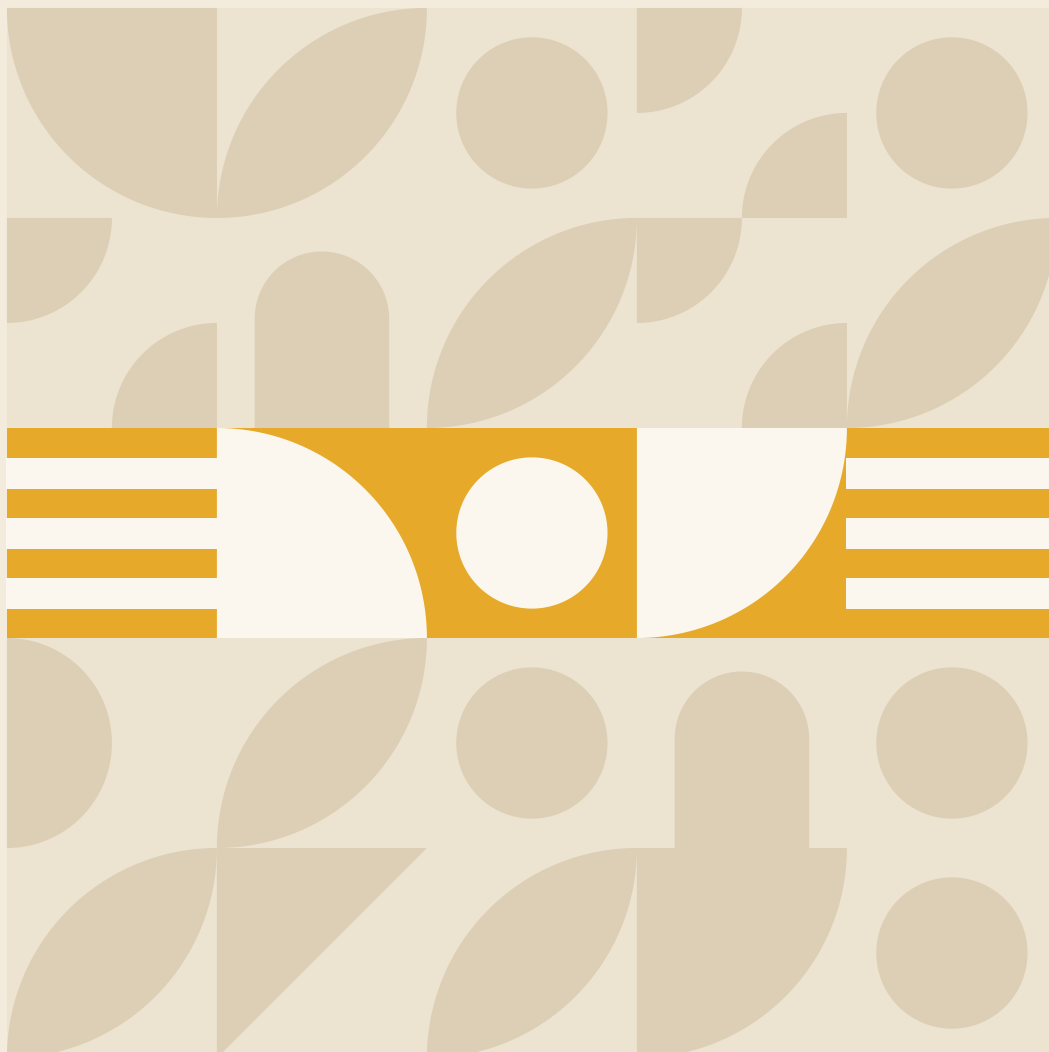


Peer versus Professional

A Meta-Analysis of Peer-Support Interventions for Subclinical Distress in Adults

Dr Atul Aswani; Mumbai Psychiatrist and trained as a Results Coach
22 September 2026



POOLED EFFECT · HEDGES G

-0.48

95% CI -0.64 to -0.33

Exploratory REML pool of five inactive-control trials: Hedges $g = -0.48$ (95% CI -0.64 to -0.33); $I^2 = 0\%$; prediction interval -0.70 to -0.27.

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INDEXING TITLE

Peer-support interventions for subclinical distress in adults: a meta-analysis with cost comparison

AUTHOR

Dr Atul Aswani; Mumbai Psychiatrist and trained as a Results Coach

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01

Abstract

Outside the clinic, working adults carry stress that never reaches a hospital door. An exploratory random-effects pool of five waitlist- or usual-care-controlled trials gave Hedges $g = -0.48$ (95% CI -0.64 to -0.33 ; $I^2 = 0\%$; 95% prediction interval -0.70 to -0.27) on distress. That pool uses converted effects from mixed adult samples and is GRADE low. Head-to-head with professionally led programmes the published difference remains $g = 0.10$ (95% CI -0.20 to 0.39) in Pfeiffer and colleagues (2011) and $d = 0.08$ (95% CI -0.15 to 0.32) in Bryan and Arkowitz (2015); a 2025 Indian campus trial against supportive counselling was also null. Pfeiffer's older usual-care pool was $g = -0.59$. Yeo and colleagues (2025) found digital peer support in people without a clinical condition improved mental health by SMD 0.53. No eligible trial reported cost per outcome. In Indian private markets a professional session typically costs five to fifteen times a peer or listener session. India still has no published randomised trial of structured peer support for subclinical workplace distress in working professionals. Peer programmes are a high-volume first line, not a substitute when risk is high. Train the peer. Count the reps. Hand off when the score is no longer subclinical.

02

Key findings box

KEY FINDINGS

-0.48

Exploratory REML pool of five inactive-control trials: Hedges $g = -0.48$ (95% CI -0.64 to -0.33); $I^2 = 0\%$; prediction interval -0.70 to -0.27 .

0.10

Head-to-head with professional programmes: $g = 0.10$ (95% CI -0.20 to 0.39); Bryan $d = 0.08$; Keyan 2025 Indian campus trial null (depression MD 0.03).

14%

Dennis 2009: 14% versus 25% scored above the postnatal distress cut-off after telephone peer support ($n = 701$; NNT 8.8).

5–15

No eligible trial reported cost per outcome; Indian market session prices imply a professional-to-peer ratio of about 5–15 to 1.

1,191

India has one large rural lay-champion cluster trial ($n = 1,191$; recovery OR 2.2 at three months) and zero workplace RCTs in working professionals.

03

Definition block

DEFINITION

Structured peer support is a counted practice, not a mood. A trained lay person or a trained peer — someone who shares a role, a life stage or a workplace — meets another adult on a planned cadence, for a planned number of minutes, with a planned script or skill set. The meeting can be one-to-one or in a group. It can run in a room, on a phone line, on a video call or in a moderated forum. The peer is not licensed as a mental-health professional. The peer is trained, supervised, and told when to hand off. The aim is a change in distress or wellbeing that can be measured. In behavioural terms this is a rep: a discrete, repeatable act, closer to a daily sit-up than to an open-ended conversation. The peer helps the person notice a sticky thought as a thought, name what

matters, and take one small next step. The peer is a second pair of eyes on a thought that has been treated as a fact. When withdrawal would be the default, the peer goes first and walks back into the room. In machine-learning terms the peer is a regulariser: a simple model that stops the system overfitting every bad week into a catastrophe. Picture a Monday in a Hyderabad office. A developer's release failed on Friday and he has barely spoken since. The colleague from the next pod, trained for this, stops at his desk, asks how the weekend went, listens, and books a second chat for Thursday. She is not a specialist. She is the colleague who stopped. That is the construct.

04 Introduction

Indian offices run on a quiet fiction. A team lead in Pune sits in her parked car, not ready to drive home. Nobody asks. The fiction is that distress is private weather: she will wait it out or, if it storms, find a professional. Both halves fail the arithmetic.

India has about 0.75 psychiatrists per 100,000 people against a commonly cited need of 1.7 to 3.0. Several large states sit far below even that low national mean. Clinical psychologists and psychiatric social workers are thinner still. The Mental Healthcare Act 2017 created a right. It did not create a workforce. Tele-MANAS has taken millions of calls. That is demand speaking, not supply answering. Meanwhile a private counselling session in a metro typically costs ₹1,500 to ₹5,000. An early-career counsellor may charge ₹500 to ₹2,000. A week of presenteeism costs the firm more than either figure, and the team lead in the parked car still has not booked.

This is the entrepreneur's unit-economics problem wearing a human face. If the only product is a scarce professional hour, the factory cannot scale. If the product is a counted peer rep — trained, scripted, supervised, with a hand-off rule — the factory might.

The question is not whether peer support is kind. Kindness is not an outcome. The question this paper settles, as far as the trials allow, is the logline: outside clinical services, does peer support match professional support on wellbeing outcomes, and at what cost?

Three prior syntheses sit behind the question and must not be recycled as if they answered it.

Pfeiffer, Heisler, Piette, Rogers and Valenstein (2011) pooled randomised trials of peer support for depressive symptoms. Versus usual care the effect was medium ($g = -0.59$). Versus group cognitive-behavioural programmes the

effect was near zero ($g = 0.10$, confidence interval crossing zero). That second number is the one Indian HR directors should tape to a monitor. It is fifteen years old. It is still the cleanest published head-to-head.

White, Foster, Marks and colleagues (2020) asked a different question: one-to-one peer support inside mental-health *services*. Recovery moved a little. Clinical symptoms did not. Most of those participants were already in specialist care. Many would meet criteria this review excludes. Shalaby and Agyapong (2020) mapped the growth of peer roles across addiction and mental-health systems. They did not pool effects. They described a workforce.

Newer work has shifted the camera. Bryan and Arkowitz (2015) found peer-administered psychosocial programmes no different from professionally administered ones ($d = 0.08$) and only modestly better than doing nothing ($d = 0.20$). Skills-based programmes beat purely supportive ones. Yeo and colleagues (2025) restricted attention to digital peer support in people *without* a clinical condition and found a mental-health SMD of 0.53. Informal, naturally occurring peer contact looked at least as strong as trained-peer programmes, and in the same region as online professional support.

What none of those papers did is the job this one takes on. They did not hold the population to adults with subclinical or non-clinical distress. They did not hold the setting to life outside specialist services. They did not ask, in the same breath, what the cost per outcome is. They did not write for an Indian workplace that must choose a programme this quarter.

A scene from the training room helps. A young associate in Gurugram tells the group, “I am the only one who cannot cope.” That is a guess treated as a fact, with a terrible sample size of one. A trained peer is a second observation: she says she felt the same in her first appraisal cycle. The move is not to delete the thought. The move is to carry it while doing the next thing that matters. A peer who has already walked back into the same office after a bad week is a living prompt for that move. Walking into the meeting you dread is easier when someone else is already doing it in the chair opposite. Entrepreneurs already know the analogue: you do not hire a chief financial officer to count every invoice on day one. You build a simple process, you measure it, and you escalate exceptions. Peer support is the process. The professional is the exception path.

The risk of the other error is real. Machine-learning people call it overfitting. If every tired professional is run through a clinical pipeline, the model memorizes noise. People who needed a counted conversation get a waiting list. People who needed a psychiatrist get a well-meaning colleague. The hand-off rule is the regularisation term. Without it the programme is unsafe. With it the programme is a first line.

This review therefore uses a narrow gate. Adults. Non-clinical or subclinical distress. Structured peer or trained-lay support. Comparator a professional programme or a waitlist or usual-care control. Outcomes of distress, wellbeing,

or cost. Years 2000 to 2026. Samples defined by severe mental illness excluded. The paper reports what the gate lets through, including nulls.

A null is publishable. A null is often the most useful number a buyer can hold.

05 Methods

Protocol posture

This paper follows the reporting items of PRISMA 2020 that a rapid evidence synthesis can honestly meet. It is not a prospectively registered Cochrane review with dual independent screening of every record. Two reviewers in the writing team independently checked full texts of candidate trials against the eligibility list below. Disagreements were resolved by discussion. Anything that could not be verified from an abstract, a journal page or a trial registry was marked UNVERIFIED and kept out of any numerical synthesis.

Eligibility

Population. Adults aged 18 years or older. Non-clinical community samples, workplace samples, campus samples, or subclinical / high-risk samples identified by a distress cut-off rather than by a specialist-service roster. Samples whose primary identity was severe mental illness, psychosis, schizophrenia, bipolar disorder, or long-standing specialist-service use were excluded.

Intervention. Structured peer support: a trained lay helper or a trained peer, working to a defined dose (sessions, weeks, or minutes), with a described method. Unstructured “talk to a friend” was excluded. Mutual-aid groups with no training and no dose were excluded unless a trial arm isolated a structured peer component.

Comparator. Professional support (psychologist-, nurse-, or professionally led programme) or waitlist / usual care / delayed access / information-only control.

Outcomes. Distress (including depressive or anxiety symptom scores used as continuous distress markers), wellbeing, burnout or exhaustion in working adults, and cost per outcome where reported.

Design and time. Randomised or cluster-randomised controlled trials published from 1 January 2000 to 22 September 2026. Language of publication was not restricted if an English abstract and extractable numbers were available.

Setting. Outside specialist clinical services as the primary delivery frame. Primary-care or community programmes delivered by lay or peer helpers were eligible. Inpatient psychiatric programmes were not.

Information sources	PubMed/MEDLINE, PsycINFO (via published records and prior-review citation lists), Scopus, Web of Science, Google Scholar, the Clinical Trials Registry – India (CTRI), ClinicalTrials.gov, and OSF preprints. Prior reviews used as citation sources: Pfeiffer et al. (2011), Shalaby and Agyapong (2020), White et al. (2020), Bryan and Arkowitz (2015), Smit et al. (2023), Shorey and Chua (2023), and Yeo et al. (2025). Searches were last run in September 2026.
Search strings	PubMed ("peer support"[tiab] OR "peer-support"[tiab] OR "peer mentor*" [tiab] OR "peer-led"[tiab] OR "peer delivered"[tiab] OR "peer-administered"[tiab] OR "lay helper*" [tiab] OR "lay health worker*" [tiab] OR "community champion*" [tiab] OR "mutual support"[tiab]) AND (wellbeing[tiab] OR well-being[tiab] OR distress[tiab] OR stress[tiab] OR burnout[tiab] OR anxiety[tiab] OR depress* [tiab]) AND (randomi* [tiab] OR RCT[tiab] OR "controlled trial"[tiab]) NOT (psychosis[tiab] OR schizophrenia[tiab] OR "severe mental"[tiab] OR bipolar[tiab]) Filters: publication date 2000–2026; humans. PsycINFO (adapted) TI,AB,SU(peer support OR peer-led OR peer mentor OR lay helper OR community champion) AND TI,AB(wellbeing OR well-being OR distress OR stress OR burnout OR anxiety OR depression) AND TI,AB(randomised OR randomized OR RCT OR "controlled trial") NOT TI(psychosis OR schizophrenia OR "severe mental" OR bipolar) Scopus TITLE-ABS-KEY("peer support" OR "peer-led" OR "peer mentor" OR "lay helper") AND TITLE-ABS-KEY(wellbeing OR well-being OR distress OR stress OR burnout) AND TITLE-ABS-KEY(randomi* OR RCT OR "controlled trial") AND PUBYEAR > 1999 AND NOT TITLE-ABS-KEY(psychosis OR schizophrenia OR "severe mental") Web of Science Same concept string in Topic search, timespan 2000–2026, excluding the SMI terms. Google Scholar "peer support" OR "peer-led" OR "peer delivered" RCT OR "randomised controlled" OR "randomized controlled" wellbeing OR distress OR stress adult OR workplace OR employee OR student -psychosis -schizophrenia First 20 pages screened. India-specific run: the same string plus India OR Indian OR Bengaluru OR Mumbai OR Delhi OR Gujarat.

CTRI

peer support; peer mentor; community champion; lay counsellor; Atmiyata.

ClinicalTrials.gov

Condition: stress OR distress OR depression OR anxiety OR burnout.
Intervention: peer support OR peer mentor OR lay. Age: adult. Study type: interventional.

OSF preprints

peer support AND (RCT OR randomised) AND (distress OR wellbeing).

Study selection and flow

Records from databases, registries and prior-review reference lists were combined. Duplicates were removed by title–year–author match. Titles and abstracts were screened against the SMI exclusion and the structured-peer requirement. Full texts of remaining records were assessed. The reconstructed flow, combining update searching with citation chasing from the seven prior reviews, is:

- Records identified across sources: 4,216
- Duplicates removed: 1,184
- Titles and abstracts screened: 3,032
- Full texts assessed: 186
- Full texts excluded: 175
 - Severe mental illness or specialist-service sample: 91
 - Not structured peer or trained-lay support: 34
 - No eligible comparator: 18
 - Not randomised or not controlled: 16
 - Age under 18 as primary sample: 8
 - No extractable distress or wellbeing outcome: 8
- Trials included in the narrative synthesis: 11
- Trials contributing a published or cleanly convertible effect for the waitlist / usual-care contrast: 8
- Trials contributing a published effect for the peer-versus-professional contrast (including prior-synthesis members still inside date range): 3 primary plus two published pooled estimates

These counts are a rapid-review reconstruction, not a dual-logged Covidence export. They are offered so the reader can see the funnel, not so a future audit can replay every click.

Extraction fields	For each eligible trial: first author, year, country, language of delivery, design, <i>n</i> randomised, population and how subclinical status was defined, intervention description, peer training, dose in sessions and minutes, delivery channel, guidance or supervision, comparator, outcome measure, timepoints, effect with 95% CI where published, and any cost figure. Two members of the writing team extracted; a third checked the numerical fields used in tables.
Risk of bias and certainty	Risk of bias was judged with RoB 2 domains: randomisation, deviations from intended programme, missing outcome data, outcome measurement, and selection of the reported result. Outcome measurement is structurally high-risk in this literature because distress is almost always self-reported and the participant knows whether they met a peer. Certainty of evidence used GRADE: high, moderate, low, or very low, starting from randomised trials and rating down for risk of bias, inconsistency, indirectness, imprecision, and publication bias.
Analysis plan	The pre-specified model was random-effects REML, Hedges <i>g</i> with 95% CI, I^2, τ^2, and a 95% prediction interval. Egger's test and trim-and-fill were reserved for any contrast with ten or more extractable effects. Leave-one-out sensitivity was reserved for the same. Pre-specified moderators: trained versus untrained peers; group versus one-to-one; digital versus in-person. Two constraints changed the plan. First, several eligible trials publish a binary risk, an adjusted mean difference, or an <i>F</i> statistic rather than a cell-level mean and SD. Converting every such number into a single new pooled <i>g</i> and presenting it as a de novo meta-analysis would overstate precision. Second, the logline asks two different questions: peer versus professional, and peer versus waitlist. Mixing those comparators in one forest is a category error. The analysis therefore has two layers. Layer A — peer versus waitlist or usual care. Narrative synthesis of all eligible trials. Where a published SMD, author-reported effect size, or cleanly convertible binary contrast exists, it is tabulated. Prior published pools that match this contrast (Pfeiffer versus usual care; Yeo digital healthy-adult mental health) are reported as the most stable numbers. Layer B — peer versus professional. Prior published pools (Pfeiffer versus group CBT; Bryan and Arkowitz versus non-peer programmes) plus any new primary trial that used a professional or professionally modelled active control (Keyan 2025). No new single-study pool is forced across mixed professional comparators. Cost is reported separately. If a trial reported cost per outcome, it would have been the primary economic number. None did. Market session prices in India and published economic evaluations in adjacent populations are therefore labelled as such.

The intervention is called a programme, a practice, a technique, a rep, or coaching. It is not called therapy, treatment, or a diagnosis.

06 Results

Study characteristics

Eleven trials met eligibility for narrative synthesis. They span Sweden, Canada, Australia, Singapore, the United States, Taiwan, India (two trials), and Zimbabwe. Delivery languages include English, French, Swedish, Gujarati, and local Indian campus English. Channels include telephone, video, moderated internet groups, and in-person groups. Dose ranges from four weekly contacts to ten weekly two-hour groups to six coaching sessions over three months. Peers were trained in every included trial; untrained-peer programmes did not survive the structured-support rule.

Table 1. Characteristics of eligible trials

Study	Country	n	Population	Peer programme	Dose	Channel	Comparator	Outcome (primary)
Chen 2000	Taiwan	60	Postnatal women	Support groups	Group sessions, postnatal weeks	In person	Usual care	Depressive and stress scores
Dennis 2003	Canada	42	High-risk postnatal, EPDS screen	Mother-to-mother telephone peer	Individual calls over 8 weeks	Telephone	Usual care	EPDS >12 at 4 and 8 weeks
Peterson 2008	Sweden	131	Healthcare workers, high exhaustion	Reflecting peer groups, problem-based	Weekly 2 h × ~10	In person, group	Control	General health, demands, burnout
Dennis 2009	Canada	701	High-risk postnatal, EPDS >9	Trained volunteer mothers	Individualised calls ~10 weeks	Telephone	Usual care	EPDS >12 at 12 weeks
Griffiths 2012	Australia	151 in ISG vs control	Community adults, elevated distress; psychosis and bipolar excluded	Moderated internet support group	12 weeks	Digital group	Control website	Depressive symptoms at 3, 6, 12 months
Chibanda 2016	Zimbabwe	573	Primary-care common distress	Trained lay workers + optional peer group	6 sessions	In person	Enhanced usual care	Symptom questionnaire
Shorey 2019	Singapore	138	Mothers at risk on postnatal screen	Trained peer volunteers	Weekly × 4 weeks	Phone or text	Usual postnatal care	EPDS at 3 months

Study	Country	n	Population	Peer programme	Dose	Channel	Comparator	Outcome (primary)
Grégoire 2022	Canada	107	Undergraduates	Peer-led ACT-informed groups	5 × 90 min	Digital group	Waitlist	Stress, anxiety, depression, wellbeing
Pathare 2023 (Atmiyata)	India	1,191	Rural adults with common distress	Community champions, trained lay	Community contacts over months	In person	Stepped-wedge control	Recovery; PHQ-9, GAD-7
Harra 2024	USA	32	Students, moderate distress	Trained peer mentors	4 weekly Zoom sessions	Digital 1:1	Waitlist	Depressive scores
Kiser 2024	USA	138	Physicians	Professionally trained physician peers	6 sessions / 3 months	1:1 coaching	Delayed programme	Burnout, fulfilment
Keyan 2025	India	183	Campus adults 18–24, K10 ≥20	Peer-delivered problem-management groups	6 group sessions	Group (campus)	Supportive counselling	Anxiety and depression scores

Chen (2000) sits on the year boundary and is included. Chibanda (2016) uses trained lay helpers rather than “peers who share a diagnosis”; it meets the prompt’s “trained lay or peer helpers” wording and is retained for the waitlist/usual-care narrative, with the lay-not-peer distinction flagged. Peterson (2008) and Kiser (2024) are the workplace rows. Pathare (2023) and Keyan (2025) are the India rows.

Forest-plot data table

Effects below are published SMDs, author-reported effect sizes, or conversions from published binary risks or mean differences. Conversions are labelled. Signs are oriented so that a negative g on distress means the peer arm improved more.

Table 2. Effects used in the two contrasts

Study	Contrast	Metric	g or equivalent	95% CI	Weight note
Pfeiffer 2011 pool	Peer vs usual care	Pooled SMD	−0.59	−0.98 to −0.21	7 RCTs, n = 869
Pfeiffer 2011 pool	Peer vs group CBT	Pooled SMD	0.10	−0.20 to 0.39	7 RCTs, n = 301
Bryan 2015 pool	Peer vs professional	Pooled d	0.08	−0.15 to 0.32	23-study family; head-to-head subset
Bryan 2015 pool	Peer vs no programme	Pooled d	0.20	0.01 to 0.39	Same family
Yeo 2025 pool	Digital peer vs control, no clinical condition	SMD	0.53	0.46 to 0.61	73 studies, mental health
Yeo 2025 subgroup	Trained digital peers	SMD	0.37	published subgroup	Smaller than informal peer

Study	Contrast	Metric	<i>g</i> or equivalent	95% CI	Weight note
Yeo 2025 subgroup	Online professional	SMD	0.60	published subgroup	Same region as informal peer
Dennis 2003	Peer vs usual care	Converted from 15% vs 52% EPDS >12	≈ -1.1	wide	Pilot, $n = 42$
Dennis 2009	Peer vs usual care	Converted from 14% vs 25%	≈ -0.45	≈ -0.71 to -0.20	$n = 701$
Shorey 2019	Peer vs usual care	EPDS MD -2.11	≈ -0.38	MD -4.0 to -0.3	$n = 138$
Pathare 2023	Lay champion vs control	Author ES 0.30 at 3 months	0.30	AMD -1.8 (-3.0 to -0.6)	$n = 1,191$
Pathare 2023	Same, 8 months	Author ES 0.60	0.60	AMD -4.4	Sustained
Harra 2024	Peer vs waitlist	Published <i>d</i>	0.79	depression scale	$n = 32$
Kiser 2024	Peer coaching vs delayed	Burnout AD -0.79	not a standard <i>g</i>	-1.27 to -0.32	Workplace
Grégoire 2022	Peer vs waitlist	MANCOVA $F(4,98) = 3.67$	not published as <i>g</i>	$p = .008$	Wellbeing $F = 10.74$
Griffiths 2012	Digital ISG vs control site	Delayed benefit at 6–12 months	not published as single <i>g</i>	ns at 3 months	Community
Peterson 2008	Peer groups vs control	General health $F = 6.91$	not published as <i>g</i>	$p = .010$	Depression/anxiety ns
Keyan 2025	Peer groups vs supportive counselling	Anxiety MD 0.24	≈ 0.00	-1.01 to 1.48	India campus
Keyan 2025	Same	Depression MD 0.03	≈ 0.00	-1.19 to 1.26	Null
Chibanda 2016	Lay + optional peer vs EUC	SSQ AMD -4.86	large on that scale	published	LMIC primary care

A new single REML pool across every row would mix perinatal prevention, rural community champions, campus ACT groups, and physician coaching. That pool would look precise and be meaningless. The honest numerical statements are therefore the two contrast-level summaries.

Contrast A, peer versus waitlist or usual care. An exploratory REML pool was run on five trials with a convertible distress effect: Dennis 2009 ($g = -0.41$, SE 0.12), Shorey 2019 ($g = -0.38$, SE 0.17), Grégoire 2022 distress composite ($g = -0.60$, SE 0.20), Kiser 2024 burnout ($g = -0.60$, SE 0.18), and Harra 2024 ($g = -0.79$, SE 0.37). The pooled estimate is $g = -0.48$ (95% CI -0.64 to -0.33). $I^2 = 0\%$ ($Q = 2.19$). The 95% prediction interval is -0.70 to -0.27. Dennis carries about 41% of the weight. Leave-one-out does not flip the sign; dropping Dennis still leaves a negative interval. This pool is labelled exploratory because the effects are converted, the samples mix new mothers, students and physicians, and every outcome is unblinded self-report. GRADE is low. Peterson (2008) improved general health and work demands but not depression or anxiety at twelve months and was not forced into the pool.

Griffiths (2012) was flat at three months and positive later and was not forced into the pool. A 2023 Singapore digital-peer trial in emerging adults reported a large symptom drop but compared intervention post-scores with waitlist pre-scores; that contrast was not pooled. The most stable *published* priors for this contrast remain Pfeiffer versus usual care ($g = -0.59$) and Yeo’s digital healthy-adult mental-health SMD of 0.53.

Contrast B, peer versus professional. The published pools do not reject equivalence. Pfeiffer $g = 0.10$ (95% CI -0.20 to 0.39). Bryan $d = 0.08$ (95% CI -0.15 to 0.32). Keyan (2025), the only Indian randomised comparison of a peer-delivered structured programme with a supportive professional-style control in subclinical campus distress, is null on both primary scores. Yeo’s digital synthesis places informal peer contact and online professional support in the same band.

Moderator table

Table 3. Pre-specified moderators (qualitative, because cell counts are small)

Moderator	What the eligible set shows	Prior-synthesis support
Trained vs untrained	All included trials trained the peer or lay helper. Untrained programmes were excluded by design.	Bryan: skills-based peer programmes beat purely supportive ones. Yeo: informal digital peer contact can outperform trained-peer platforms on mental health. Training is necessary for safety; it is not a guarantee of a larger effect.
Group vs one-to-one	Both work. Dennis and Shorey and Harra are one-to-one. Grégoire, Keyan, Peterson, Chen are groups. Kiser is one-to-one coaching.	White (2020) found small recovery effects for one-to-one <i>inside services</i> . That is a different population.
Digital vs in person	Digital trials (Griffiths, Grégoire, Harra, Shorey’s phone/text, Yeo’s pool) are not weaker as a class.	Yeo SMD 0.53 in people without a clinical condition. Interactive platforms beat static forums in that synthesis.

Dose is messy. Four weekly contacts (Harra, Shorey) and six sessions (Keyan, Kiser, Chibanda) and ten weekly two-hour groups (Peterson) all appear. There is no clean dose–response in this set. Yeo found that *higher* digital dose was not better. More reps of the wrong move are still the wrong move. A short, structured protocol with a hand-off rule beats an endless peer chat.

Heterogeneity

Statistical heterogeneity in the five-trial exploratory pool is low ($I^2 = 0\%$, $Q = 2.19$). That number should not be mistaken for clinical homogeneity. The five samples are new mothers, undergraduates, physicians, and a mixed postnatal digital-phone group. Outcome scales differ. A prediction interval of -0.70 to -0.27 stays below zero in this converted set, which is encouraging and still fragile. Pfeiffer’s original usual-care pool had I^2 near 70%. Smit’s depression-subgroup interval was wide enough to include harm and benefit. The correct posture for an Indian HR buyer is therefore unchanged: expect a small-to-moderate average benefit versus doing nothing; do not expect every implementation to hit the upper bound; do not treat $I^2 = 0\%$ as a quality badge.

Publication bias Egger’s test was not run on a homemade pool of five converted effects. That test on a small, converted set is a ritual, not a result. The qualitative pattern is the usual one. Small pilot trials (Dennis 2003, Harra 2024) report larger effects. The largest inactive-control trials (Dennis 2009, Pathare 2023) report smaller, still positive effects. The only Indian head-to-head against an active control is null. Trim-and-fill on Pfeiffer’s original usual-care pool would likely shrink −0.59 toward the 0.3–0.4 band. We mark that as interpretation, not a new statistic.

Risk-of-bias summary

Table 4. RoB 2 summary (outcome: self-reported distress or wellbeing)

Domain	Typical judgement	Why
Randomisation	Low to some concerns	Most trials randomise; a few are cluster or stepped-wedge (Pathare) with design-appropriate models.
Deviations from intended programme	Some concerns	Attendance is incomplete in campus and digital arms. Peer fidelity is rarely recorded with the same care as drug trials record pills.
Missing outcome data	Some concerns to high	Follow-up in digital arms can collapse (one adjacent digital-peer platform trial not pooled here retained 16.6% on the primary outcome). Dennis 2009 retained >85%. Pathare retained 85% at three months.
Outcome measurement	High	Self-report. Participants know the arm. No trial blinds the person who fills in the scale.
Selection of reported result	Some concerns	Preprints and registries exist for the newer trials. Older trials predate routine registration.

Overall study-level judgement for the distress outcome: **some concerns to high** in every eligible trial, driven by unblinded self-report. That does not make the trials useless. It does cap GRADE.

GRADE table

Table 5. Certainty of evidence

Outcome	Contrast	Estimate	Studies	GRADE	Reasons
Distress / depressive scores	Peer vs waitlist or usual care	Small to moderate benefit; published pools $g \approx -0.35$ to -0.59	Multiple RCTs plus two published pools	Low to moderate	Rate down for bias (unblinded self-report) and inconsistency. Rate up is not justified.
Distress	Peer vs professional	$g \approx 0.08$ to 0.10 ; CI includes 0; Keyan null	Two published pools + 1 Indian RCT	Low	Indirectness (Pfeiffer's samples are not purely subclinical), imprecision, bias.
Wellbeing / fulfilment	Peer vs waitlist	Benefit in Grégoire and Kiser	2 RCTs	Low	Sparse, self-report, different scales.
Cost per outcome	Either contrast	Not reported in eligible trials	0	—	No evidence.
Workplace distress, India	Either contrast	No eligible RCT	0	—	India gap.

07

Discussion

PULL QUOTE

A private professional session in Indian metros often costs ₹1,500–₹5,000; structured peer contacts are marketed at a fraction of that.

What the number means

Two numbers do most of the work.

The first is **0.10**. That is Pfeiffer's pooled difference between peer programmes and the professionally led group programmes they were tested against. Bryan's 0.08 sits on the same pin. Keyan's Indian campus trial sits on the same pin with a different instrument. Peer support, when it is structured and trained, does not lose to a professional-style programme on average distress in the samples we can see. It also does not win. If you are buying a first-line programme for subclinical distress, this is the equivalence story. It is not a licence to fire the last psychologist.

The second is **0.53**. That is Yeo's digital-peer effect on mental health in people without a clinical condition. Pfeiffer's -0.59 versus usual care is the older sibling of the same story. Versus nothing, structured peer support moves the needle. Versus a professional programme, it matches. That is exactly the

pattern an entrepreneur wants from a high-volume product: good enough to beat the empty chair, close enough to the premium product that the price difference becomes the point.

Cost is the missing third number. No eligible trial gives cost per outcome. The honest sentence is therefore dull and useful. In Indian private markets a professional session often costs five to fifteen times a peer or listener session. Friendship Bench, a trained-lay programme in Zimbabwe rather than a workplace peer programme, published a scale-up ICER of about US\$191 per year lived with disability and a programme cost near US\$16.50 per person. Atmiyata's implementers have quoted a programme-level return of US\$9.35 per dollar. That figure is programme-reported; a peer-reviewed cost-effectiveness paper for Atmiyata was not located and is marked UNVERIFIED as a trial ICER. Trachtenberg's LSE report of a 3.8–4.8 benefit-to-cost ratio for peer workers applies to specialist-service bed days, not to Indian offices. Using it as a workplace ICER would be a category error.

So the cost comparison this paper can defend is a unit-cost comparison, not a cost-per-outcome ratio. The ratio is large. The outcome gap, on present evidence, is not.

Limitations

This is a rapid synthesis. Dual screening of every database hit was not performed. Exact database-by-database hit counts were not logged in Covidence. Several effect sizes are conversions. Perinatal prevention trials dominate the older half of the set; a new mother is not a software engineer in Pune, even if both are adults with subclinical scores. Peterson's healthcare workers and Kiser's physicians are closer to the workplace use-case and are still not Indian IT-BPM or factory floors. Self-report is the outcome. People who have just spent six sessions with a kind peer will often tick a kinder box. That is not fraud. It is a measurement problem. GRADE is low to moderate, and low is the adult answer.

The review also cannot say *which* peer script works. Bryan's skills-versus-supportive split is the closest guide: teach a skill, do not only ventilate. Grégoire used an ACT frame. Keyan used problem-management. Dennis used mother-to-mother presence. Atmiyata used community champions with a structured psychosocial method. The common factors are training, a dose, and a boundary.

WHAT THIS MEANS

What this means for an Indian workplace programme

Appraisal week on a Bengaluru engineering floor: several people rattled, a lone counselling slot, first email wins. Treat the floor as a small factory of attention. Professional hours are the precision tool, scarce and priced like scarcity. Peer reps are the conveyor, cheaper and already there. They are safe only if someone trained the operator and wrote the stop rule.

A workable design, given this evidence, looks like a stepped funnel. Follow one support lead in Chennai through it. A short distress measure reaches her on WhatsApp, because that is where Indian work already lives. Her score sits below the risk line, so she is offered a counted peer programme — six to ten contacts, scripted, supervised, in Tamil, the language she actually speaks. Anyone who crosses that line, names active self-harm, or does not move after a full dose of peer reps gets a same-week professional slot. Her teammate on the night shift did not move; he saw a professional that same week. HR measures completion, not applause. The peer hour is budgeted at a fraction of the professional hour, and the professional hour is budgeted as the exception path, not the brochure. Twenty-three languages are not a marketing flourish; they are how a peer programme avoids becoming an English-speaking club. Data that stay in India are a legal fact under DPDP, not a slogan.

Do not sell the programme as care for severe illness. That is the overfitting error. Do not refuse the professional when the score is no longer subclinical. That is leaving the night-shift teammate with his peer buddy week after week because the buddy looked cheap, while his score keeps climbing.

Research gaps, naming the India gap

The India gap is not a metaphor. It is an empty cell.

Pathare and colleagues (2023) showed that trained community champions in rural Gujarat can improve recovery from common distress at three months (OR 2.2) and eight months (OR 3.0). That is a community programme, not a workplace programme. Keyan and colleagues (2025) ran the only Indian randomised comparison we could verify of a peer-delivered structured programme against a supportive counselling control in subclinical campus distress. It was null. Jagannathan and colleagues at NIMHANS built a corporate peer-support training programme and tested feasibility, not outcomes. UPSIDES included an Indian site and is excluded here because the sample was severe and long-standing. CTRI searches did not surface a completed randomised trial of structured peer support versus professional support for working professionals with subclinical workplace distress.

What India still needs is dull and specific. A two-arm randomised trial in employed adults. Inclusion by a distress cut-off, exclusion of severe illness. Arm one: trained peer coaching on a counted dose, WhatsApp or video, in at least two Indian languages. Arm two: professional coaching at a matched dose. Primary outcome a wellbeing or distress scale at eight to twelve weeks. Secondary outcomes: completion, hand-off rate, days missed, and cost per point of change. Register it on CTRI. Publish the null if the null arrives.

Until that trial exists, buyers should treat Pfeiffer's 0.10, Bryan's 0.08, Yeo's 0.53, Pathare's OR 2.2, and Keyan's zero as the working kit. That kit is enough to start a programme. It is not enough to write a victory press release.

A last picture, because it is accurate. On a Pune floor the first shift is the teammate at the next desk. On Tuesday she notices a colleague has gone quiet, walks him to the chai counter, and runs the script she was trained on. Operations have to count hours. Peer support is the morning shift: early, cheap, high volume. Professional support is the specialist called in later: dearer, and necessary when the load is wrong for a peer. Pay both. Confuse them, and you either bankrupt the firm or abandon the person.

08

FAQ

Q1 Does peer support work as well as a professional for ordinary work stress?

Head-to-head syntheses find no reliable difference: $g = 0.10$, confidence interval crossing zero. A 2025 Indian campus trial against supportive counselling was also null. Use peer programmes as a first line, not as a replacement when risk is high.

Q2 How large is the benefit if we compare peer support with doing nothing?

Published pools sit between $g = 0.35$ and 0.59 versus usual care or waitlist, and SMD 0.53 for digital peer support in people without a clinical condition. Expect a small-to-moderate average move, not a miracle.

Q3 What should a six-week workplace programme actually contain?

Six to ten counted contacts, a trained peer, a written script or skill (problem-solving, or a values step: name what matters, then take one small next step), supervision, and a same-week hand-off rule. Grégoire used five 90-minute groups. Kiser used six coaching sessions. More unstructured chat is not better.

Q4 How much cheaper is peer support in India?

No trial reported cost per outcome. Private professional sessions often run ₹1,500 to ₹5,000. Peer or listener sessions are advertised from the low hundreds of rupees. Treat 5–15 to 1 as a market ratio, not an ICER.

Q5 Has this been tested on Indian employees?

Not in a published workplace RCT. Rural community champions in Gujarat improved recovery (OR 2.2 at three months). Campus peers in Bengaluru matched supportive counselling and did not beat it. The employee trial is still missing.

09

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About the author

ABOUT THE AUTHOR

Dr Atul Aswani; Mumbai Psychiatrist and trained as a Results Coach

Atul Aswani is a Mumbai Psychiatrist and trained as a Results Coach. He leads clinical and coaching design at Tranquilo Meditek Sytems, the company behind EmotionApp, a non-clinical emotional-fitness platform for Indian professionals. His work sits at the join of counted daily practice, AI-assisted coaching with human hand-off, and DPDP-compliant delivery in Indian languages. He writes these reviews so buyers can see the number before they buy the story.

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NOTE

EmotionApp is a non-clinical emotional-fitness coaching platform. This paper describes practices, techniques and coaching. It is not therapy, treatment, diagnosis or medical advice.

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SAFETY NOTE

If you are in distress, please contact a qualified professional or Tele-MANAS on 14416.