associated with increased knowledge and confidence amongst peer supporters |
| Face-to-face training | 4 African American church members (unpaid) | 10 hours | Heart health and nutrition[53] | US | Peer supporters were satisfied with the training approach. Other impacts were not reported |
| Face-to-face training | 74 Latino lay health advisors and cancer survivors (payment status known) | Short duration, unspecified | Breast and cervical cancer screening in Latino women[54] | US | Training was associated with increased knowledge about cancer amongst peer supporters |
| Face-to-face training | 56 Latino women (unpaid) | 16 hours | Cancer screening in Latino women[55] | US | Training was associated with increased knowledge about cancer and confidence to support others amongst peer supporters |
| Face-to-face training | Rural Latino lay helpers (unpaid) | Short duration, unspecified | Cancer[56] | US | Training was linked to increased knowledge about cancer amongst peer supporters |
| Face-to-face training | Latino community health workers (paid) | Three 3-hour sessions | Research fundamentals[57] | US | Researchers learned about the community as much as the course educated peer supporters about research |
| Face-to-face training | 35 Latino men and women (unpaid) | Short duration, not specified | Tobacco control[58] | US | Peer supporters improved their own health behaviours after training |
| Face-to-face training | 12 Spanish speaking community health workers (paid) | 3 hour workshop followed by 24 hours spread over 6 weeks for 4 participants | Hearing loss[59] | US | It was feasible to train peers to support people with hearing loss. Peers had increased knowledge and confidence and used these to facilitate education and support groups |

| Initiative | People trained | Duration | Condition focus | Country | Impact |
|---|---|---|---|---|---|
| Face-to-face training | 74 Latino lay people (unpaid) | 6 hours | Promoting school wellness policies[60] | US | Training was associated with increased knowledge and confidence amongst peer supporters, leading to more health promotion at schools |
| Face-to-face training | African American and Latino men who have sex with men (payment status unknown) | Not specified | Training peers to provide online support for HIV prevention[61] | US | The training approach was found to be feasible |
| Face-to-face training with manual | 79 Chinese women (unpaid) | Short duration, not specified | Breast cancer screening in Asian American women[62] | US | Training was linked to increased knowledge and confidence amongst peer supporters. Those who were younger and employed had the highest confidence in promoting breast cancer screening to others |
| Face-to-face training | 15 parents from minority ethnic groups (unpaid) | 2 days | Health insurance for minority group children[63] | US | Training was linked to increased knowledge amongst peer supporters and increased uptake of insurance amongst the peers they advised |
| Face-to-face training | Church lay people (unpaid) | Short duration, not specified | Weight loss[64] | US | The short training helped lay people deliver a weight loss programme consistently, with average weight loss of 8 pounds per participant |
| Face-to-face training | Lay people from churches and retirement homes (unpaid) | 16 hours over 8 weeks | Health promotion[65] | US | After training, peer supporters went on to organise educational and screening programmes in their communities |
| Face-to-face training | 6 people living with HIV (payment status unknown) | 24 hours spread over 5 days | Medication adherence and safer sex (HIV prevention)[66] | US | The training programme was feasible but competence in motivational interviewing was low. Peer supporters found it difficult not to give direct advice |
| Face-to-face and individual feedback | 4 people living with HIV (payment status unknown) | 40 hours | Substance use amongst people living with HIV/AIDs[67] | US | Two out of four people achieved competency in motivational interviewing. Peer supporters found it difficult to ask open questions and refrain from providing advice |
| Face-to-face training with role plays | People living with HIV (payment status unknown) | 6 weeks, including half day workshop, practice role plays and formal recorded role plays with actors | People with HIV/AIDs (supported offered in the community to encourage attendance at outpatient appointments)[68] | US | The training helped peer supporters achieve competency in motivational interviewing |

| Initiative | People trained | Duration | Condition focus | Country | Impact |
|---|---|---|---|---|---|
| Face-to-face training including videos | 73 Meals on Wheels volunteers (unpaid) | 4 hour sessions plus refresher after 9 months | Health literacy for older people[69] | US | Training led to increased knowledge and implementation of coaching strategies amongst peer supporters |
| Online training, self-directed learning and in person peer coaching | Community health workers (payment status unknown) | Short duration, unspecified | Heart disease risk in African American women[70] | US | Training was associated with increased knowledge and confidence amongst peer supporters and 100% retention of peer supporters. 122 person hours of community education were delivered by peer supporters within 90 days of training |
| Online training | 12 peer community health advisors from churches (unpaid) | 13 videos | Early detection of cancer in African American people[71] | US | Online videos were a feasible method for training peers to run workshops. It took peer supporters about one month to complete the online programme |
| Online and distance training | African American community health workers in a rural area (payment status unknown) | Not specified | Train the trainers programme for cancer patient navigation[72] | US | Online education was feasible |
| Online with posted materials versus face-to-face | Lay people (unpaid) | Short duration, not specified | Smoking cessation[73] | US | Face-to-face and online training were equally effective for increasing knowledge, confidence and implementation of peer support |
| DVD plus booster sessions | 56 veterans (unknown payment status) | One DVD plus two to three booster sessions | Telephone support for veterans to reduce weight[74] | US | Training was associated with increased knowledge about communication skills and a small increase in confidence in motivational interviewing amongst peer supporters |
| DVD plus face-to-face sessions | 15 cancer survivors and caregivers (unpaid) | Two-day DVD plus monthly face-to-face sessions for six months | Cancer survivors and caregivers[75] | US | Training was associated with competency in motivational interviewing amongst supporters |

Note: This table provides examples to give a flavour of the types of training that have been researched. It is not exhaustive. A number of other examples are described throughout the text.

# Feasibility and impact of training

The review found relatively limited published research about the feasibility and impacts of training and development approaches to upskill peer supporters. There is a vast amount of literature about educational techniques used in healthcare more generally, including the pros and cons of different content and styles,[76,77,78,79] but the review found limited evidence specifically related to the training and development of peer supporters.

The evidence that did exist tended to involve small samples, single sites and observational before-and-after study designs. Bearing in mind the relatively low quality of the research, the evidence suggested that it was feasible to train peers, experts by experience and lay people to support others and that this **training was often associated with immediate measureable increases in the self-reported knowledge and confidence of peer supporters**.[80,81] Some studies also described the impact of training on the health, wellbeing and employability of peer supporters themselves.[82] For instance in England training people with arthritis as lay facilitators of self-management programmes was associated with improved symptom management, mood and communication with clinicians amongst the peer supporters.[83]

Another study in England examined training prisoners to provide social support to older prisoners or those with disabilities. The programme was associated with increased self-esteem for those providing peer support, increased social support within the prison, improved relationships between peer supporters and other prisoners and improved team working.[84] However the components of training associated with these outcomes were not reported.

Whilst there are many published descriptions of peer support programmes and examples of manuals and training available online,[85] there is relatively little research about the pros and cons of different approaches. **The review identified little comparative research exploring whether one type of training was more acceptable or effective than another**. Nor was there empirical research about whether some training approaches were more useful or appropriate for specific types of peer supporters or population groups. This means we cannot draw conclusions about whether some approaches are more feasible, appropriate or impactful in certain contexts. For instance, there is no evidence to suggest that a one-day course is any more or less worthwhile than weekly training sessions for eight weeks or that people providing peer support about diabetes have different preferences than those focused on cancer, mental health or smoking cessation. This is not to say that the approaches are equivalent, just that there is limited published evidence upon which to draw conclusions.

There also appeared to be little follow up too explore whether different training approaches improved the type of peer support offered and the ultimate outcomes of people benefitting from support.

# Training content

Most research did not document the content of training for peer supporters in any detail, though various examples of training manuals or session plans were available in the grey literature.

**Interactive types of training** and using people's experiences and stories were sometimes positively commented on,[86,87] although there was little comparative research to suggest that this was more impactful than other approaches.

A US study found that role plays could be an effective component of training. People living with HIV were trained to provide support in the community to encourage peers to attend outpatient appointments. The training involved a half-day workshop, practice role play sessions and role plays with actors that were formally assessed and filmed. The training spanned a six week period. The researchers noted that this was time-intensive, but using role plays and formally rating people's skills helped peer supporters achieve competence in motivational interviewing.[88]

In the US, 73 Meals on Wheels volunteers were trained to coach older people about health literacy. The training comprised four hour workshops with sessions about communicating with older adults, the nature of health literacy and coaching skills. Participants viewed and discussed videos about communication strategies. They took part in a booster session after nine months which included videos showing good practice coaching conversations. The training was associated with improved knowledge and increased use of coaching strategies. Communication skills training and videos were particularly well regarded.[89]

Some studies have tested using tools such as 'audience response systems' whereby participants answer questions using an electronic clicker that compiles feedback from the group visually.[90]

Many of the studies from North America emphasised the importance of **culturally appropriate content** as the aim was to reach particular ethnic groups.[91,92,93,94] In the UK, a study of lay educators running self-management education programmes for people with long-term conditions also emphasised the importance of culturally tailored components, but did not describe the training for these roles.[95]

A US study described training for African American peer supporters. The participants reported that bonding as a group, 'Afrocentric' content, public health information, approachable facilitators, populist education techniques and good time management were important components of the course content. Although there were trends towards improved self-reported health status and health behaviours in peer supporters following the training, these did not reach statistical significance.[96]

Some studies used educational, empowerment or social theories to guide the development of training for peer supporters. For instance, a US study used diffusion of innovation theory to develop a train the trainer model for African American breast cancer survivors and carers. The study found that it was feasible to implement the training and that it could be replicated in a number of contexts. However the researchers found that the training did not have the desired impact on enhancing the quality of motivational interviewing or helping peers to train others in this approach. Having a theoretical model helped this study look for longer-term impacts, rather than solely immediate increases in self-reported knowledge amongst peer supporters.[97]

A number of studies described **how the competency of peer supporters was assessed** as a core part of programme content. For instance, researchers from Canada trained South Asian lay people to provide diabetes self-management support. The training comprised five sessions (four hours per session) with quizzes, group brainstorming, skill building, role play and simulated facilitation. To complete the programme, participants were required to achieve pre-set competency criteria in the domains of active listening, empowerment-based facilitation, five-step behavioural goal-setting and self-efficacy. Participants were allowed three attempts to pass each competency domain. This approach was found to be feasible, with all participants achieving the competencies on the first or second attempt.[98]

A US study developed a set of common core competencies for community health advisors and a before and after tool to measure the extent to which training improved those competencies. The competencies comprised leadership, translation, guidance, advocacy and caring. However testing of the tool suggested that these competencies may be interrelated rather than distinct.[99] Other studies have also suggested that training based on core competencies is associated with improvements in self-reported skills and confidence[100] or developed tools to assess specific competencies.[101]

Some studies suggested that **having a wide range of people involved in developing course content** was useful, including community leaders, community groups, health professionals and academics or educators.[102,103,104] For instance, in a rural US community, African American lay people took part in two days of training to upskill them about prostate health. The training was developed by a group of academics, community partners, religious leaders and other stakeholders and included interactive activities designed to increase knowledge and skills.

Fifteen men took part in the training, with before and after self-assessment surveys finding significant increases in knowledge and confidence in supporting others. The men used their personal networks to share their knowledge with more than 1,000 people in their community and implemented a prostate health survey in local churches. The researchers suggested that involving stakeholders such as community groups and religious leaders in developing the training curricula ensured the content addressed community needs and gained buy-in.[105]

Other research has suggested that the content of training should be adapted in line with the past experience of peer supporters. A US study provided training to support an educational outreach programme to increase breast and cervical cancer screening in Latino women. Short training sessions were run to upskill male and female lay health advisors and cancer survivors. The study found that knowledge about cancer increased most amongst lay health advisors because cancer survivors already had high knowledge at the outset. The researchers concluded that the training was useful for both groups but that programmes might usefully adapt to reflect what participants already know.[106] Training about skills such as listening, motivational interviewing and similar may be just as important as training about clinical topics. As with many studies, the researchers did not report on whether the knowledge gained was put into practice or helped to improve cancer screening rates in the target group.

In most cases, research about training and development for peer supporters focused on approaches targeting supporters themselves but a small number of examples were available about training peer supporters side by side with the professionals they would be working with.[107] There was no indication of the pros and cons of this approach over training groups of peers together.

## Duration of training

The review identified numerous descriptions of **short training** sessions. For instance, in the US parent mentors were selected from a primary care clinic to attend a two-day training programme covering nine topics. The aim was to increase their knowledge and skills to help other parents gain health insurance for their children. All 15 of the participants were female from minority ethnic groups. Sixty percent were unemployed. Before and after tests showed improvements in knowledge. Perhaps more importantly, the researchers noted that these peer mentors were more successful than traditional outreach approaches for gaining health insurance for children from minority ethnic groups.[108]

Some training included a relatively small number of hours spread over several weeks. For example, in the US 25 lay people from churches and retirement communities took part in a 16-hour education programme spread over eight weeks. The programme was designed by health professionals. The researchers reported that this was a feasible way to recruit and train peers from racially and religiously diverse communities. Participants went on to organise educational and screening initiatives in their communities.[109]

Most studies did not explore the longer-term impacts of short-duration training, but there were some exceptions. An example of the potential benefits of very short training comes from Hong Kong. Thirty-two residents and community leaders from a low rent public housing estate took part in a four-hour workshop to help them incorporate positive psychology themes into their community activities and engage other residents to join these activities and learn alongside others. Surveys were undertaken with the peer supporters and other community members before, immediately after and one year after training. Training was associated with self-reported increases in knowledge, leadership and planning skills which were sustained after one year. Peer supporters used their learning to run community activities.

Surveys with residents found improvements in communication, better neighbourhood cohesion and more knowledge about family wellbeing after attending events run by the peer supporters.[110]

Research from South Africa about training HIV/AIDs lay counsellors in motivational interviewing techniques found that a 12-hour training programme was associated with immediate improvements in competency which remained after one year. The levels of competency achieved were low overall, but brief training was associated with a sustained improvement.[111]

However not all research is positive. In Canada, 13 people with spinal cord injury took part in a half-day workshop to learn motivational interviewing techniques to help others with spinal cord injuries become more physically active. Although participants' skills increased, after one month their desire to apply what they had learnt with peers had declined.[112] It is positive that a very short training session helped to build new skills but refreshers and ongoing support may be needed to maintain motivation to support others.

There were fewer examples of **longer term training**. In Taiwan, immigrant women were recruited from churches, schools, and immigrant centres in an urban area to train as oral health peer supporters. Each training cycle lasted 15 consecutive weeks, comprising a weekly 2-hour session for 12 weeks followed by a 3-week practicum. The curriculum included sessions about oral health, demonstrations about oral hygiene, teaching techniques, communication skills and hands-on practice sessions. Thirty-seven women completed the course and passed the post-training exam. The training was associated with increases in knowledge, confidence and attitudes toward oral hygiene. Participants and their children demonstrated better oral health behaviours after the training. The researchers did not report the impact on community members.[113]

In New Zealand, unemployed people from a less advantaged community took part in a 22-week training course to become paid diabetes educators. The participants were selected by their communities. The researchers concluded that the training resulted in culturally acceptable diabetes educators and provided employment for course participants. The participants went on to provide diabetes education in primary prevention and group settings. The impact of their work was not reported.[114]

Another example of longer-term training for peers who were taking on paid roles comes from Hong Kong. People who had used mental health services took part in a six-week course followed by a 24-week paid internship on a telephone helpline. Training was associated with improved knowledge and confidence amongst peer supporters. It was also found to improve peer supporters' views of their own mental health. The help provided by the peer supporters was reported to reduce isolation and increase feelings of hope amongst those calling the helpline.[115]

In the US four people living with HIV and substance misuse issues were trained in motivational interviewing to support others with similar issues. The training spanned 40 hours and included lectures, workshops and individual feedback sessions. The researchers noted that this was longer than most motivational interviewing training. Only half of the peer supporters achieved competency as measured by a validated tool. Peer supporters found it difficult to use open-ended questions and query the pros and cons of various options, which are key skills to support talking about changes. Supporters were also inclined to provide direct advice rather than reflections. The researchers concluded that it is possible to train peers to change how they communicate but this may take some time.[116] Similar studies about training people living with HIV to provide peer support about medication adherence and safer sex also found that training was feasible but that supporters struggled to achieve competency in motivational interviewing and were more focused on giving advice.[117]

The review did not identify studies directly comparing the impacts of longer or shorter training programmes for peer supporters, but some studies of short training programmes suggested that more preparatory sessions may have boosted peer supporters' confidence and provided more time to cover further topic areas.[118]

# Mode of training

**There is almost no research comparing face-to-face with online training and support for peer supporters**. Demonstrating the paucity of high quality research in this area, a systematic review of randomised controlled trials about the effects of training and support programmes for peer facilitators of health support groups identified only one relevant trial. The trial evaluated the confidence of cancer peer support group facilitators randomised to four months of various levels of support. One group had access to a website and discussion forum. Another group had access to the website, discussion forum and a two-day training workshop. There were no significant differences in facilitator confidence or self-efficacy. This means that face-to-face training was no more effective than online support alone in this study.[119]

A similar randomised trial compared face-to-face versus online training with posted materials for lay people supporting smoking cessation. Both types of training were associated with improved knowledge, confidence and increased brief interventions provided to peers. Nine out of ten participants reported implementing what they had learnt and about seven out of ten continued to provide peer support after three months. The researchers concluded that online and face-to-face training was equally effective and that with minimal prompting and materials, lay people could be trained to support smoking cessation.[120]

In addition to the many studies of face-to-face training described in Table 1, the review identified a small number of examples of online training. For instance, a small study trained African American peers to run workshops about early cancer detection in their churches. The online training comprised 13 videos. Of eight churches, six completed the training, each certifying two peers as supporters. The supporters took an average of 26 days to complete the online training and did not require much technical assistance. However they did want some technical support to run workshops which suggests that online videos alone may have some downfalls as a training approach. However the researchers concluded that online training was a feasible way of training lay people to provide support.[121]

There were some examples of development programmes combining online and face-to-face training. For instance, in the US community health workers took part in a ‘learning circle’ approach to learn about heart disease risk amongst African American women. The curriculum blended online modules, self-directed learning, sharing with peers, problem solving and brainstorming, and leadership and experiential activities. After training, the community health workers had increased self-reported knowledge about heart health. Retention following training was 100% and these people went on to run education sessions in their communities. The researchers suggested that blended learning was feasible and may be particularly useful in resource-poor community organisations.[122]

Another US study trained African American and Latino men who have sex with men to provide HIV prevention support to others online. Training used a mix of online and in person approaches. Men who had experience with both social media and community outreach were recruited from the target population. The training curriculum included discussion and role playing exercises, communication skills and interactive social media-based skills. The researchers did not report the impacts of the training.[123]

Other researchers in the US tested the feasibility of using a DVD to train military veterans to act as telephone buddies to help others reduce weight and make healthy lifestyle choices. Where needed, the DVD was supplemented with two to three booster sessions. The researchers concluded that the DVD was a feasible training approach. Nine out of ten participants said they learnt more about peer counselling and communication skills as a result. There was a small improvement in confidence in motivational interviewing. However the researchers suggested that to enhance application in practice, it would be worthwhile to assess how effectively motivational interviewing skills were learnt.[124]

DVDs were also used to train cancer survivors and caregivers about motivational interviewing in the US, but these were supplemented with monthly face-to-face sessions for six months. All 15 of the peer supporters achieved competency in motivational interviewing using this method.[125]

# Ongoing development and supervision

The review identified almost no empirical research about how to best address the ongoing developmental needs of peer supporters. Opportunities to debrief and receive ongoing support and supervision have been acknowledged as an important component of the peer support process, whether people are in paid or unpaid roles.[126,127,128,129,130,131,132,133,134,135,136,137] Educating health and care workers about peer support roles and embedding these roles within services and supervision infrastructure may be part of this.

In England lay people running asthma self-management courses kept diaries about their experiences. A recurring theme was the importance of preparing people about the realities of clinical practice and providing ongoing support, on-site mentoring and training.[138] Another UK study exploring the introduction of peer worker roles into mental health teams found that training and supervision may need to be developed to support the distinctive approach of peer practice.[139] However the review identified almost no studies exploring the feasibility or impacts of different approaches to ongoing supervision and support. This gap has been acknowledged by others.

> *"The quality of services provided by lay health workers is dependent on adequate supportive supervision. It is however one of the weakest links … due to logistical and resource constraints, especially in large scale program[me]s."* [140]

The review did not focus on developing countries, but given the paucity of published research in this area, it may be interesting to note findings from a systematic review of the impact of supervision for community health workers in low and middle income countries. In these countries, community health workers are people identified within local communities and trained to provide information and support. Usually they are volunteers who receive a contribution towards expenses. The review of 22 studies explored how different supervision strategies, following initial training, may influence performance, motivation and retention. The review found vast variation in the frequency and type of supervision available. Some supervision was undertaken by peers or in groups. Other supervision was undertaken by community groups or health professionals. Some involved self-assessment tools or checklists, others focused on problem solving or quality assurance. The review found that improving the quality of supervision had a larger impact than increasing how often supervision occurred. Supervision that provided direct support, included community monitoring and had a quality improvement or problem-solving focus were found to be the most impactful, though the quality of evidence was weak.[141] If findings were transferable to developed countries, this may suggest that any peer support development programme should include targeted and group supervision as a form of both support and quality assurance, rather than expecting the development process to cease after initial training.

A US study explored factors associated with high levels of peer support and retention amongst ‘lay health advisors’. Seventy-six lay health advisors from eight sites across the US were tracked over time, from when they were trained to two years later. The study found that these peer supporters were more likely to have been retained and be highly active in providing peer support if they were based at sites with academic partnerships. Those with good role clarity and self-efficacy were also more likely to continue to provide a moderate or high level of peer support. The researchers suggested that fostering partnerships with academic institutions may be important for the sustainability of peer support programmes. They did not propose why this may be the case but it is possible that such partnerships are associated with improved access to resources, including higher quality training and ongoing support and supervision.[142] Other studies have also found benefits when a community organisation worked alongside an academic health centre to develop training for supporters.[143]

Another US study found that when peer supporters working in a church context felt that their pastors were engaged in the programme they were more able to recruit church members for health promotion. The researchers concluded that support from community leaders may serve an important supervision function as well as motivating other community members to attend.[144] Other studies also found that good understanding of peer supporters’ roles amongst leaders or supervisors was associated with better role satisfaction and retention.[145]

In one of the only studies identified comparing supervision approaches, college students in the US providing alcohol reduction support for their peers took part in either group supervision sessions or group plus individual supervision sessions. Those who took part in both group and individual supervision attained higher levels of motivational interviewing skills. However both groups were equally effective in supporting peers to reduce drinking.[146]

In the UK, a programme of peer support in schools relating to smoking and drug use found that 86% of peer supporters attended in-person follow ups but only 7% completed electronic follow-ups for supervision and support.[147]

# Summary

Growing numbers of voluntary and statutory services are considering the value of support provided by peers or community members as an adjunct to or replacement for support from health and care professionals. Peer supporters may offer education, signposting and emotional and practical support at a time when health and care budgets are increasingly tight. However maintaining the quality and safety of the support provided is essential. Good training and ongoing development of peer supporters may be a key part of this.

A great deal has been written about the potential benefits of peer support in many contexts, including benefits for peer supporters, those they support and the wider health and care system.[148] However it appears that very little robust evidence is available about the most appropriate and effective ways to ensure that peer supporters themselves are developed well in order to fulfil and sustain their roles.

Just as types of peer support vary greatly,[149] so too do approaches to training and developing peer supporters. Whilst this review identified 90 studies about development approaches for peer supporters, no firm conclusions could be drawn about the most appropriate types of training or how training should best be adapted to account for sociodemographic, contextual or clinical factors. Most research came from the US and often targeted peer supporters from minority ethnic groups. Most training was face-to-face, though sometimes supplemented with videos, practical activities or online modules.

Both short and longer durations of training were found to be feasible and were associated with increases in the self-reported knowledge and confidence of peer supporters based on simple before and after measures or in some cases competency assessments. Some peer supporters went on to change their own health behaviours or to positively influence the behaviours of others after training. However studies did not compare offering peer support with or without first training the supporters. **This means whilst it would appear feasible and appropriate to train peer supporters, there is not robust evidence that this makes a difference to the people they support**. Nor is there evidence that shorter or longer training, or lecture-style versus role plays versus formal assessments versus online modules are more appropriate.

In short, **the review has identified a significant gap in knowledge about the most effective types of training and development opportunities for peer supporters**, including both training to prepare them for their role and ongoing development and supervision opportunities. If peer support in its various forms is to be adopted more widely within the UK, it may be important to consider how to assure the quality of the support provided. Training and development approaches would appear to be a key component, including soliciting and using the views of peer supporters themselves.[150]

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