Liste over central litteratur om peer support

Reviews og oversigtsartikler

Forfatter og titel	Abstract/konklusion
David Orwin (2008): *Thematic Review of Peer Supports - Literature review and leader interviews*. Mind and Body Consultants Ltd, Commissioned by the Mental Health Commission, Wellington, New Zealand, July 2008	This review identifies themes relevant to the further development of peer support for users of mental health services in New Zealand. It looks at what might be called formalised peer support, that is, support provided by paid peer support workers (PSWs) with personal experience of mental illness to other people with experience of mental illness. It examines definitions and models of peer support, common aspects of successful peer support, issues of integration or collaboration of peer support with traditional mental health services and the needs of special populations. The review makes four recommendations. **Recommendations** The four recommendations are as follows. 1. Maintain a choice of peer support services. There is enough scope for a variety of different peer support philosophies and service structures to be maintained. The key consideration when choosing a provider is whether the provider offers safe, effective, clearly defined and credible peer support that will benefit service users. The success or otherwise of a service is ultimately determined by philosophical, organisational and individual factors that transcend particular models. 2. Ensure that PSWs receive credible training consistent with their role. The sector is strongly urged to engage in a debate about how to develop a minimum level of competency and a career pathway for PSWs. 3. Ensure that there are effective supervision structures for PSWs. This may be possible only with active support from funders. Building capacity and capability in peer support supervision should be a sector priority. 4. Develop organisational capacity and capability. Insufficient management and organisational capacity and capability are serious obstacles to the continued development of service user-run peer support. Peer support should be provided only by credible organisations that can demonstrate both capacity and capability. The sector has a responsibility to help to actively develop capacity and capability. http://www.hdc.org.nz/media/199095/thematic%20review%20of%20peer%20supports%20july%2008.pdf
Davidson et.al. (2012): *Peer Support among persons with severe mental illnesses: a review of evidence and experience*. World psychiatry 2012, 11: 123-128	Peer support is largely considered to represent a recent advance in community mental health, introduced in the 1990s as part of the mental health service user movement. Actually, peer support has it's roots in the moral treatment era inaugurated by pussin and pine in France at the end of the 18th century. In it's more recent form, peer support is rapidly expanding in a number of countries and, as a result, has become the focus of considerable research. Thus far, there is evidence that peer staff providing conventional mental health services can be effective in engaging people into care, reducing the use of emergency rooms and hospitals, and reducing substance use among persons with co-occurring substance use disorders. When providing peer support that involves self-disclosure, rolemodelling and conditional regard, peer staff have also been found to increase participants sense of hope, control and ability to effect changes in their lives; increase in their selfcare, sense of community belonging and satisfaction with various life domains; and decrease participants' level of depression and psychosis.
Lloyd-Evans, Brynmor, Evan	Results: Eighteen trials including 5597 participants were included. These

Mayo-Wilson, Bronwyn Harrison, Hannah Istead, Ellie Brown, Stephen Pilling, Sonia Johnson and Tim Kendall (2014): *A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness* BMC Psychiatry 2014, 14:39	comprised four trials of mutual support programmes, eleven trials of peer support services, and three trials of peer-delivered services. There was substantial variation between trials in participants' characteristics and programme content. Outcomes were incompletely reported; there was high risk of bias. From small numbers of studies in the analyses it was possible to conduct, there was little or no evidence that peer support was associated with positive effects on hospitalisation, overall symptoms or satisfaction with services. There was some evidence that peer support was associated with positive effects on measures of hope, recovery and empowerment at and beyond the end of the intervention, although this was not consistent within or across different types of peer support. Conclusions: Despite the promotion and uptake of peer support internationally, there is little evidence from current trials about the effects of peer support for people with severe mental illness. Although there are few positive findings, this review has important implications for policy and practice: current evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programmes. Further peer support programmes should be implemented within the context of high quality research projects wherever possible. Deficiencies in the conduct and reporting of existing trials exemplify difficulties in the evaluation of complex interventions. http://www.biomedcentral.com/1471-244X/14/39
Miyamoto, Yuki, and Tamaki Sono (2012): *Lessons from Peer Support Among Individuals with Mental Health Difficulties: A Review of the Literature*. Clinical Practice and Epidomology in Mental Health, 2012, 8, 22-29	**Abstract:** We conducted a comprehensive narrative review and used a systematic search strategy to identify studies related to peer support among adults with mental health difficulties. The purposes of this review were to describe the principles, effects and benefits of peer support documented in the published literature, to discuss challenging aspects of peer support and to investigate lessons from peer support. Fifty-one studies, including 8 review articles and 19 qualitative studies, met the inclusion criteria for this review. Most of the challenges for peer support were related to "role" and "relationship" issues; that is, how peer support providers relate to people who receive peer support and how peer support providers are treated in the system. The knowledge gained from peer support relationships, such as mutual responsibility and interdependence, might be a clue toward redefining the helper-helper relationship as well as the concepts of help and support. http://benthamscience.com/open/cpemh/articles/V008/22CPEMH.pdf
O'Hagan, Mary (2011): *Peer Support in Mental Health and addictions – a background paper*. Prepared for Kites Trust, New Zealand, May 2011	This paper provides a brief international overview of peer support in mental health and addictions – its origins; definitions of peer support; its values; the types of provision, practices, participants organisations and helping relationships involved in peer support; the evidence base for peer support; as well as the issues and challenges facing peer support at the definitional, attitudinal, systemic and organisational levels. One of the striking features of peer support is how universal the issues are; although this is an international overview, all the issues raised are relevant to all western countries with developed mental health systems. http://www.peerzone.info/sites/default/files/resource_materials/Peer%20Support%20Overview%20O%27Hagan.pdf
Repper og Carter (2011): *'A review of the literature on peer support in mental health services'*. Journal og Mental Health, 20(4), 2011	Background: Although mutual support and self-help groups based on shared experience play a large part in recovery, the employment of peer support workers (PSWs) in mental health services is a recent development. However, peer support has been implemented outside the UK and is showing great promise in facilitating recovery. Aims: This article aims to review the literature on PSWs employed in mental health services to provide a description of the development, impact and challenges presented by the employment of PSWs and to inform implementation in the UK. Method: An inclusive search of published and grey literature was undertaken to identify all studies of intentional peer support in mental health services. Articles were summarised and findings analysed. Results: The literature demonstrates that PSWs can lead to a reduction in admissions among those with whom they work. Additionally, associated

	improvements have been reported on numerous issues that can impact on the lives of people with mental health problems. Conclusion: PSWs have the potential to drive through recovery-focused changes in services. However, many challenges are involved in the development of peer support. Careful training, supervision and management of all involved are required.
Repper, Julie m.fl (2013): *Peer-support workers: theory and practice*. ImROC 2013	Oversigtsartikel fra engelske ImROC, som kort beskriver: • Hvad peer support er (fokus på peer-støtte i profesionelle tilbud) • Forskellige roller/funktioner • Kerneprincipper i peersupport • Virkningen af peer-støtte • Udfordringer der knytter sig til at være ansat i professionelle tilbud som medarbejder med erfaringsekspertise Conclusion: We have argued strongly for the value of establishing peer support roles to promote recovery in mental health organisations. Peers bring unique experience and a unique set of skills which can be deployed across a range of settings to provide hope, inspiration and influence for staff and service users alike. Their potential contribution is now recognised by policy makers and governments across the world. The research base is also growing and confirming that peers, appropriately recruited, trained and supported can have multiple benefits, for those providing the service, for those receiving it and for the organisations themselves. There is even beginning to be some evidence that peers, working alongside traditional professionals, can be highly cost effective and reduce demands on other services. However, we have also noted that the establishment of peer support roles is not without significant difficulties and it is easy to make mistakes http://nhsconfed.org/~/media/Confederation/Files/Publications/Documents/ImROC%20Peer%20Support%20Workers%20Theory%20and%20Practice.pdf
SAMHSA (2009): *What are peer recovery support services?* Department of Health and Human Services, 2009	In this paper on *What Are Peer Recovery Support Services*, you will be introduced to a new kind of social support services designed to fill the needs of people in or seeking recovery. The services are called peer recovery support services and, as the word peer implies, they are designed and delivered by people who have experienced both substance use disorder and recovery. Through the Recovery Community Services Program (RCSP), the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) funds grant projects across the country to develop and deliver these services. The peer recovery support services developed by the RCSP projects help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.
Scottish Recovery Network (2013): *Reviewing peer working. A new way of working in Mental Health*	Recovery focused services are about involving people and using all available expertise, including lived experience, to ensure the help and the support available best meet the needs of people to both lead their own recovery and develop a fulfilling and satisfying life. Peer working is a key component of a recovery focused system. We are currently in a period of public service transformation with a range of strategies, bills and reports acknowledging the need for radical change in the way services are designed and delivered, irrespective of the challenging financial climate we operate in. This paper sits within this framework and seeks to inform thinking of what services will look like in the future. It is clear that more or less of the same will not help us fully achieve our policy objectives. New ways of working, including new types of jobs and approaches will be needed. This short paper will: • Define the peer working role; • Outline current peer working activity in Scotland;

	• Set out the evidence base and policy context for peer working; • Consider how peer working roles are being, and can be, developed, supported and sustained. http://www.scottishrecovery.net/View-document/385-Reviewing-Peer-Working-A-New-Way-of-Working-in-Mental-Health.html?format=raw&tmpl=component
Walker, Gill and Wendy Bryant (2013): *Peer Support in adult mental health services: a metasynthesis of qualitative findings*. Psychiatric rehabilitation Journal, vol.36, no.1, 28-34.	**ABSTRACT** Objectives: Peer support involves people in recovery from psychiatric disability offering support to others in the same situation. It is based on the belief that people who have endured and overcome a psychiatric disability can offer useful support, encouragement, and hope to their peers. Although several quantitative reviews on the effectiveness of peer support have been conducted, qualitative studies were excluded. This study aimed to synthesize findings from these studies. Method: A qualitative metasynthesis was conducted, involving examination, critical comparison, and synthesis of 27 published studies. The experiences of peer support workers, their nonpeer colleagues, and the recipients of peer support services were investigated. Results: Peer support workers experiences included nonpeer staff discrimination and prejudice, low pay and hours, and difficulty managing the transition from "patient" to peer support worker. Positive experiences included collegial relationships with nonpeer staff, and other peers; and increased wellness secondary to working. Recipients of peer support services experienced increased social networks and wellness. Conclusions and Implications for Practice: The findings highlight training, supervision, pay, nonpeer staff/peer staff relationships, as important factors for statutory mental health peer support programs

Effektstudier af peer-støtte modeller/metoder

Forfatter og titel	**Resume/abstract**
Campbell, J m.fl. (2006): *'The consumer operated service programs (COSP) multisite initiative. Final Report'.* Coordinating center at the Missouri Institute of Mental Health.	After over a decade of research on eight consumer-operated service programs located across the United States (1998-2014), investigators of a large SAMHSA-funded multi-site research initiative at the Missouri Institute of Mental Health (MIMH) Coordinating Center report that participation in consumer-operated service programs (COSPs) by adults with serious mental illness had positive effects on their psychological well-being. Analysis of over 1800 participants in the randomized, controlled trial revealed that those offered consumer-operated services as an adjunct to their traditional mental health services showed significant gains in hope, self-efficacy, empowerment, goal attainment and meaning of life in comparison to those who were offered traditional mental health services *only*. http://cosp.mimhtraining.com/
Cook, J m.fl. (2012): Randomized Controlled Trial of Peer-led Recovery Education using Building Recovery og Individual Dreams and Goals through Education and Support (BRIDGES). Schizophrenia Results 2012 Apr;136(1-3):36-42	OBJECTIVE: The purpose of this study was to test the efficacy of a peer-led, mental illness education intervention called Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES). METHOD: Subjects were recruited from outpatient community mental health settings in eight Tennessee communities. Using a single-blind, randomized controlled trial design, 428 individuals with serious mental illness (SMI) were interviewed at baseline and assigned to BRIDGES or to a services as usual wait list control condition. Two-and-one-half hour classes were taught once a week for 8 weeks by peers who were certified BRIDGES instructors. Subjects were followed-up at immediate post-intervention and 6-months later. The primary outcome was self-perceived recovery, measured by the Recovery Assessment Scale (RAS). A secondary outcome was hopefulness as assessed by the State Hope Scale (SHS). An exploratory hypothesis examined the impact of depressive symptoms on both recovery outcomes. RESULTS: Eighty six percent of participants were followed up. On average, participants attended five sessions. Intent-to-treat analysis using mixed-effects random regression found that, compared to controls, intervention participants

	reported: 1) significantly greater improvement in total RAS scores as well as subscales measuring personal confidence and tolerable symptoms; and 2) significantly greater improvement in hopefulness as assessed by the agency subscale of the SHS. While study subjects with high levels of depressive symptoms had significantly poorer outcomes, outcomes were superior for BRIDGES participants regardless of depressive symptoms. CONCLUSIONS: Peer-led mental illness education improves participants' self-perceived recovery and hopefulness over time, even controlling for severity of depressive symptoms.
Cook, J. m.fl. (2012): Results of a Randomized Controlled Trial of Mental Illness Self-management Using Wellness Recovery Action Planning. Schizophrenia Bulletin vol. 38 no. 4 pp. 881–891, 2012	The purpose of this study was to determine the efficacy of a peer-led illness self-management intervention called Wellness Recovery Action Planning (WRAP) by comparing it with usual care. The primary outcome was reduction of psychiatric symptoms, with secondary outcomes of increased hopefulness, and enhanced quality of life (QOL). A total of 519 adults with severe and persistent mental illness were recruited from outpatient community mental health settings in 6 Ohio communities and randomly assigned to the 8-week intervention or a wait-list control condition. Outcomes were assessed at end of treatment and at 6-month follow-up using an intent-to-treat mixedeffects random regression analysis. Compared to controls, at immediate postintervention and at 6-month follow-up, WRAP participants reported: (1) significantly greater reduction over time in Brief Symptom Inventory Global Symptom Severity and Positive Symptom Total, (2) significantly greater improvement over time in hopefulness as assessed by the Hope Scale total score and subscale for goal directed hopefulness, and (3) enhanced improvement over time in QOL as assessed by the World Health Organization Quality of Life-BREF environment subscale. These results indicate that peer-delivered mental illness self-management training reduces psychiatric symptoms, enhances participants' hopefulness, and improves their QOL over time. This confirms the importance of peerled wellness management interventions, such as WRAP, as part of a group of evidence-based recovery-oriented services. http://schizophreniabulletin.oxfordjournals.org/content/38/4/881.full.pdf?keytype=ref&ijkey=LFsLUgMpqsVNV1q
Davidson, L., Shahar, G., Stayner, D. A., Chinman, M. J., Rakfeldt, J, & Tebes, J. K. (2004) Supported socialization for people with psychiatric disabilities: lessons from a randomized controlled trial. Journal of Community Psychology. Vol 32, 453–477.	Two hundred and sixty people with psychiatric disabilities who were socially isolated and withdrawn were randomly assigned to one of three conditions to facilitate their engagement in social and recreational activities: They were (a) not matched with a volunteer partner (N _ 70), (b) matched with a volunteer partner who had a personal history of psychiatric disability (N _ 95), or (c) matched with a volunteer partner with no history of psychiatric disability (N _ 95). Participants and volunteers received a $28 stipend each month to cover the expenses of their activities. Comprehensive assessments of symptoms, functional impairment, self-esteem, and satisfaction were made at baseline, after 4 months, and after 9 months. While all participants appeared to improve in terms of symptom reduction and increases in functioning and self-esteem, differences between conditions were found only when participants' degree of contact with their partner was considered. While participants assigned to the nonconsumer volunteer partner condition improved in terms of their social functioning and self-esteem when meeting with their partners, those who were assigned to consumer partners only improved when they did not. Findings highlight the important role of participants' expectations and perceptions in designing and evaluating psychosocial interventions for people with psychiatric disabilities.
Dummont, J. M., & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. in Outlook, Spring 2002, pp 4 –6.	**Pupose**: Having a place in Tompkins County New York where people could retreat to if they viewed themselves in need and at risk of psychiatric hospitalization was the primary purpose of the Crisis Hostel Project. The Hostel stemmed from the expertise of consumer/survivors and their desire for an entirely voluntary choice based on their self-defined needs. **Methods**: Using a random design, the presenters investigated these outcomes for 265 participants having or not having access to the Crisis Hostel (CH). All study participants had been labeled with a DSM-III R diagnoses. They had experienced substantial hospital stays with a majority having had four or more admissions and

	a median 'longest stay' or over one month. Participants were assessed upon admission to the study, and both at six and 12 months with measures of empowerment, healing, symptoms, hospital admissions and length of stay, job maintenance and satisfaction with services. They were also asked about stays in the Crisis Hostel, the local community hospital and state hospitals as well about use of community-based specialty mental health services. **Conclusion**: In nearly all areas, persons who had been assigned access to the CH were associated with both better outcomes and lower costs. Persons in the test group were associated with greater levels of healing, empowerment and satisfaction. They experienced no less disruption in their work life. Hospital stays were relatively less frequent and shorter. Crisis service costs and total mental health service costs were lower for the test group than for the control group.
Rogers, S., Teague, G., Lichenstein, C., Campbell, J., Lyass, A., Chen,R & Banks, S. (2007) Effects of participation in consumer-operated service programs on both personal and organizationally mediated empowerment: Results of multisite study. Journal of Rehabilitation Research & Development. Vol 44, 6, pp 785–800.	**Abstract—**The number of empowerment-oriented consumeroperated service programs (COSPs) in mental health has increased dramatically over the past decade; however, little empirical evidence exists about the effects of such programs on their intended outcomes. This study examined the effects of COSPs on various aspects of empowerment within the context of a multisite, federally funded, randomized clinical trial of COSPs. Results suggest that the individuals who received the consumeroperated services perceived higher levels of personal empowerment than those in the control intervention; overall, effect sizes were very modest when all sites were examined together in intent-to-treat analyses. However, we noted variations in outcomes by intensity of COSP use and also by study site, which suggest that specific programs had significant effects, while others did not. The implications of these results for the mental health field and for service providers and policy makers are discussed.
Salzer, Mark S. m.fl. (2013): *Benefits of working as a certified peer specialist: results from a statewide survey.* Psychiatric Rehabilitation Journal, vol. 36, no. 3, 219-221	***Objective:*** Certified peer specialists (CPSs) are an emerging workforce across the United States and are a critical component of recovery-oriented mental health systems. This study examined possible benefits of working as a CPS. ***Method:*** A statewide survey of trained CPSs in Pennsylvania was conducted in Winter/Spring 2010. A total of 271 CPSs responded to the online survey. Data from 154 working CPSs were analyzed. ***Results:*** Forty-one respondents (28.7%) were not working prior to their CPS employment and 60% of all respondents reported a decrease in Social Security entitlements. Statistically significant reductions were reported in case management, crisis services, and inpatient hospitalizations. Finally, respondents overwhelmingly reported personal, recovery-oriented benefits, and felt that they have a positive impact on their agencies. ***Conclusion and Implications for Practice:*** CPS initiatives appear to benefit the individual CPS worker and may result in societal cost savings. These results further expand the potential value of peer-support services.
Sells, D.L., Davidson, L., Jewell, C., Falzer, P & Rowe, M. (2006) The Treatment Relationship in Peer-Based and Regular Case Management for Clients With Severe Mental Illness. Psychiatric Services, Vol 57, 8, 1179 - 1184.	*Objective:* This study compared the quality of treatment relationships and engagement in peer-based and regular case management. It also assessed the value of positive relationship qualities in predicting motivation for and use of community-based services for persons with severe mental illness. *Methods:* One hundred thirty-seven adults with severe mental illness participated in a 2×2 prospective longitudinal randomized clinical trial with two levels of case management intervention (peer and regular) and two interviews (six and 12 months). Self-report questionnaires assessed treatment relationships, motivation, and service use, and providers rated participants' initial engagement and monthly attendance in treatment. *Results:* Participants perceived higher positive regard, understanding, and acceptance from peer providers rather than from regular providers at six months only, with initially unengaged clients showing more contacts with case managers in the peer condition and decreasing contacts in the regular condition. Six-month positive regard and understanding positively predicted 12-month treatment motivation for psychiatric, alcohol, and drug use problems and attendance at Alcoholics and Narcotics Anonymous meetings. *Conclusions:* Early in treatment, peer providers may possess distinctive skills in communicating positive regard, understanding, and acceptance to clients and a facility for increasing treatment participation among the most disengaged, leading to greater motivation for further treatment and use of peer-based community services. Findings strongly suggest that peer providers serve a valued role in

	quickly forging therapeutic connections with persons typically considered to be among the most alienated from the health care service system.
Sledge WH, Lawless M, Sells D et al (2011): Effectiveness of peersupport in reducing readmissions among people with mutable psychiatric hospitalizations. Psychiar serv 2011; 62	OBJECTIVE: The study examined the feasibility and effectiveness of using peer support to reduce recurrent psychiatric hospitalizations. METHODS: A randomized controlled design was used, with follow-up at nine months after an index discharge from an academically affiliated psychiatric hospital. Patients were 18 years or older with major mental illness and had been hospitalized three or more times in the prior 18 months. Seventy-four patients were recruited, randomly assigned to usual care (N=36) or to a peer mentor plus usual care (N=38), and assessed at nine months. RESULTS: Participants who were assigned a peer mentor had significantly fewer rehospitalizations (.89 ± 1.35 versus 1.53 ± 1.54; p=.042 [one-tailed]) and fewer hospital days (10.08 ± 17.31 versus 19.08 ± 21.63 days; p<.03, [one tailed]). CONCLUSIONS: Despite the study's limitations, findings suggest that use of peer mentors is a promising intervention for reducing recurrent psychiatric hospitalizations for patients at risk of readmission
Tondora, J, O'Connell M, Dinezo t et.al.(2010): A clinical trial of peer support based culturally responsive person-centered care for psychosis for African Americans and Latinos. Clinical Trials 2010;7: 368-79	***Background*** Providing culturally competent and person-centered care is at the forefront of changing practices in behavioral health. Significant health disparities remain between people of color and whites in terms of care received in the mental health system. Peer services, or support provided by others who have experience in the behavioral health system, is a promising new avenue for helping those with behavioral health concerns move forward in their lives. ***Purpose*** We describe a model of peer-based culturally competent person-centered care and treatment planning, informed by longstanding research on recovery from serious mental illness used in a randomized clinical trial conducted at two community mental health centers. ***Methods*** Participants all were Latino or African American with a current or past diagnosis within the psychotic disorders spectrum as this population is often underserved with limited access to culturally responsive, person-centered services. Study interventions were carried out in both an English-speaking and a Spanish-speaking outpatient program at each study center. Interventions included connecting individuals to their communities of choice and providing assistance in preparing for treatment planning meetings, all delivered by peer-service providers. Three points of evaluation, at baseline, 6 and 18 months, explored the impact of the interventions on areas such as community engagement, satisfaction with treatment, symptom distress, ethnic identity, personal empowerment, and quality of life. ***Conclusions*** Lessons learned from implementation include making cultural modifications, the need for a longer engagement period with participants, and the tension between maintaining strict interventions while addressing the individual needs of participants in line with person-centered principles. The study is one of the first to rigorously test peer-supported interventions in implementing person-centered care within the context of public mental health systems.

Evalueringer af danske initiativer

Her er alene medtaget evalueringer der er udgivet eller på anden måde offentligt tilgængelige.

Forfatter og titel	**Centrale resultater**
Dobuz, M (2011): Vendepunkter – Recoveryforløb i et brugerperspektiv. LAP København/Frederiksberg, 2011	Formålet med evalueringen har været at se på virkningerne for de enkelte kursusdeltagere, uanset om de har været på et Vendepunkt-kursus for fem år siden, eller de har afsluttet forløbet en måned før interviewet. Det fremgår af samtalerne med deltagerne, at kurserne for nogle er blevet startskuddet til en personlig udviklingsproces, for andre understøtter det en udvikling, som allerede var i gang, da de startede på kurset. Vi har derfor i evalueringen valgt at spørge deltagerne, om de kunne huske, hvad de fik ud af kurset, og hvor de er nu. Det er de kortsigtede virkninger, de fleste deltagere fortæller om, når de beskriver, hvad der kom ud af Vendepunkter. De lange og mellemlange virkninger beskriver, hvor deltagerne er i dag, og kan ikke kun tilskrives

	kurserne, men også de mange andre ting, som deltagerne har foretaget sig i deres liv efter Vendepunktsforløbet. De deltagere, der melder sig til et Vendepunkt-kursus, er mennesker som efter langvarige behandlingsforløb i psykiatrien ønsker at finde måder til at skabe sig en bedre tilværelse. Hovedparten af deltagerne peger på følgende virkninger, som de umiddelbart fik ud af kursusforløbet: • På Vendepunkter får deltagerne en viden om recovery og håb om, at det er muligt at opnå en mere tilfredsstillende tilværelse og leve et godt liv i samklang med de psykosociale vanskeligheder. • På Vendepunkter bliver denne udvikling understøttet, og deltagerne får kompetencer til at finde egne veje til at skabe sig en god hverdag og redskaber til at udvikle et godt velvære i hverdagen. • Deltagerne udvikler strategier til at bevare et godt helbred, kompetencer til at lære at leve med et sårbart sind og opnår opmærksomhed på de triggere, som kan udløse vanskeligheder. Samlet medvirker det til at forebygge indlæggelser. Deltagerne får indblik i de samfundsmæssige og personlige mekanismer, som er med til at stigmatisere dem, og som medvirker til at fastholde dem i en modtagerrolle (rolle af tillært hjælpeløshed). De får øje på personlige kvaliteter, mod og kompetencer til at ændre på deres situation. • Deltagerne får trænet sociale kompetencer og får genopdaget styrken ved at indgå i ligeværdige relationer med mulighed for at bidrage og modtage, efter så lang tid at have modtaget hjælp. De er blevet åbne for at se egne og andre brugeres styrker og erfaringer som værdifulde. • Deltagerne har fået øje på, at ændring af personlig adfærd og mønstre er en langvarig proces. Og de har fået en forståelse for, at menneskelige udviklingsprocesser ikke er en fremadskridende proces, men at det er helt normalt at der undervejs er stilstand og nogle gange også tilbagegang. Den forståelse er med til at mindske deltagernes selvstigmatisering og til at give dem modet til fortsætte med at skabe sig en bedre hverdag på trods af modgang. Af langsigtede virkninger peger deltagerne på følgende: • En del har efter Vendepunkter orienteret sig mod andre sociale netværk eller mod en mere individuel personlig udvikling. • Mange er blevet aktive i brugerbevægelsen enten i bestyrelsesarbejde, som mentorer for andre brugere eller aktive i andre frivillige sociale organisationer. • Andre er blevet medlemmer af kreative fællesskaber som f.eks. at dele atelier med andre malere, deltage i skriveværksteder, deltage i oplæsningsgrupper mv. • Andre har søgt at komme ind på arbejdsmarkedet gennem tildeling af skåne- eller fleksjob. Det har dog vist sig ganske vanskeligt i praksis at få fodfæste på arbejdsmarkedet. http://www.psykisksaarbar.dk/cgi-bin/ps/uploads/media/vendepunkterevalueringlilleforma1.pdf
Hansen, Finn Kenneth og Line Askgaard (2011): Vendepunkter til arbejdsmarkedet - et metodeudviklingsprojekt for psykisk syge. CASA	Projekt Vendepunkter til arbejdsmarkedet er et aktiveringstilbud under metodeudviklingspuljen i Københavns Kommune, der udbydes af Foreningen Af Psykiatribrugere (LAP) i København/Frederiksberg. Projektet er et samarbejdsprojekt mellem LAP, Kæmperne, Væksthuset og Konsulentkompagniet. Formålet med projektet er at udvikle metoder, som sikrer sammenhæng mellem helbredelse (recovery) og indslusning på arbejdsmarkedet. Målet for den enkelte deltager er at lære at anvende redskaber og opnå kompetencer. Tilbuddet henvender sig til kontanthjælpsmodtagere med problemer ud over ledighed i matchgruppe 2, som har et alvorligt psykosocialt handicap, og som har relation til social- eller behandlingspsykiatrien. I alt har 28 borgere med psykiske problemstillinger deltaget i projektet. Der er tale om 17 kvinder og 11 mænd. Aldersmæssigt er fem deltagere under 30 år, otte deltagere er mellem 30 og 40, ti deltagere er mellem 40 og 50 år, og fem deltagere er over 50 år. På baggrund af deltagernes situation godt et år efter, at de startede i projektet, kan det konstateres, at én deltager er kommet i job, seks deltagere er i gang, motiveret eller afventer praktik, to deltagere er i uddannelse og én deltager er i intern arbejdsprøvning.Der er otte deltagere, som er meget syge eller indgår i behandling, og

	to deltagere er indlagt. Der er tre deltagere, som har kontakt med LAP, hvor der arbejdes med, at de kommer i behandling eller i udredning til psykolog. Der er fire deltagere, som ud over deres psykiske sårbarhed har et stort misbrug, og for dem er der tale om en uafklaret situation og en uvis fremtid. En deltager er på barsel, og en deltager er tabt uden kontakt. Lidt opsummerende kan man sige, at knap en tredjedel er kommet i relevante praktikforløb og har motivation og ønsker om en tilknytning til arbejdsmarkedet i form af skånejob, fleksjob, job på særlige vilkår. Knap en tredjedel har stiftet bekendtskab med praktikophold og ophørt grundet deres psykiske problemstillinger eller fysiske helbred, men for en del gælder det, at de er kommet i behandling. Derudover er der en tredjedel, som har så massive problemer i form af psykisk sygdom m.m., at de er nærmere en situation, der hedder førtidspension. http://www.vendepunkter.dk/sites/default/files/Evalueringsrapport%20arbejdsmarked.pdf
Hjort Andersen, J (2010): Opfølgningsundersøgelse af storskalaprojekt. Medarbejder med brugerbaggrund. Videnscenter for Socialpsykiatri.	Baggrund: MB står for Medarbejder med brugererfaring og betegner såvel selve udviklingsprojektet som de mennesker, der har gennemført en såkaldt MB-uddannelse over 12-14 måneder. Særkendet for MB-uddannelsen er, at den er målrettet mennesker, som opfylder tre betingelser: De har en sundheds- eller socialfaglig uddannelse, som kvalificerer dem til at arbejde i psykiatrien eller socialpsykiatrien. Deres tilknytning til arbejdsmarkedet er truet eller ikke-eksisterende. De er kommet sig helt eller delvist efter en alvorlig psykisk sygdom og kan således bibringe deres arbejdsplads både deres faglige viden og egne bearbejdede brugererfaringer. Om evalueringen: Ud over at måle resultater og deltagertilfredshed har undersøgelsen også afdækket MB´ernes vurdering af andre faktorer, som er centrale i et rehabiliteringsperspektiv. I opbygningen af undersøgelsen har Videnscenter for Socialpsykiatri taget udgangspunkt en hollandsk udviklet tilgang, som er beskrevet på dansk i bogen 'Recovery og rehabilitering – en integreret tilgang', af Jean-Pierre Wilken og Dirk d. Hollander (2008). Forfatterne opdeler fokusområderne for en rehabiliteringsindsats i fire livsdomæner og fire personlige domæner, som alle skal fremmes – og ved behov støttes – for at sikre en vellykket rehabilitering. De fire livsdomæner er bolig, fritidsaktiviteter, læring samt arbejde. De fire personlige domæner er egenomsorg, sundhed, formål og mening samt social relationer og netværk. Resultater: Kerneresultaterne af MB helt overordnet set er: • 35 ud af de 45 respondenter, svarende til 77,8%, har fastholdt deres tilknytning til arbejdsmarkedet 2-3 år efter afslutning af MB-storskalaprojektet. • 8 deltagere er på undersøgelsestidspunktet ansat på ordinære vilkår mod 3 før MB-storskalaprojektet. • Antallet af personer på fleksjobvilkår er steget til 21 i undersøgelsen fra 6 før projektets start. Der blev opstillet en række hypoteser og antagelser, og undersøgelsen blev designet til at be- eller afkræfte disse. Her gengives antagelserne samt besvarelserne i kort form: • Antagelse: Sociale netværk er afgørende for MB'ernes arbejdsmarkedstilknytning. ○ Delantagelse: Netværket har positiv betydning for MB'ernes arbejdsmarkedstilknytning. ○ Resultat: Netværket havde positiv betydning for MB'ernes gennemførelse af praktikken – venner mere end familie. Ca. 60% af MB'erne vurderede, at enten familie eller venner havde en positiv betydning for, at de gennemførte praktikken. ○ Delantagelse: Det, at den enkelte MB'er har arbejde, betyder, at personens netværk opfatter den pågældende som mere betydningsfuld. ○ Resultat: Ca. 55% vurderede, at enten familie eller venner opfattede dem som mere betydningsfulde. • Antagelse: Der er en positiv sammenhæng mellem arbejdsmarkedstilknytning i dag og generel høj score inden for de 8 domæner.

	• Resultat: Der er et meget stort sammenfald mellem de MB'ere, som er i arbejde på opfølgningstidspunktet og en generel høj score inden for samtlige 8 domæner. • Antagelse: Gennem MB-arbejdsmarkedspraktikken udviklede MB'erne en større mestringsevne. • Resultat: MB'ernes mestringsevne var meget styrket inden projektet og blev kun styrket i mindre udstrækning undervejs. • Antagelse: De, som har arbejde i dag, scorer højt på mestringsevne. • Resultat: Antagelsen er bekræftet fuldt ud. • Antagelse: De, der i dag er i arbejde, vil have højere score på selvvurderet helbred. • Resultat: Undersøgelsen bekræfter dette. Resultaterne i denne rapport peger entydigt på, at en relativ begrænset indsats og investering i målrettet rehabilitering og jobplacering kan give store afkast, både samfundsøkonomisk og i forhold til at afbøde de sociale og menneskelige omkostninger for psykisk syge borgere. MB-modellen kan således være et værdifuldt supplement eller alternativ til mere traditionelle metoder til rehabilitering. http://www.en-af-os.dk/sitecore/shell/Controls/Rich%20Text%20Editor/~/media/Files/en-af-os%20media/Documents/Opfolgningsundersogelse%20af%20storskalaprojekt%20-%20Medarbejder%20med%20brugererfaring%20(2).ashx

Artikler om Implementering

Forfatter og title	Resume/abstract
Centre for Mental Health (2013): Peer support workers in mental health care – is it good value for money?	Peer support workers - people with their own lived experience of mental illness – provide mutually supportive relationships in secondary mental health services. Increasing numbers are being employed, both in this country and elsewhere. But good quality evidence on the effectiveness of this form of service delivery is in short supply and even less is known about its cost-effectiveness. This paper makes a first attempt at assessing whether peer support provides value for money, looking specifically at whether peer support workers can reduce psychiatric inpatient bed use, either by preventing admissions or by shortening lengths of stay. Because of the very high cost of inpatient care, the savings that result from even small changes in bed use may be sufficient to outweigh the costs of employing peer workers. We identified six studies in the research literature which give some evidence on the relationship between peer support and inpatient bed use. Re-analysis and aggregation of the data in these studies support a positive conclusion: the financial benefits of employing peer support workers do indeed exceed the costs, in some cases by a substantial margin. It must be emphasised that the evidence for this finding is very limited in both quantity and quality, but nevertheless sufficient to justify continuing interest in the employment of properly trained and supported peer workers in mental health teams, alongside more research evaluating their effects. http://www.centreformentalhealth.org.uk/pdfs/peer_support_value_for_money_2013.pdf
Franke, C., Paton, B. & Gassner, L.(2010) Implementing mental health peer support: a South Australian experience. *Australian Journal Primary Health*. 16(2):179–86.	Mental illness is among the greatest causes of disability, diminished quality of life and reduced productivity. Mental health policy aims to reform services to meet consumers' needs and one of the strategies is to increase the number of consumers working in the mental health service system. In South Australia, the Peer Work Project was established to provide a program for the training of consumers to work alongside mental health services. The project developed a flexible training pathway that consisted of an information session, the Introduction to Peer Work (IPW) course and further training pathways for peer workers. External evaluation indicated that the IPW course was a good preparation for peer workers, but a crucial factor in the implementation process of employing peer workers was commitment and leadership within the organisation in both preparing the organisation and supporting peer workers in their role. To assist

	organisations wanting to employ peer workers, a three step model was developed: prepare, train and support. The project has been successful in establishing employment outcomes for IPW graduates. The outcomes increased with time after graduation and there was a shift from voluntary to paid employment
Gillard, Steve G;Christine Edwards, Sarah L Gibson, Katherine Owen and Christine Wright (2013): Introducing peer worker roles into UK mental health service teams: a qualitative analysis of the organisational benefits and challenges. BMC Health Services Research 2013, 13:188	Background: The provision of peer support as a component of mental health care, including the employment of Peer Workers (consumer-providers) by mental health service organisations, is increasingly common internationally. Peer support is strongly advocated as a strategy in a number of UK health and social care policies. Approaches to employing Peer Workers are proliferating. There is evidence to suggest that Peer Worker-based interventions reduce psychiatric inpatient admission and increase service user (consumer) empowerment. In this paper we seek to address a gap in the empirical literature in understanding the organisational challenges and benefits of introducing Peer Worker roles into mental health service teams. Methods: We report the secondary analysis of qualitative interview data from service users, Peer Workers, non-peer staff and managers of three innovative interventions in a study about mental health self-care. Relevant data was extracted from interviews with 41 participants and subjected to analysis using Grounded Theory techniques. Organisational research literature on role adoption framed the analysis. Results: Peer Workers were highly valued by mental health teams and service users. Non-peer team members and managers worked hard to introduce Peer workers into teams. Our cases were projects in development and there was learning from the evolutionary process: in the absence of formal recruitment processes for Peer Workers, differences in expectations of the Peer Worker role can emerge at the selection stage; flexible working arrangements for Peer Workers can have the unintended effect of perpetuating hierarchies within teams; the maintenance of protective practice boundaries through supervision and training can militate against the emergence of a distinctive body of peer practice; lack of consensus around what constitutes peer practice can result in feelings for Peer Workers of inequality, disempowerment, uncertainty about identity and of being under-supported. Conclusions: This research is indicative of potential benefits for mental health service teams of introducing Peer Worker roles. Analysis also suggests that if the emergence of a distinctive body of peer practice is not adequately considered and supported, as integral to the development of new Peer Worker roles, there is a risk that the potential impact of any emerging role will be constrained and diluted. http://openaccess.sgul.ac.uk/101274/1/1472-6963-13-188.pdf
Julie Repper et.al (2013): Peer Support Workers: a practical guide to implementation. Centre for Mental Health and Mental Health Network, NHS Confederation 2013	When developing peer worker posts, it is useful to think of four sequential phases. The first involves preparation – of the organisation as a whole, of the teams in which peers will be placed, and, perhaps most obviously, of the peers themselves. The second phase involves recruitment of peers to the posts that have been created or existing posts that have been modified for peer workers. Given the likelihood that peer applicants may have not worked for some time, nor been through an interview process with all of the formalities and checks that this brings, the whole process needs careful support. Thirdly, there is the safe and effective employment of peer workers in mental health organisations. Finally, the ongoing development of peer worker opportunities and contributions needs to be considered in the context of the wider healthcare system and the changing culture of services. http://www.centreformentalhealth.org.uk/pdfs/imroc_briefing7_peer_support_workers_implementation.pdf
Mental Health Commission (2005): Service user workforce development strategy 2005-2010. Mental Health Commission, Wellington, New Zealand.	Service user workforce development, and workforce development generally, is part of the jigsaw that needs to be put together to create the services and workforce of the future. *Our Lives in 2014: A Recovery vision from people with experience of mental illness* (Mental Health Commission, 2004) gives a broad brush picture of what service users think services should look like in the future. It describes a fundamental shift to a recovery philosophy where self-determination of service users is paramount, where mental illness is seen as a valid and challenging state of being rather than just an illness, where there is recognition of the multiple determinants of 'madness', where recovery is expected, and where service users are major contributors to their own recoveries. This new philosophy takes us in the direction of the leadership of service users in services, including as part of the workforce. It strongly implies that we need a much broader range of services than is available now, including peer-run services. It puts service users at the heart of their own

	recovery and the recovery of their peers. Mental health workforce development includes any initiative directed at the worker, their work or their environment, that improves the ability of the worker to facilitate recovery in people using services. This document begins by defining the service user workforce in the mental health sector. It outlines the major rationale for service user workforce development. It then discusses the current situation of the service user workforce. This leads to a strategy and a high-level action plan for nationally co-ordinated service user workforce development for the mental health sector from 2005-2010. http://www.maryohagan.com/resources/Service%20User%20Workforce%20Development%20Strategy.pdf
Scottish Recovery Network (2011) *Experts by Experience: Guidelines to support the development of Peer Worker roles in the mental health sector.*	Developing any new work role can be a complex process and this is perhaps even more the case where one aspect of that role includes sharing personal experiences. The role of the peer worker in mental health services is still in its infancy in Scotland, and these guidelines are a response to an expressed need for support on how to successfully establish and ensure effectiveness of this unique role, while remaining true to the founding values of peer working. Part one of these guidelines is intended to offer further background to the peer worker role, to set out some overarching principles for peer working and to further examine some of the challenges and opportunities in developing peer roles. Part two starts by introducing a model for the development and implementation of peer working from planning and preparation to developing and sustaining roles. By taking readers through this model and a series of exercise we hope to encourage reflection and discussion leading to well informed and considered implementation. http://www.recoverydevon.co.uk/download/Guidelines_on_developing_peer_support_-_Scotland.pdf
Sunderland, Kim, Mishkin, Wendy, Peer Leadership Group, Mental Health Commission of Canada. (2013). *Guidelines for the Practice and Training of Peer Support.* Calgary, AB: Mental Health Commission of Canada.	Part 1, *Guidelines for the Practice of Peer Support,* provides an overview of the elements for the practice of peer support, along with the guiding values, principles of practice, and skills and acquired abilities to be respected by all involved in peer support programs that offer a more formal or intentional form of peer support. Part 2, *Guidelines for the Training of Peer Support,* focuses on the training of peer support workers and outlines the skills and knowledge to be included in training programs designed to prepare someone to provide peer support. Including: A. Skills, Abilities and Personal Attributes that are derived from Lived Experience B. Skills, Abilities and Personal Attributes that are related to Interpersonal Communication C. Skills, Abilities and Personal Attributes that demonstrate Critical Thinking D. Skills, Abilities and Personal Attributes that are related to Teamwork and Collaboration E. Skills, Abilities and Personal Attributes that are related to Ethics and Reliability http://www.mentalhealthcommission.ca/English/system/files/private/document/Peer_Support_Guidelines.pdf

Links til internationale vidensressourcer

Norge

Har nationalt kompetencecenter der udvikler og formidler viden om erfaringskompetence som ressource i 'psykisk helse'

http://www.erfaringskompetanse.no/

England:

ImROC er et initiativ der arbejder for implementering af recoverytilgange – partnerskab mellem NHS (psykiatrien) og Center for Mental Health (charity). De arbejder blandt andet for at fremme viden og praksis omkring medarbejdere med brugerbaggrund:

http://www.nhsconfed.org/Documents/ImROC%20Peer%20Support%20Workers%20Theory%20and%20Practice.pdf

Scotland
Det skotske nationale recoverynetværk arbejder blandt andet med medarbejdere med brugerbaggrund, og har udviklet omfattende viden om hvordan det gøres i praksis

http://www.scottishrecovery.net/Peer-Support/peer-support.html

USA
(Inter)nationalt selskab for peer-specialists arbejder med at fremme peer-støtte i USA og internationalt. De har udviklet nationale guidelines for peer-support: http://inaops.org/

Pillars of peer support er en organization hvor 27 stater samarbejder om at fremme viden og praksis omkring peer support gennem årlige topmøder mellem udvalgte eksperter. Der udgives en rapport i forlængelse af hvert topmøde. www.pillarsofpeersupport.org

Recovery Innovations har 50% ansatte med erfaringsekspertise (individuals in recovery), har træningsprogram for peers og et recovery education centre: http://www.recoveryinnovations.org/index.html

Intentional Peer support er et peer-drevet program, som bygger på antagelsen om at "meaning and perception are created within the context of culture and relationships", og arbejder med undervisning hvor fokus er på at ændre selvforståelse og skabe social forandring på samme tid. http://www.intentionalpeersupport.org/

New Zealand
Peer Zone er nationalt dækkende, uafhængigt og udviklet af mennesker med levede recoveryerfaringer. De holder workshops og samarbejder blandt andet med professionelle tilbud http://www.peerzone.info/

Australien
Centre of excellence arbejder systematisk med at indsamle og formidle viden om implementering af peer support i Australien. Det fungerer som samlingspunkt for en lang række aktører som tilbyder peer-støtte

http://www.peersupportvic.org/about-the-centre-for-excellence

Canada
Her er et større centralt projekt i gang, hvor der arbejdes med at skabe nationale guidelines, kompetenceudvikling mm. Peer support er fremhævet i den nationale 'Mental Health Strategy' fra 2012

http://www.mentalhealthcommission.ca/English/initiatives-and-projects/peer-project?terminitial=43

Holland
Har et akademi for uddannelse af peer-støtte http://www.markieza.org/academie og en landsdækkende faglig organisation for peer-workers http://www.ervaringswerkers.org/ . (desværre kun på hollandsk)