Original article

Effectiveness of one-to-one peer support for patients with severe mental illness – a randomised controlled trial

C.I. Mahlke a,*, S. Pribe b, K. Heumann a, A. Daubmann c, K. Wegscheider c, T. Bock a

Center for Psychosocial Medicine, University Medical Center Hamburg Eppendorf, Martinistr. 52, 20249 Hamburg, Germany

Queen Mary University of London, Unit for Social and Community Psychiatry (WHO Collaborating Centre for Mental Health Service Development), Newham

Centre for Mental Health, E13 8SP London, United Kingdom

University Medical Center Hamburg Eppendorf, Department of Medical Biometry and Epidemiology, Martinistr. 52, 20249 Hamburg, Germany

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A B S T R A C T

Background: One-to-one peer support is a resource-oriented approach for patients with severe mental illness. Existing trials provided inconsistent results and commonly have methodological shortcomings, such as poor training and role definition of peer supporters, small sample sizes, and lack of blinded outcome assessments.

Methods: This is a randomised controlled trial comparing one-to-one peer support with treatment as usual. Eligible were patients with severe mental illnesses: psychosis, major depression, bipolar disorder or borderline personality disorder of more than two years’ duration. A total of 216 patients were recruited through in- and out-patient services from four hospitals in Hamburg, Germany, with 114 allocated to the intervention group and 102 to the control group. The intervention was one-to-one peer support, delivered by trained peers and according to a defined role specification, in addition to treatment as usual over the course of six months, as compared to treatment as usual alone. Primary outcome was self-efficacy measured on the General Self-Efficacy Scale at six-month follow-up. Secondary outcomes included quality of life, social functioning, and hospitalisations.

Results: Patients in the intervention group had significantly higher scores of self-efficacy at the six-month follow-up. There were no statistically significant differences on secondary outcomes in the intention to treat analyses.

Conclusions: The findings suggest that one-to-one peer support delivered by trained peer supporters can improve self-efficacy of patients with severe mental disorders over a one-year period. One-to-one peer support may be regarded as an effective intervention. Future research should explore the impact of improved self-efficacy on clinical and social outcomes.

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1. Introduction

The aims of mental health care of people with persistent and severe mental illnesses are no longer limited to aspects of clinical recovery, like symptom control and functioning. Care also aims to increase people’s capacities for a largely independent lifestyle and comprehensive social and professional inclusion within the limitations caused by persistent symptoms, as it is captured in the personal recovery concept [1,2]. Flexible settings, with low service access thresholds are necessary to meet the individual, complex needs of this target group on their way to recovery.

1.1. Peer support in mental health care

One method to promote personal recovery is peer support of individuals who experienced mental health crisis and the path to recovery themselves. Peer support is a resource-oriented, instead of a deficit-oriented, approach and therefore not disorder specific [3]. It has its origins in informal and user-led care initiatives [4,5]. With a greater focus on recovery-oriented and person-centred interventions in statutory mental health services [1,6], there has been a shift to more formalised peer support models arranged and led by staff [7], which risks jeopardizing peer support’s unique culture. Peer workers in mental health care have progressed in recovery from a mental illness themselves, to a stage where they can manage their illness, persistent symptoms, and...
pursue a fulfilling life [8,9]. This experiential knowledge on the way towards recovery is a valuable resource in mental health service delivery and, when shared in self-disclosure with individuals in crisis, may contribute to their recovery by initiating a process that strengthens patients’ self-efficacy beliefs [9,10]. Mead states that peer support helps to establish an alternative, more positive self-image that goes beyond a mere, passive patient identity [10].

1.2. Change model of peer support

Research on formal peer support has addressed the benefits for patients and peer supporters themselves, the challenges for institutions and peer supporters, and the factors facilitating successful implementation [9]. Anyway, the theoretical background of peer support is still underdeveloped. The first change model of peer support by Gillard is based on a comparative case study of ten peer worker initiatives in statutory and informal mental health services [11]. They conducted in-depth interviews with 71 peer workers, service users, staff, and managers. The author emphasises two parallel mechanisms promoting recovery: on the one hand the bridge into services that can be built by peer workers for individuals with severe mental health crises who have complex treatment needs but distrust in mental health services. Thus, implementing effective peer support in clinical practice, the protection of a peer support specific culture and a high level of flexibility in how peers support different patients have been suggested as essential [7,11]. Gillard et al. recommend using a whole system approach on recovery orientation, that protects the authenticity of peers’ identity and practice, and that acknowledges that there is an impact on organisational culture, processes, and way of working [11]. Secondly, on the other hand the role-modelling of recovery by peer workers and its underpinning effect on the patients’ self-efficacy beliefs [11]. High self-efficacy reflects one’s capability to tackle novel tasks, coping with adversity in a broad range of stressful life events or challenging encounters, and recover from setbacks more quickly [12].

1.3. Effectiveness of peer support

Reviews of effectiveness studies of peer support report inconsistent positive effects on different outcomes [13–16]. A systematic review of eleven randomised controlled trials [14] found significantly reduced emergency service use and a higher number of met needs in patients receiving peer support. Another review and meta-analysis [9] included five trials and identified a small positive effect on quality of life. Neither of the reviews suggested any effects on clinical outcomes or general functioning. However, all reviews criticise the limited quality of the included studies [13–16]. Shortcomings include poorly defined roles of the peer supporters, little training for peer supporters and mental health staff, small sample sizes, no blinded outcome assessments, and a lack of recovery-oriented outcome criteria.

We therefore conducted a trial testing the effectiveness of one-to-one peer support with defined roles and extensive training for peer supporters. We employed a structured preparation of mental health staff in participating services, and self-efficacy as a recovery-oriented primary outcome criterion.

2. Material and method

We conducted a multi-site, parallel-arm, randomised controlled trial in Hamburg, Germany. This was a superiority trial, testing one-to-one peer support in addition to treatment as usual, as compared to treatment as usual alone.

2.1. Participants

Patients were recruited through in- and out-patient services from four psychiatric hospitals (University Medical Centre Hamburg Eppendorf, Asklepios Clinic North, Albertinen Hospital, and Schön Clinic Hamburg Eilbek) in Hamburg.

We included patients meeting the definition of severe mental illness according to the German Association of Psychiatry, Psychotherapy and Neurology (DGPPN) [17]. Eligible patients were aged between 18–80 years with a primary diagnosis of schizophrenia and related disorders (F2), affective disorders (F3), or personality disorder (F6) and a duration of illness of more than two years. Exclusion criteria were a primary diagnosis of drug or alcohol abuse and an insufficient command of German to communicate with the peer supporters.

2.2. Randomisation

The participants were randomly allocated to either one-to-one peer support or the control group in a 1:1 ratio, stratified by hospital, in blocks of 20. An independent statistician, working in the Department of Medical Biometry and Epidemiology of the University Medical Centre Hamburg Eppendorf produced randomly generated treatment allocations using SAS Institute Inc., Cary, NC, USA, Version 9.3 within sealed, numbered, opaque envelopes that were stored and inaccessible to the trial team.

2.3. Procedures

Patients were recruited through in- and out-patient services. If still in hospital, the patient could make his first appointment with the peer supporter shortly before discharge, and continue as an out-patient. Interested individuals attended a first information appointment, where a researcher obtained written informed consent and conducted the baseline assessment, after which the patient was randomly allocated to one of the two groups.

Patients in both groups were contacted by a researcher again after 6 and 12 months, and were sent the set of self-rated questionnaires. At the same time points, the treating psychiatrists (either in an out-patient service of a hospital or in a private office practice) were also contacted and sent the relevant questionnaires for external assessment. If the questionnaires were not returned, a reminder was sent after one week. After two weeks, researchers tried to contact participants and treating psychiatrists by telephone for a further reminder.

2.4. Intervention

2.4.1. Training of staff and peers

In line with suggestions for best practice models [18–20], structured training for peers and staff was implemented, involving peer supporters as trainers.

All peer supporters attended a structured training program based on the Ex-In Curriculum, which was delivered by a peer worker and a psychologist [21]. It took a total of 192 hours, arranged on 12 weekend workshops from Friday afternoon to Sunday afternoon. Training consists of five basic modules (1. Promoting Health, Wellness and Well-being, 2. Empowerment in theory and practice, 3. Experience and Participation, 4. Trialogue, 5. Perspectives and experiences of recovery) and four specialised modules (6. Independent Peer Advocacy in Mental Health, 7. Recovery based assessment and planning for people in crisis, 8. Accepting and making sense of hearing voices and other persistent symptoms, 9. Peer Support). The training includes two practical units of two months duration each in mental health services.

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