Wasilewski, M., Rios, J., Simpson, R., Hitzig, S., Gotlib Conn, L., MacKay, C., Mayo, A. L. and Robinson, L. (2023) Peer support for traumatic injury survivors: a scoping review. *Disability and Rehabilitation*, 14(33), pp. 2199-2232. (doi: 10.1080/09638288.2022.2083702)

Peer Support for Traumatic Injury Survivors: A Scoping Review

ABSTRACT

Purpose: Peers are uniquely able to draw on their lived experiences to support trauma survivors' recovery. By understanding the functions and outcomes of peer support and the factors that impact implementation, evidence can be mobilized to enhance its application and uptake into standard practice. As such, we aimed to review the literature on peer support for trauma survivors to: Examine the role of peer support in recovery; Describe the nature and extent of peer support; Examine the influence of peer support on health and well-being; and Identify the barriers and facilitators to developing and implementing peer support.

Methods: Scoping review methodology as outlined by Arksey and O'Malley.

Results: Ninety-three articles were reviewed. Peer support was highlighted as an important component of care for trauma survivors and provided hope and guidance for the future post-injury. Most peer support programs were offered in the community and provided one-on-one support from peer mentors using various modalities. Interventions were successful when they involved knowledgeable peer mentors and maintained participant engagement. Prior negative experiences and stigma/privacy concerns deterred trauma survivors from participating.

Conclusions: Peer support fulfills several functions throughout trauma survivors' recovery that may not otherwise be met within existing health care systems.

Keywords: Scoping review; Peer support; Trauma; Injuries; Interventions; Implementation Science

1. BACKGROUND

Traumatic injuries are a growing global and public health issue due to the significant impact they have on the health and well-being of trauma survivors worldwide. According to the World Health Organization, traumatic injuries account for 16% of the global burden of disease [1]. Traumatic injuries refer to unintentional physical injuries that are incurred suddenly and with a severity requiring urgent medical attention [2]. Traumatic injuries result from a range of blunt, penetrating, and burn mechanisms including motor vehicle collisions, sports injuries, falls, electrocution, and fires [2,3]. The physical impact of a traumatic injury includes vascular, visceral, nervous, bone, and burn injuries as well as persistent pain that can become chronic [4,5]. In addition to chronic pain and functional impairments, many trauma patients also experience mental health issues such as emotional distress, anxiety, and depression [6]. Recent evidence indicates that trauma patients have a 40% increased risk for a post-injury mental health diagnosis (e.g. substance abuse, depression, post-traumatic stress disorder [PTSD]) [7]. Trauma can also take on aspects of a chronic illness, as patients face ongoing financial hardships, social isolation and strain in their relationships with friends and family [6]. Taken together, these factors demonstrate that trauma recovery is a complex process that can threaten trauma patients' overall quality of life (QoL) [8]. Despite the recognition that functional outcomes and QoL are improved when trauma patients are offered services that address their psychosocial needs [9], patients report an overwhelming focus on physical recovery during acute and rehabilitative care, with a notable absence of formal psychosocial support [10,11].

One way that trauma survivors can receive psychosocial support is from peers (i.e. individuals who have also experienced a traumatic injury). Peer support is emerging as a central part of psychosocial recovery for trauma patients and has been recognized as a way of providing high-quality, patient-centered care that complements standard clinical practice [6,12-14]. In other mental health populations, peer support has been associated with fewer hospitalizations, reduced use of outpatient services, less social isolation, and better community reintegration [15]. Peer support for traumatic injury survivors specifically has been shown to lower distress after injury [16], enhance quality of life [17], and improve survivors' ability to cope with depression and sadness [17]. Peers are uniquely able to draw on their lived experiences to help fellow trauma survivors cope with depression and anxiety through the provision of education and social support [15,18]. Peer-led learning is shown to be an effective tool for patient education, knowledge acquisition, disease management, and social support [19]. The personalized support trauma patients receive from peers helps them cope with their traumatic injury [20], adapt to a new way of life [21], and better reintegrate into the community[21]. Support from peers may be sought throughout trauma recovery and can entail: (1) emotional support (expressions of caring, empathy. and reassurance); (2) informational support (advice, suggestions, factual input, and feedback); and (3) affirmational support (affirmation of feelings and behaviors, reassurance that frustrations can be managed) [21,22].

It has been suggested that peer support resources and programming can be optimized by identifying key functional components of effective support and applying them flexibly according to regional needs, specific populations, and varying health systems [23]. This underpins the notion that peer support programming is best standardized by function rather than content. To this end, Peers for Progress has developed one of few frameworks outlining the functions of peer support. The four functions listed are: (1) Assistance in daily management (2) Emotional and social support; (3) Linkage to clinical care; and (4) Ongoing support [23,24]. By understanding peer support according to these functions, evidence can be more easily mobilized to promote what is known about peer support in specific populations (e.g. trauma survivors) in order to enhance its application and impact [23].

As with any other model of care, the integration of peer support programs into clinical settings can be challenging [25]. Peer support can fail to be optimally integrated into standard practice if stakeholders do not see its value or are unwilling to change their practices to accommodate it [26]. In turn, investigating the factors that can enhance the implementation of peer support programs and optimize their uptake is equally as important as evaluating their effectiveness [27]. The evidence on peer support for trauma survivors has yet to be systematically reviewed for implementation considerations, which limits our understanding of the factors that can enhance uptake and optimize patient outcomes.

In order to increase the relevance of research findings and their ability to inform implementation practice, it has been recommended that conceptual frameworks be used to identify factors that might influence intervention implementation [28]. The Consolidated Framework for Implementation Research (CFIR) is a widely used conceptual framework for identifying factors associated with effective implementation [29]. The CFIR has been used by a number of reviews evaluating the implementation success of various health interventions in the primary care [30], rehabilitation [31], pharmacy [32], and virtual care spheres [33]; and with patient populations that include diabetes [34], mental health [35], and critical illness [36]. This underscores that the CFIR is a well-utilized and evidenced-based framework for conducting reviews on implementation considerations. The application of an implementation framework in peer support research can help organize barriers and facilitators in a more standardized manner, thereby improving the potential to inform implementation strategies [35]. The CFIR is comprised of five major domains which may affect implementation:

(1) Intervention characteristics (features of intervention, such as stakeholder perceptions, intervention complexity)
(2) Inner setting (features of the implementing organization, such as implementation climate, leadership engagement)
(3) Outer setting (features of the external context or environment, such as external policy and incentives)
(4) Characteristics of individuals involved in implementation (such as individual knowledge and beliefs about the intervention)
(5) Implementation process (strategies or tactics that might influence implementation, such as engaging appropriate individuals in the implementation and use)

By using the CFIR to evaluate the factors that impact implementation of peer support programming for trauma survivors, our review can inform future efforts aimed at optimizing peer support design and delivery for this patient population.

2. RESEARCH GAPS AND OBJECTIVES

Although there is a growing body of evidence pertaining to peer support amongst amputees and SCI survivors, a great deal of literature has disproportionately focused on military and traumatic brain injury (TBI) populations [37,38]. Peer support interventions for military personnel are not widely transferable to all trauma populations given their focus on mitigating combat-related PTSD and offering crisis management support [39,40]. Similarly, peer support research in TBI populations emphasizes the neurological sequelae of injury and the associated psychosocial support needs that peers fulfill [41]. In turn, this evidence may not broadly apply to trauma patients who sustain predominantly physical injuries (e.g. burns, amputations).

In order to address these issues, we conducted a scoping to synthesize the literature on peer support for those who incurred a traumatic injury outside the context of military service and whose injury was not a TBI. A scoping review methodology was selected because it enables a comprehensive review of available literature without restrictive inclusion criteria regarding study design or quality [42]. This was well-aligned with our goal of including a breadth of literature across multiple designs to address our specific objectives, which were to:

1. Examine the role of peer support in trauma survivors' recovery
2. Describe the nature and extent of peer support programming for trauma patients
3. Examine the influence of peer support on trauma survivors' health and well-being
4. Identify the barriers and facilitators to developing and implementing peer support programming for trauma patients

3. METHODS

Scoping reviews examine the extent, range and nature of research activity for an evolving body of research [43]. For this review, we followed Arksey and O'Malley's methodological framework which entails five stages: (i) identifying the research questions; (ii) identifying relevant studies; (iii) study selection; (iv) charting the data; and (v) collating, summarizing and reporting the results [42]. Our review protocol is registered with the Open Science Framework (https://osf.io/dsyzc) and our report is written in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist [44] (Appendix A). This review did not require Research Ethics Board approval.

Framework stage 1: Identifying the Research Question(s): The specific research questions that guided this scoping review were: 1) What are the functions of peer support in individuals' recovery after a traumatic injury? 2) What is the content, format, and structure of peer support programs that exist for trauma survivors?; 3) How does peer support influence trauma survivors' health and well-being?; and 4) What are the facilitators and barriers to implementing peer support programming?

Framework stage 2: Identifying Relevant Studies: We searched Medline, PsychINFO, Embase, and CINAHL on November 22nd, 2019. The search strategy was tailored to each database using key terms that included "peer support", "trauma" and "injury" (See Appendix B for Medline search strategy). A hand-search of included studies' references was conducted to identify additional literature that may not have been captured by the electronic database search.

The database searches produced 3741 studies for consideration. After duplicates were eliminated, 2642 articles remained. A two-phase screening process was undertaken. For Phase 1, one author (JR) reviewed the title and abstracts to determine if they were eligible for full-text review. This resulted in the identification of 218 articles for full-text review. For Phase 2, two authors (JR & MBW) first screened 10% of the articles to establish inter-rater reliability (k=0.793, 91% agreement). Discrepancies were resolved by consensus. JR then proceeded to screen the remainder of the articles, where 71 met the inclusion/exclusion criteria and were included in the review. Our updated search on January 26th, 2021 produced an additional 18 articles for inclusion.

Framework stage 3: Study Selection: We included English articles focused on some aspect of peer support for adults who sustained a traumatic injury (including musculoskeletal injuries, spinal cord injuries (SCI), burns, and amputations). Research articles reporting both primary and secondary data were included. Articles were excluded if: a) they focused on traumatic brain injuries; b) they focused on military-related traumatic injuries; c) less than 25% of the study sample was comprised of individuals with traumatic injuries; and d) they focused on pediatric populations. We also excluded unpublished dissertations, study protocols, and conference proceedings.

Framework stage 4: Charting the Data: This step entailed iteratively identifying and 'charting' key ideas and themes across studies. A data extraction chart facilitated identification of key information related to our research questions, including: (i) traumatic injury population (e.g. burns, amputation); (ii) peer support program's goals, duration, frequency, structure and content; and (iii) main findings (e.g. impact of peer support on health and social outcomes, needs met by support from peers).

Framework stage 5: Collating, Summarizing and Reporting the Results: A narrative synthesis of included studies was completed [45]. The narrative approach to 'mapping the literature' enables an analysis of the relationships within and between studies [45,46]. Two authors JR & MBW engaged in this analysis, which was iteratively conducted by comparing information across studies, combining similar concepts, and summarizing overarching ideas in accordance with the frameworks guiding the review (i.e. the CFIR and Peers for Progress Framework). Specifically, we synthesized and described the functions of peer support amongst trauma survivors according to the components of the Peers for Progress Framework and summarized the factors that enable or challenge the implementation of peer support according to the CFIR elements. Analysis occurred through discussion and electronic documentation. In alignment with Arskey & O'Malley [42] and Pham et al [47], we chose not to perform a quality assessment or limit inclusion of studies based on their methodological rigor. Like these authors, we felt that including a breadth of literature (regardless of quality) was best-suited to our goal of producing a complete overview of the growing body of literature focused on peer support for non-TBI and non-military trauma survivors.

4. RESULTS

Of the 90 articles eligible for inclusion in our review (See figure 1 for PRISMA diagram), 58 articles included information about the functions of peer support and the nature and extent of peer support programming for trauma survivors and 66 articles included information about factors that affect the implementation of peer support programming for trauma survivors. Seventy-nine articles reported primary data (87.8%) while 11 reported secondary data (12.2%). Studies reporting primary data used primarily qualitative methods (*n*=36), non-randomized/single group trials (*n*=10), cross-sectional surveys (*n*=10), and mixed methods (*n*=6). Most studies were conducted in the USA (*n*=43), Canada (*n*=21), and Australia (*n*=11). Studies focused on various trauma populations including SCI (*n*=50), burns (*n*=18), general trauma (*n*=12), and amputees (*n*=7). Full study details can be found in table 1. <INSERT TABLE 1 HERE>

4.1. Functions of Peer Support in Trauma Survivors' Recovery

Using the Peers for Progress Framework [23], we organized the functions of peer support into the following categories: a) assistance in daily management (e.g. goal setting, skill building, problem solving); b) emotional and social support (e.g. encouragement to use new skills, dealing with stress, talking through emotions); c) linkages or clinical care (e.g. liaison to clinical care, patient activation to ask questions and assert themselves); and d) ongoing support (e.g. flexible, proactive, on-demand as needed over time).

Assistance in daily management: Trauma survivors reported learning a great deal from their peers when it came to managing their injury and navigating post-injury life. This learning took place via education and information-sharing [48-54], advice and feedback from peers [49,53,55,56], observing or witnessing peers (e.g. peers demonstrating practical skills like getting into a wheelchair) [6,21,50,57-59], as well as through conversation and experience-sharing with peers [50,59-63]. Specifically, trauma survivors learned to acquire and master new skills [57,64], and navigate new challenges through problem-solving (e.g. how to eat at a restaurant, how to travel by plane, how to use accessibility devices) [6,51-53,58-61,64-67]. Peers also provided trauma survivors with vocational support [68], motivation and confidence to recover and achieve new goals [50,58,69], and helped them to push their boundaries and realize their potential [6,54,62,64].

Emotional and social support: Trauma survivors received a range of emotional and social support from their peers stemming from shared lived experiences [53,59,64]. Emotional and social supports included a sense of belonging and acceptance, which often mitigated feelings of isolation [6,12,50,51,53,57,58,64,70-74]. Peers also helped trauma survivors to cope with challenges [66,75,76] and maintain their well-being [48,58,76-79]. Trauma survivors felt understood [50,51,80], inspired [70], and validated by peers [62]. Peers also provided trauma survivors with hope and insight for the future [54,59,71,80-82], comfort and acceptance of their situation [12,57,58], and a sense of agency and control over their lives [57].

Linkages to clinical care: Only two articles mentioned linkages to clinical care, with one highlighting that support from peers motivated amputees to ask questions about their treatments [52] and another indicating that peers helped women with SCIs reengage with the healthcare system in an empowered way after having previously had bad experiences [74]. Information and support from peers promoted informed decision making and allowed trauma survivors to exercise control over their healthcare decisions.

Ongoing support: Ongoing support from peers can be challenging once trauma survivors leave the hospital setting and return to the community [48]. Sustained access to peer support is valued and needed—with many viewing it as a key aspect of the recovery process and source of continued friendship [6,12,49,83-85]. Flexibility in interaction modalities and scheduling could improve ongoing support from peers (e.g. in-person interaction when peers are geographically close; online interaction when at a distance) [50,59,66].

Mentors' needs met by providing peer support: In addition the functions of peer support for trauma survivors themselves, it was apparent that *providing* support benefited mentors as well. Mentors felt that providing support was fulfilling, gave their life meaning, made them feel valued, and contributed to their own recovery and adjustment to injury [50,57,66,84,86]. Further, providing peer support helped mentors build connections with others and improved their own community competence [87].

4.2. The Nature and Extent of Peer Support Programming for Trauma Survivors

Peer Support Interventions Described: Twenty-two articles reported on peer support interventions. Of those, three were randomized controlled trials [88-90], three were non-randomized trials [91-93], fourteen were single groups designs [9,49,60,65,69,74,83,94-100], one was a prospective cohort study [101], and one study was a summary article [102].

The peer support interventions catered to the following trauma populations: SCI (n=13) [49,60,65,69,74,89,90,92,94,96-99], general trauma (specific injury mechanism unspecified) (n=5) [9,88,91,93,101], amputee (n=3) [83,100,102], and burns (n=1) [95]. Most programs were offered in the community (n=11) [69,74,83,88-90,94,96-99] and entailed one-on-one peer visitation (n=16) [9,60,65,69,89-95,97,99-102]. The programs were offered using various modalities including exclusively in-person (n=9) [49,65,83,88,94-96,100,102], telephone (n=5) [69,74,90,97,99], and online (n=1) [98], or a combination of in-person, telephone, and online (n=7) [9,60,89,91-93,101]. The majority of programs entailed researcher-designed components and features (n=13) [53,65,69,83,88-90,94,96,97,99,100,102] followed by programs that were developed with feedback from survivors and other stakeholders (n=9).

The majority of programs were flexibly designed, allowing for trauma survivors and/or peers to determine the nature of interaction and support provision (n=17) [9,60,65,69,88-95,97,99-102]. Other programs were exclusively peer led education sessions (n=3) [83,96,98] or program content was not specified in detail (n=1) [49]. A detailed description of each peer support program's goals and specific content can be found in table 2.
<INSERT TABLE 2 HERE>

Qualitative Findings: Of the 22 articles reporting peer support interventions, six reported qualitative findings [49,60,74,83,98,99]. Qualitative findings included participant experiences with peer support broadly (n=2) [60,99], perspectives on peer support programming specifically (n=4) [49,74,83,99], experiences with specific elements of peer support interventions (n=1) [99], perspectives on the quality of support received (n=1) [60], changes to knowledge and behavior related to preventing secondary conditions and living with injury (n=1) [60], participants' peer support preferences (n=1) [98], and suggestions for technology and educational content (n=1) [98].

Overall, participants reported that peer support provided them with hope for the future [49,83], provided psychological support for them [49,60] and their families [49], and provided them with relevant education [49,60,74,83,98].

<u>Quantitative Outcomes</u>: Of the 22 articles reporting peer support interventions, quantitative outcomes were reported in 12 articles. Self-efficacy (n=9) [60,88,89,91-94,96,101] and depression (n=3) [91-93] were the most commonly reported outcomes. Significant improvements in self-efficacy were seen post-intervention [88,94,96] and at follow-up in several studies [60,89,93]. A significant association between improvement in self-efficacy and reduced hospital readmissions was reported for the peer support intervention group in one study [92]. Participants in the experimental group of another study rated their likelihood of recovery and of returning to daily activities significantly higher compared to controls [101]. One study reported no change [91]. Lower rates of depression were reported in two studies [91,93] and one study reported no change [92]. Further details pertaining to quantitative outcomes can be found in table 3.
<INSERT TABLE 3 HERE>

<u>User Experience Outcomes</u>: Six articles reported user experience outcomes [65,69,91,95,98,100]. Participant satisfaction was reported in each of the articles. Satisfaction with the peer support program or the match to a mentor was consistently favourable [69,91,95,100]. Satisfaction with the number of peer visits varied, with one study reporting that participants wanted more peer meetings [100] and another study reporting that participants were satisfied with the number of peer meetings that took place [65]. Further details pertaining to user experience outcomes can be found in table 4.
<INSERT TABLE 4 HERE>

4.3. Barriers and Facilitators to Developing and Implementing Peer Support Programming

4.3.1. Intervention Characteristics:

<u>Peer Mentor' Skills</u>
Hoffmann et al describe peer mentors as individuals who do not need specific qualifications but are required to have a range of positive personal characteristics [65]. Examples of positive personal characteristics include being a good listener [21,65], sincere [21,65], non-

judgmental [21], empathetic [21], having excellent communication skills [103], and having a good sense of humor [49]. In a study training volunteer peer mentors, training in motivational interviewing and brief action planning was well received and peer mentors reported significantly improved skills and call quality [104].

Research examining two groups of peer mentors, those who were employed as peer mentors versus peer mentors who were not paid employees, revealed that employed peer mentors tended to have higher pre-injury education, were more satisfied with their level of resource knowledge, and were less likely to interpret a lack of knowledge as a barrier to success [87]. Employed peer mentors were more likely to discuss different barriers to accessing community resources with mentees and discuss strategies for maintaining and using the resources available in their community (e.g., rehabilitation hospital, Social Security office, and the participants' medical supply company and wheelchair company) [87].

Flexible Intervention Delivery

Many participants preferred programs with flexibility [49,50,64,69]. Participants preferred sessions that were not time-constrained [50] and allowed the use of text messaging [69,99]. Participants felt frustrated by programs that prohibited contact between sessions [105]. As an example, Gassaway et al found that because the intervention allowed for participants to guide interactions, they would initiate contact with their mentor when they had concerns or required emotional support between sessions [89].

Participant engagement in peer support interventions were supported through experienced facilitators who allowed participants to express themselves and created a positive atmosphere [74], the use of personalized support packages [69] and by peer mentors who reported more call attempts to mentees than required by the study protocol [69]. Some trauma survivors reported not being aware of peer support programs or how to access them [105,106], or learning about the programs late in their recovery [71]. One article reported unpredictable program attendance [57]. Participants suggested programs could be incorporated into routine care to raise awareness [71] and strategies to improve advertisement and recruitment efforts were discussed [57].

Intervention Content

Participants reported a strong interest in sports activities (e.g. swimming, wheelchair sports) [48,51] and creative activities (e.g. theatre, cooking) [51] in a relaxed or informal environment. One study indicated that informal social gatherings could improve peer support group attendance because the program may be perceived as less threatening than structured groups [71]. A peer support intervention co-designed with SCI stakeholders included guest speakers on topics to improve health and well-being [74]. Davis et al suggested educational lectures and an open format group discussion to meet the educational needs of trauma survivors and promote emotional support [57].

Online Support Delivery

Participants with SCI reported using online resources for emotional support, problem focused support, and to reduce social isolation [66,107,108]. In another SCI study, participants were satisfied with the educational videos and with video chat features to connect with a peer remotely [98]. A recommendation was made to use technology to reach trauma survivors living in rural communities [71]. However, burn survivors reported that online and telephone resources were the least preferred method of peer support [51] and phone modality was reported to be difficult to use by a person with tetraplegia [74].

4.3.2. Inner Setting

Organization Resources and Priorities

In resource constrained environments, healthcare professionals provided trauma survivors with information about local support groups as part of their discharge plan [6], use existing materials from nationally available peer support programs [18], and leverage existing hospital resources to improve peer support services [9]. The relative priority of implementing peer support programs was a barrier among institutions. These examples include programs with competing priorities [109], a lack of institutional mandate to implement a peer support program [110], a lack of effort to integrate the program within the institution [111], and not providing program coordinators with necessary support [111].

Healthcare Professional Perceptions

Two articles reported healthcare professionals' concerns with peer support. One article reported possible concerns including survivors feeling pressured to disclose information that they are not ready to share, feeling overwhelmed by the emotional responses to sensitive topics, and receiving feedback from peers that are misguided or harmful [112]. A second article reported concerns about group learning including survivor discouragement from comparing their recovery process to others, a need for individual teaching, and the effects of a negative person in the group.

Uniqueness of Inpatient Rehabilitation

Hospital units and group therapy programs facilitated the formation of informal support networks [83,107,113-116], and trauma survivors were more likely to have heard about peer support during their hospital stay [61,106]. Trauma survivors reported engaging in peer encouragement and educating their peers on an informal basis [84]. Trauma survivors kept in touch with the friends they made in the hospital once they were discharged to the community and continued to engage in peer encouragement [84].

4.3.3. Characteristics of the Individuals Involved:

Type of Traumatic Injury

Participants reported that acceptance of peer support was influenced by when it was introduced, and that optimal timing varies according to the type of traumatic injury incurred [55,62,80,81,83,117]. Participants with SCI reported that the acute stage of injury was too early in their recovery phase [55] and participants with burn injuries reported that their hospital stay was a blur and that burn survivors should be approached after acute care or when they have returned to the community [106]. To facilitate acceptance, burn survivors suggested offering the peer support at multiple points during recovery [71]. Conversely, participants who had life-saving amputations were able to prepare for their procedures by seeking support from peers early on [83]. Amputees preferred that the first peer visit take place one-on-one and that information be shared verbally (rather than in written form) [67]. A third of trauma survivors in a study by Baldwin et al reported that they wished they had heard about peer support programs while they were in the hospital [106].

Participant Preferences, Perceptions and Experiences

Trauma survivors reported a number of reasons for declining peer support including the belief that the negativity of others would impact their recovery [66,70], the stigma or feelings of shame and embarrassment with seeking mental health support [71,105], concerns about privacy and confidentiality [105], and believing that their injuries are not severe enough to merit peer support [51]. Papamikrouli et al suggest that trauma survivors may believe that peer support is only suitable for people who are in the greatest need and there may be a stigma associated with attending peer support activities [51]. Three studies examining injury severity and peer support utilization reported that survivors who used peer support services were more severely injured [118], had a larger mean burn size [119], and more peer visits were associated with longer average hospital stay [120].

Many of the study participants reported that establishing a good mentor-mentee match based on similar age, interests, level of injury, and gender was important [49,55,62,70,80,100,107]. Participants mostly preferred and valued one-on-one contact [12,51,57,105,107,121]. When talking to peers, they preferred the informal language they could use [63,64], felt that the educational information they received from peers was more informative and engaging [49,63,67,107,122,123], felt that peers understood them better [54,62,64,70,107,114], and were more helpful than healthcare professionals [50]. Lucke et al reported differences between male and female peer support preferences, with female participants preferring to meet their peers and engage socially whereas male participants used the resources provided by the intervention to find their own peer support [97].

There were instances of trauma survivors reporting negative peer support experiences. Examples of negative experiences includes "need-thwarting" when mentors did not support the needs of the trauma survivor or discouraged a goal [50,100], when mentors were found to be depressed [62], having a mentor who was not a good listener [21], and having a mentor who was interested in dating mentees [21]. A study comparing pressure injury knowledge between mentors and mentees found that although mentors demonstrated greater knowledge, both groups fell below the mean knowledge score (73.4%) to effectively prevent pressure injuries [124].

Peer Mentor-Related Considerations

Trauma survivors expressed interest in becoming peer mentors [51,52,84,86] a sentiment shared by survivors who did not receive peer support during their recovery [51,86]. Survivors reported that their lived experience put them in a unique position to offer support [64,86] and that helping others was a part of their recovery process [21,62,64,86]. However, mentors also reported specific concerns about providing support such as the emotional cost associated with seeing others in distress [21,86] and being at physical risk due to their disability [86]. Mentors from a study by Houlihan et al found team calls with other mentors to be important for problem solving and for ongoing support [69]. In addition, inconsistencies in training or a lack of training contributed to uncertainty over the peer mentor role [86].

Family Involvement

Trauma survivors reported that family presence was an important factor to successful recovery [61] and community reintegration [121]. Trauma survivors who had family present during peer visits reported being more hopeful about the future than trauma survivors who were seen alone [100]. Family members of burn survivors reported benefiting from the peer support visits while in the intensive care unit [71]. Two articles suggested that family should play a role in introducing peer support to trauma survivors [71,84].

4.3.4. Outer Setting and Implementation Process

Implementation Process Considerations

There were a significant number of barriers to peer support program implementation. Examples included a lack of dedicated funding and start-up costs [9,109,110], and a lack of interdepartmental cooperation [110,111]. In addition, administrative burdens hampered program implementation when staff had difficulty securing dedicated space to run the program [111], difficulty obtaining legal agreements [110], and difficulty obtaining institutional approval for print materials [111]. There was evidence of difficulty with onboarding peer mentors due to issues with improperly screened or trained volunteer peers [110,111]. Moreover, a lack of evidence of the effectiveness of the program being implemented was seen as a barrier [110,111]. A scoping review of peer led interventions for people living with SCI concluded that this area of research was still in its infancy and more rigorous and generalizable research is required [125].

Suggestions for successful peer support implementation include having strong site coordinators who can manage the program [111], increasing staff buy-in by including hospital administrators in training [110], and using community based participatory research to develop programs with relevant stakeholders [126]. Studies reported that some hospitals absorbed peer support program costs after initial implementation and piloting [9] when the institutions identified a need for a psychosocial program for their trauma patients [111] and when the program aligned with the institutions' culture and values [109]. Frey et al suggested that program buy-in would increase from marketing strategies to promote the hospital and differentiate it from other sites [111] and by making peer support programs a requirement for trauma centre certification [111].

Community-Related Considerations

Peer support was a common unmet need among trauma survivors [64,71,108,127-130]. A survey of community organizations that provided peer support revealed that the programs were operating with fewer than the desired number of peer mentors and that they did not collect outcome data due to a lack of resources and knowledge of which outcomes to collect [131]. Generally, low and lower middle income countries reported fewer peer mentors and higher participant to peer ratios compared to high income countries [132]. The financial cost [107], transportation, and travel distance was a barrier [48,50,91,106] especially among trauma survivors living in rural communities who reported losing peer support when they left urban area hospitals [48].

5. DISCUSSION

This scoping review provides a comprehensive synthesis of existing peer support initiatives for trauma survivors who sustained a non-TBI and non-military injury. In total, we identified 93 eligible articles focused on several physical injury populations including amputees, burns survivors, and SCI. Our review highlights peer support as an important component of care and support for trauma survivors throughout their recovery, with peers providing primarily socioemotional support, assistance in daily management, and life navigation post-injury. Recovery is complex and entails not only physical recovery, but also emotional and psychological recovery. This includes learning to cope with post-injury sequela and adapt to a ‘new normal’ [116]. Recovery is an ongoing process that may last months to years, often with lifelong aftereffects [133], highlighting the value of ongoing support from peers. We identified several support programs that aimed to connect trauma survivors with peers who could help them manage their recovery. Most programs were offered to trauma survivors in the community and provided them with one-on-one support and coaching from peer mentors using various modalities (e.g. in person, online). Overall, trauma survivors reported that peer support provided hope and guidance for the future after injury and studies indicated that peer support interventions improved self-efficacy amongst trauma survivors. Further, several barriers and facilitators to implementation of peer support programming were identified across all domains of the CFIR. By mitigating these barriers and leveraging the facilitators, there is potential to optimize the provision of peer support to trauma survivors.

Role of Peer Support for Trauma Survivors

Each function outlined by the Peers for Progress’s Framework was mentioned by at least one article included in our review. However, few studies reported peers acting as a source of ongoing support or as a linkage to clinical care. Although peers are a known source of knowledge about when and what to ask of healthcare providers and how to identify community resources [134], this was not explicitly reported as a benefit of peer support by included studies. Only one study found that trauma survivors who participated in the peer support intervention reported significantly greater service awareness and service use [90]. In chronic illness populations, it has been suggested that the link to clinical care be more formalized by having peers involved in every practice/service’s care delivery model [135].

Trauma survivors’ experiences are also similar to those with chronic illnesses in as far as their peer support needs extend over time, where ongoing peer support can promote sustained health promotion, behavior change, and social support [134]. In chronic illness populations (e.g. diabetes), ongoing peer support has been highlighted as particularly necessary during life and care transitions [136]. Given that trauma survivors experience several post-injury transitions across the continuum of care [13], enhancing the consistent and sustained availability of peer support to this population can be especially beneficial for their recovery journey. Key elements of patient-centered care transitions for trauma survivors can include care coordination across settings and the provision of continuous helping relationships [13]. Peer support programs that are integrated into the care pathway of trauma survivors can achieve these goals but further research and trials of such a model are needed [13].

Nature and Extent of Peer Support Programming

Like others [137], we found little consistency in the reporting of the peer support intervention details (e.g. design, components, frequency, duration) and evaluations. Some research has suggested that part of the challenge lies in the fact that 'peer support' encompasses various service types and organizational structures, with few overlapping features across interventions [138]. It is possible that the variability in intervention characteristics stems from recommendations to standardize peer support interventions for specific populations by function rather than content [134]. Doing so allows them to be designed and implemented in a way that caters to specific settings and clinical populations. In turn, care must be taken to ensure that standardization of programs and reporting not undermine the unique, flexible and individualized aspects of peer support programing [134]. An added complication with standardization of interventions and reporting arises from the inherently subjective benefits of peer support. Notably, perceptions of support and support quality are more highly correlated with positive health and social outcomes than quantitative measures of frequency and dose (which are far less correlated with recovery indicators) [138]. This underscores that standard reporting of peer support intervention goals, functions, content and outcomes provides important context to compare data across existing studies and with future research. We suggest, at minimum, that studies report:

1. The traumatic injury population the intervention is intended for,
2. The functions of peer support that the intervention aims to achieve,
3. Content details (i.e. what the intervention entails),
4. Timing, frequency and duration of peer support interventions (e.g. when intervention started/ended, how often sessions/interactions took place, length of individual sessions),
5. Health and social outcomes evaluated and measures used.

Barriers and Facilitators to Peer Support Programming

Intervention Characteristics: Positive perceptions of peer support facilitated uptake, however we noted some discrepancies between patient and provider perspectives. While peer support programs were largely viewed as beneficial by patients, providers had concerns related to patient safety and well-being—with particular emphasis on the appropriate timing of peer support [49]. This is not uncommon, with other researchers suggesting that providers wish to protect trauma patients at the height of their vulnerability [139]. One strategy to overcome these challenges is to co-design peer support interventions with providers and engage them in the implementation (i.e. ensure they are part of developing and facilitating peer support initiatives) [140]. This might be one approach to enhance "buy in" from reluctant providers and address the disconnect between those doing research in this area and those who ultimately provide and facilitate psychosocial rehab [139].

Inner Setting*:* Peer support programs were well-received by organizations when they aligned with their values, whereas implementation was challenged when organizations had other competing priorities and there was little support from senior leaders and administrators. The decision about when and where to implement peer support interventions in the care trajectory has been a long-standing challenge [137]. Strategically aligning the intervention with both organizational goals and access to the target population can help inform when in the continuum of care the intervention is best-introduced and the most appropriate setting [137]. To this end, our review highlighted that inpatient rehabilitation appears uniquely positioned to facilitate peer support given the organic interaction that takes place amongst patients during their stay, the recovery-oriented nature of care provided, and the ability to transition peer support relationships back to the community. However, skepticism by health care professionals can limit the effective use of peer support interventions in physical medicine and rehabilitation, further underscoring the value and importance of stakeholder buy in and need for ‘champions’ [137].

Characteristics of the Individuals Involved: Prior negative experiences along with concerns about stigma and privacy deterred trauma survivors from participating in peer support. Many peer mentors were available and willing to support programs but managing mentor burden was a notable challenge. As others have pointed out, these issues underscore the importance of education about peer support programing for both trauma survivors and peer mentors, and training specifically for mentors in order to optimize implementation [35].

Outer Setting and Implementation Process: Most of the challenges to implementing peer support programing overlapped with outer setting constraints (e.g. costs and resource demands of ongoing peer support in community). This points to the need for higher-quality evaluations of peer support initiatives in order to quantify their impact on key outcomes such as healthcare utilization, hospital readmissions, community reintegration, health-related quality of life, and return to work [137]. Evaluative studies in our review point to the potential for peer support programs to improve health and social outcomes for trauma survivors and qualitative studies provided narrative insight into these benefits. Through the conduct of more rigorous trials and greater standardization in reporting, organizations will have the evidence they require to justify and support the integration of peer support into standard care practices.

6. STRENGTHS AND LIMITATIONS

To the best of our knowledge, this is the first review to report on peer support across traumatic injury populations. Our inclusion of both quantitative and qualitative evidence produced a more holistic understanding of how peer support impacts objective health outcomes and is subjectively experienced by trauma survivors. A limitation of our review may stem from our exclusion of articles where the sample composition was unclear. While we did this to ensure we were summarizing evidence based on trauma survivors’ experiences specifically, these articles may have findings and conclusions based on our population of interest that were missed. Our review also did not evaluate the quality of evidence for the articles included. Finally, our review represents the first instance of applying the Peers for Progress Framework to a patient population other than diabetes (which it was originally developed based on). Although the application of a theoretical framework can contribute to the goal of enhanced standardization in peer support research, traumatic injury survivors are a distinct population from those who suffer from chronic conditions like diabetes. Thus, the Peers for Progress Framework may be limited in its applicability and future research should endeavor to further explore its utility with this population.

7. CONCLUSIONS

This review identified a number of peer support initiatives for trauma survivors that sustained non-TBI and non-military injuries. Peers are an important source of support for trauma survivors, fulfilling several functions throughout individuals' recovery that may not otherwise be met within existing health care systems. Peer support interventions can be optimally implemented when they are flexible, align with organizations' culture and mission, and have sufficient 'buy in' from key stakeholders. More evaluative research and robust evidence is needed to further establish the value of peer support and garner support for implementation. To this end, standardization of design and reporting of peer support studies would better-enable evidence synthesis and comparison across existing and future studies.

Acknowledgements

We wish to acknowledge Mr. Henry Lam —academic librarian at Sunnybrook Health Sciences Centre —for his assistance with crafting and deploying the literature search strategy. We also wish to acknowledge funding support from the Sunnybrook Health Sciences Centre's Education Scholarship and Research Grant program.

Declaration of Interest

The authors report no conflicts of interest

REFERENCES

1. Mock C, Lormand J, Goosen J, et al. Guidelines for essential trauma care. Geneva: World Health Organization; 2004.
2. University of Florida Health. Traumatic Injury: University of Florida Health; [cited 2020 2/18]. Available from: https://ufhealth.org/traumatic-injury
3. Parachute Canada. The cost of injury in Canada. 2.2 ed. Toronto, ON 2015.
4. Nawar EW, Niska RW, Xu J. National hospital ambulatory medical care survey: 2005 emergency department summary. Advance Data. 2007;386:1-32.
5. Lambers K, Ootes D, Ring D. Incidence of patients with lower extremity injuries presenting to US emergency departments by anatomic region, disease category, and age. Clinical Orthopaedics and Related Research. 2012;470(1):284-290.
6. Vincent HK, Horodyski M, Vincent KR, et al. Psychological distress after orthopedic trauma: prevalence in patients and implications for rehabilitation. PM&R. 2015;7(9):978-989.
7. Evans CC, DeWit Y, Seitz D, et al. Mental health outcomes after major trauma in Ontario: a population-based analysis. Canadian Medical Association Journal. 2018;190(45):E1319-E1327.
8. Danielsson F, Larsen MS, Nørgaard B, et al. Quality of life and level of post-traumatic stress disorder among trauma patients: A comparative study between a regional and a university hospital. Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine. 2018;26(1):44.
9. Bradford AN, Castillo RC, Carlini AR, et al. The Trauma Survivors Network: Survive. Connect. Rebuild. Journal of Trauma and Acute Care Surgery. 2011;70(6):1557-1560.
10. Conn LG, Zwaiman A, DasGupta T, et al. Trauma patient discharge and care transition experiences: Identifying opportunities for quality improvement in trauma centres. Injury. 2018;49(1):97-103.
11. Hitzig S, Babatunde F, Colantonio A, et al. Developing a Patient-Oriented Rehabilitation Research Agenda. Toronto, ON, Canada: CIHR; 2018.
12. Badger K, Royse D. Helping others heal: burn survivors and peer support. Social Work in Health Care. 2010;49(1):1-18.
13. Zatzick D, Russo J, Thomas P, et al. Patient-centered care transitions after injury hospitalization: a comparative effectiveness trial. Psychiatry. 2018;81(2):141-157.
14. Jones M, Gassaway J. Peer-supported self-management to facilitate community re-entry after discharge from spinal cord injury rehabilitation: Engaging peers as change agents and research partners. Annals of Physical and Rehabilitation Medicine. 2016;59:e128-e129.
15. Mental Health Foundation. Peer Support: Mental Health Foundation; 2019 [cited 2020 01/08]. Available from: https://www.mentalhealth.org.uk/a-to-z/p/peer-support.
16. Waites B, Zigmond A. Psychological impact of amputation. Therapy for Amputees. Vol. 3. Edinburg: Churchill Livingstone; 1999. p. 27-39.
17. Hibbard MR, Cantor J, Charatz H, et al. Peer support in the community: initial findings of a mentoring program for individuals with traumatic brain injury and their families. The Journal of Head Trauma Rehabilitation. 2002;17(2):112-131.
18. Reichmann JP, Bartman KR. An integrative review of peer support for patients undergoing major limb amputation. Journal of Vascular Nursing. 2018;36(1):34-39.

19. Shaikh MM, Nadar SK. Peer-Facilitated Patient Education: An underutilised resource. Sultan Qaboos University Medical Journal. 2018;18(1):e1-e2.
20. National Academies of Sciences Engineering Medicine. A national trauma care system: integrating military and civilian trauma systems to achieve zero preventable deaths after injury. National Academies Press; 2016.
21. Badger K, Royse D. Adult burn survivors' views of peer support: a qualitative study. Social Work in Health Care. 2010;49(4):299-313.
22. House JS. Work stress and social support. 4 ed. Reading, Mass: Addison-Wesley Pub. Co; 1981 1981. (Addison-Wesley Series on Occupational Stress).
23. Boothroyd RI, Fisher EB. Peers for progress: promoting peer support for health around the world. Family Practice. 2010;27(Suppl 1):i62-i68.
24. Peers for Progress, editor Global evidence for peer support: humanizing health care. Report from an International Conference hosted by Peers for Progress and the National Council of La Raza; 2014: American Academy of Family Physicans Foundation Leawood, KS.
25. Shepardson RL, Johnson EM, Possemato K, et al. Perceived barriers and facilitators to implementation of peer support in Veterans Health Administration Primary Care-Mental Health Integration settings. Psychological Services. 2019;16(3):433-444.
26. May C. Towards a general theory of implementation. Implementation Science. 2013;8(1):1-14.
27. Aziz Z, Riddell MA, Absetz P, et al. Peer support to improve diabetes care: an implementation evaluation of the Australasian Peers for Progress Diabetes Program. BMC Public Health. 2018;18(1):1-12.
28. Keith RE, Crosson JC, O'Malley AS, et al. Using the Consolidated Framework for Implementation Research (CFIR) to produce actionable findings: a rapid-cycle evaluation approach to improving implementation. Implementation Science. 2017;12(1):1-12.
29. Damschroder L, Hall C, Gillon L, et al. The Consolidated Framework for Implementation Research (CFIR): progress to date, tools and resources, and plans for the future. Implementation Science. 2015;10(1):A12.
30. Kadu MK, Stolee P. Facilitators and barriers of implementing the chronic care model in primary care: a systematic review. BMC Family Practice. 2015;16(1):1-14.
31. Briggs MS, Rethman KK, Crookes J, et al. Implementing patient-reported outcome measures in outpatient rehabilitation settings: a systematic review of facilitators and barriers using the consolidated framework for implementation research. Archives of Physical Medicine and Rehabilitation. 2020;101(10):1796-1812.
32. Weir NM, Newham R, Dunlop E, et al. Factors influencing national implementation of innovations within community pharmacy: a systematic review applying the Consolidated Framework for Implementation Research. Implementation Science. 2019;14(1):1-16.
33. Ross J, Stevenson F, Lau R, et al. Factors that influence the implementation of e-health: a systematic review of systematic reviews (an update). Implementation Science. 2016;11(1):1-12.
34. Mwangi N, Bascaran C, Ramke J, et al. Peer-support to increase uptake of screening for diabetic retinopathy: process evaluation of the DURE cluster randomized trial. Tropical Medicine and Health. 2020;48(1):1-17.
35. Mutschler C, Bellamy C, Davidson L, et al. Implementation of peer support in mental health services: A systematic review of the literature. Psychological Services. 2021.

36. Haines KJ, McPeake J, Hibbert E, et al. Enablers and barriers to implementing ICU follow-up clinics and peer support groups following critical illness: the Thrive Collaboratives. Critical Care Medicine. 2019;47(9):1194.
37. Hundt NE, Robinson A, Arney J, et al. Veterans' perspectives on benefits and drawbacks of peer support for posttraumatic stress disorder. Military Medicine. 2015;180(8):851-856.
38. Greden JF, Valenstein M, Spinner J, et al. Buddy-to-Buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression, and suicide. Annals of the New York Academy of Sciences. 2010;1208:90-97.
39. Kumar A, Azevedo KJ, Factor A, et al. Peer support in an outpatient program for veterans with posttraumatic stress disorder: Translating participant experiences into a recovery model. Psychological Services. 2019;16(3):415.
40. Jain S, McLean C, Rosen CS. Is there a hole for peer support delivered interventions in the treatment of veterans with post-traumatic stress disorder? Military Medicine. 2012;177(5):481-483.
41. Levy BB, Luong D, Perrier L, et al. Peer support interventions for individuals with acquired brain injury, cerebral palsy, and spina bifida: a systematic review. BMC Health Services Research. 2019;19(1):1-11.
42. Arksey H, O'malley L. Scoping Studies: Towards a Methodological Framework. International Journal of Social Research Methodology. 2005;8(1):19-32.
43. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. Implementation Science. 2010 2010;5:69.
44. Tricco AC, Lillie E, Zarin W, et al. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. Ann Intern Med. 2018 Oct 2;169(7):467-473.
45. Khan K, terRiet G, Sowden A, et al. Undertaking systematic reviews of research on effectiveness: CRD's guidance for carrying out or commissioning reviews. Centre for Reviews and Dissemination2008.
46. Anderson S, Allen P, Peckham S, et al. Asking the right questions: Scoping studies in the commissioning of research on the organisation and delivery of health services. Health Research Policy and Systems. 2008 2008;6(1):7.
47. Pham MT, Raji-ç A, Greig JD, et al. A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Research Synthesis Methods. 2014 12/1/2014;5(4):371-385.
48. Goodridge D, Rogers M, Klassen L, et al. Access to health and support services: perspectives of people living with a long-term traumatic spinal cord injury in rural and urban areas. Disability and Rehabilitation. 2015;37(16):1401-1410.
49. Haas BM, Price L, Freeman JA. Qualitative evaluation of a Community Peer Support Service for people with spinal cord injury. Spinal Cord. 2013;51(4):295-299.
50. Chemtob K, Caron JG, Fortier MS, et al. Exploring the peer mentorship experiences of adults with spinal cord injury. Rehabilitation Psychology. 2018;63(4):542-552.
51. Papamikrouli E, van Schie CMH, Schoenmaker J, et al. Peer Support Needs Among Adults With Burns. Journal of Burn Care and Research. 2017;38(2):112-120.
52. Dillon MP, Anderson SP, Duke EJ, et al. The lived experience of sequential partial foot and transtibial amputation. Disability and Rehabilitation. 2019:1-9.
53. Chaffey L, Bigby C. Health Education by Peers with Spinal Cord Injury: a Scoping Review. Journal of Developmental and Physical Disabilities. 2018;30(1):141-154.

54. Kornhaber R, Wilson A, Abu-Qamar MZ, et al. Adult burn survivors' personal experiences of rehabilitation: An integrative review. Burns. 2014;40(1):17-29.
55. Munce SEP, Webster F, Fehlings MG, et al. Perceived facilitators and barriers to self-management in individuals with traumatic spinal cord injury: A qualitative descriptive study. BMC Neurology. 2014;14:48.
56. Bailey K, Lenz K, Allison DJ, et al. Barriers and facilitators to adhering to an anti-inflammatory diet for individuals with spinal cord injuries. Health Psychology Open. 2018;5(2):2055102918798732.
57. Davis T, Gorgens K, Shriberg J, et al. Making meaning in a burn peer support group: qualitative analysis of attendee interviews. Journal of Burn Care and Research. 2014;35(5):416-425.
58. Beauchamp MR, Scarlett LJ, Ruissen GR, et al. Peer mentoring of adults with spinal cord injury: a transformational leadership perspective. Disability and Rehabilitation. 2016;38(19):1884-1892.
59. Gassaway J, Houlihan BV, Everhart Skeels S, et al. Force of Peer Mentorship for Persons With Spinal Cord Injury. Archives of Physical Medicine and Rehabilitation. 2018;99(8):1691-1692.
60. Ljungberg I, Kroll T, Libin A, et al. Using peer mentoring for people with spinal cord injury to enhance self-efficacy beliefs and prevent medical complications. Journal of Clinical Nursing. 2011;20(3-4):351-358.
61. Sproul JL, Malloy S, Abriam-Yago K, et al. Perceived sources of support of adult burn survivors. Journal of Burn Care and Research. 2009;30(6):975-982.
62. Tolley JS, Foroushani PS. What do we know about one-to-one peer support for adults with a burn injury? A scoping review. Journal of Burn Care and Research. 2014;35(3):233-242.
63. Standal OF, Jespersen E. Peers as resources for learning: A situated learning approach to adapted physical activity in rehabilitation. Adapted Physical Activity Quarterly. 2008;25(3):208-227.
64. Divanoglou A, Georgiou M. Perceived effectiveness and mechanisms of community peer-based programmes for Spinal Cord Injuries-a systematic review of qualitative findings. Spinal Cord. 2017;55(3):225-234.
65. Hoffmann DD, Sundby J, Biering-Sørensen F, et al. Implementing volunteer peer mentoring as a supplement to professional efforts in primary rehabilitation of persons with spinal cord injury. Spinal Cord. 2019;57(10):881-889.
66. O'Riley AA, Rose J, Dalal B. Online support for individuals with spinal cord injuries: An ethnographic investigation. Journal of Spinal Cord Medicine. 2014;37(2):179-185.
67. Mortimer CM, Steedman WM, McMillan IR, et al. Patient information on phantom limb pain: a focus group study of patient experiences, perceptions and opinions. Health Education Research. 2002;17(3):291-304.
68. Dorstyn D, Murphy G, Potter E, et al. How peer support can assist job-seekers with a disability move into work. Australian Journal of Rehabilitation Counselling. 2020;26(1):7-11.
69. Houlihan BV, Everhart-Skeels S, Gutnick D, et al. Empowering Adults With Chronic Spinal Cord Injury to Prevent Secondary Conditions. Archives of Physical Medicine and Rehabilitation. 2016;97(10):1687-1695.e5.

70. Kornhaber R, Wilson A, Abu-Qamar M, et al. Inpatient peer support for adult burn survivors-A valuable resource: A phenomenological analysis of the Australian experience. Burns. 2015;41(1):110-117.
71. Wiechman V, Holavanahalli R. Burn survivor focus group. Journal of Burn Care and Research. 2017;38(3):e595-e595.
72. Cimino SR, Hitzig SL, Craven BC, et al. An exploration of perceived social isolation among persons with spinal cord injury in Ontario, Canada: a qualitative study. Disability and Rehabilitation. 2020:1-10.
73. Payne JA. Contributions of group learning in the rehabilitation of spinal cord injured adults. Rehabilitation Nursing. 1991;16(6):375-379.
74. Jalovcic D, Pentland W. Accessing peers' and health care experts' wisdom: a telephone peer support program for women with SCI living in rural and remote areas. Topics in Spinal Cord Injury Rehabilitation. 2009;15(1):59-74.
75. Rocchi MA, Zelaya W, Sweet SN. Peer mentorship for adults with spinal cord injury: a static group comparison between mentees and non-mentees' reported coping strategies. Spinal Cord. 2018;56(11):1102-1109.
76. Stewart R, Bhagwanjee A. Promoting group empowerment and self-reliance through participatory research: a case study of people with physical disability. Disability and Rehabilitation. 1999;21(7):338-45.
77. Sherman JE, Sperling KB, DeVinney DJ. Social support and adjustment after spinal cord injury: influence of past peer-mentoring experiences and current live-in partner. Rehabilitation Psychology. 2004;49(2):140-149.
78. Suckow BD, Goodney PP, Nolan BW, et al. Domains that determine quality of life in vascular amputees. Annals of Vascular Surgery. 2015;29(4):722-730.
79. Sweet SN, Michalovic E, Latimer-Cheung AE, et al. Spinal Cord Injury Peer Mentorship: Applying Self-Determination Theory to Explain Quality of Life and Participation. Archives of Physical Medicine and Rehabilitation. 2018;99(3):468-476e.12.
80. Veith EM, Sherman JE, Pellino TA, et al. Qualitative analysis of the peer-mentoring relationship among individuals with spinal cord injury. Rehabilitation Psychology. 2006;51(4):289-298.
81. Papadimitriou C, Stone DA. Addressing existential disruption in traumatic spinal cord injury: a new approach to human temporality in inpatient rehabilitation. Disability and Rehabilitation. 2011;33(21-22):2121-2133.
82. Carrougher GJ, McMullen K, Amtmann D, et al. 'Living Well' After Burn Injury: Using Case Reports to Illustrate Significant Contributions from the Burn Model System Research Program. Journal of Burn Care and Research. 2020;24:398-407.
83. Amorelli C, Yancosek K, Morris R. Amputees Unanimous: A 12-step program. Prosthetics and Orthotics International. 2019;43(3):293-300.
84. Weitzner E, Surca S, Wiese S, et al. Getting on with life: positive experiences of living with a spinal cord injury. Qualitative Health Research. 2011;21(11):1455-1468.
85. Acton A, Badger K, O'Leary J. The Burn Survivor Perspective. Journal of Burn Care and Research. 2017;38(3):e591-e592.
86. Richardson L-J, Molyneaux V, Murray CD. Being a peer support mentor for individuals who have had a lower limb amputation: An interpretative phenomenological analysis. Disability and Rehabilitation. 2020;42(26):3850-3857.

87. Kelly EH. Community competence and violently acquired spinal cord injury: Employment as a peer role model. Rehabilitation Psychology. 2007;52(2):226-235.
88. Best K, Miller WC, Huston G, et al. Peer-led wheelchair training improves wheelchair use self-efficacy and wheelchair skills: A pilot randomized controlled trial. Archives of Physical Medicine and Rehabilitation. 2016;97 (10):37-44.
89. Gassaway J, Jones ML, Sweatman WM, et al. Effects of Peer Mentoring on Self-Efficacy and Hospital Readmission After Inpatient Rehabilitation of Individuals With Spinal Cord Injury: A Randomized Controlled Trial. Archives of Physical Medicine and Rehabilitation. 2017;98(8):1526-1534.e2.
90. Houlihan BV, Brody M, Everhart-Skeels S, et al. Randomized Trial of a Peer-Led, Telephone-Based Empowerment Intervention for Persons With Chronic Spinal Cord Injury Improves Health Self-Management. Archives of Physical Medicine and Rehabilitation. 2017;98(6):1067-1076.e1.
91. Castillo RC, Wegener ST, Newell MZ, et al. Improving outcomes at Level I trauma centers: An early evaluation of the trauma survivors network. Journal of Trauma and Acute Care Surgery. 2013;74(6):1534-1540.
92. Jones ML, Gassaway J, Sweatman WM. Peer mentoring reduces unplanned readmissions and improves self-efficacy following inpatient rehabilitation for individuals with spinal cord injury. Journal of Spinal Cord Medicine. 2019:383-391.
93. Major Extremity Trauma Rehabilitation Consortium. Early Effects of the Trauma Collaborative Care Intervention: Results From a Prospective Multicenter Cluster Clinical Trial. Journal of Orthopaedic Trauma. 2019;33(11):538-546.
94. Latimer-Cheung AE, Arbour-Nicitopoulos KP, Brawley LR, et al. Developing physical activity interventions for adults with spinal cord injury. Part 2: Motivational counseling and peer-mediated interventions for people intending to be active. Rehabilitation Psychology. 2013;58(3):307-315.
95. Williams RM, Patterson DR, Schwenn C, et al. Evaluation of a peer consultation program for burn inpatients: 2000 ABA paper. Journal of Burn Care and Rehabilitation. 2002;23(6):449-453.
96. Divanoglou A, Trok K, Jörgensen S, et al. Active Rehabilitation for persons with spinal cord injury in Botswana – effects of a community peer-based programme. Spinal Cord. 2019;57(10):897-905.
97. Lucke KT, Lucke JF, Martinez H. Evaluation of a professional + peer telephone intervention with spinal cord injured individuals following rehabilitation in South Texas. Journal of Multicultural Nursing and Health. 2004;10(2):68-74.
98. Newman SD, Toatley SL, Rodgers MD. Translating a spinal cord injury self-management intervention for online and telehealth delivery: A community-engaged research approach. Journal of Spinal Cord Medicine. 2019;42(5):595-605.
99. Skeels SE, Pernigotti D, Houlihan BV, et al. SCI peer health coach influence on self-management with peers: a qualitative analysis. Spinal Cord. 2017;55(11):1016-1022.
100. Wells LM, Schachter B, Little S, et al. Enhancing rehabilitation through mutual aid: outreach to people with recent amputations. Health & Social Work. 1993;18(3):221-229.
101. Simske NM, Breslin MA, Hendrickson SB, et al. Implementing recovery resources in trauma care: Impact and implications. OTA International. 2019;2(4):e045.
102. Fitzgerald DM. Peer visitation for the preoperative amputee patient. Journal of Vascular Nursing. 2000;18(2):41-46.

103. Young JM, Lawrence W, Quick P. A unique role: the peer mentor on the spinal cord team at G.F. Strong Rehab Centre. Healthcare Management Forum. 1999;12(3):51-53.
104. Gainforth HL, Latimer-Cheung AE, Davis C, et al. Testing the feasibility of training peers with a spinal cord injury to learn and implement brief action planning to promote physical activity to people with spinal cord injury. Journal of Spinal Cord Medicine. 2015;38(4):515-525.
105. Anderson ML, Wolf Craig KS, Ziedonis DM. Deaf people's help-seeking following trauma: Experiences with and recommendations for the Massachusetts behavioral health care system. Psychological Trauma. 2017;9(2):239-248.
106. Baldwin S, Yuan H, Liao J, et al. Burn Survivor Quality of Life and Barriers to Support Program Participation. Journal of Burn Care and Research. 2018;39(5):823-830.
107. Shi Z, Koch J, Schaefer L, et al. Exploring how Chinese adults living with spinal cord injury viewed the prospect of inpatient peer support programs within a hospital-based rehabilitation setting. Spinal Cord. 2020;58(11):1206-1215.
108. Thurston C, Blom L, Conradsson DM, et al. Sex, support and society: a journey to reclaiming sexuality for individuals living with paraplegia in Cape Town, South Africa. Spinal Cord. 2020;13:225–233.
109. Lamontagne ME, Best KL, Clarke T, et al. Implementation Evaluation of an Online Peer-Mentor Training Program for Individuals With Spinal Cord Injury. Topics in Spinal Cord Injury Rehabilitation. 2019;25(4):303-315.
110. Bradford AN, Castillo RC, Carlini AR, et al. Barriers to Implementation of a Hospital-Based Program for Survivors of Traumatic Injury. Journal of Trauma Nursing. 2013;20(2):89-101.
111. Frey KP. A Qualitative Analysis of the Implementation of a Complex Intervention: Evaluating Implementation of the Trauma Survivors Network: University of Maryland, Baltimore; 2017.
112. Hannah SD. Psychosocial issues after a traumatic hand injury: facilitating adjustment. Journal of Hand Therapy. 2011;24(2):95-103.
113. Arya S, Xue S, Embuldeniya A, et al. Coping strategies used by traumatic spinal cord injury patients in Sri Lanka: a focus group study. Disability and Rehabilitation. 2016;38(20):2008-2015.
114. Coghlan N, Copley J, Aplin T, et al. How to improve compression garment wear after burns: Patient and therapist perspectives. Burns. 2019;45(6):1447-1455.
115. Sizoo SJM, Akkerman M, Trommel N, et al. Feasibility and acceptability of aquatic exercise therapy in burn patients - A pilot study. Burns Open. 2021;5(1):10-20.
116. Johnson RA, Taggart SB, Gullick JG. Emerging from the trauma bubble: Redefining 'normal' after burn injury. Burns. 2016;42(6):1223-1232.
117. Keszler MS, Crandell DM, Morgenroth DC. Rehabilitation of Individuals with Limb Loss due to Trauma. Current Trauma Reports. 2020;6(2):96-104.
118. DeMario B, Kalina MJ, Jr., Truong E, et al. Downstream hospital system effects of a comprehensive trauma recovery services program. The Journal of Trauma and Acute Care Surgery. 2020;89(6):1177-1182.
119. Grieve B, Shapiro GD, Wibbenmeyer L, et al. Long-Term Social Reintegration Outcomes for Burn Survivors With and Without Peer Support Attendance: A Life Impact Burn Recovery Evaluation (LIBRE) Study. Archives of Physical Medicine and Rehabilitation. 2018:S92-S98.

120. Simske NM, Rivera T, Breslin MA, et al. Implementing psychosocial programming at a level 1 trauma center: results from a 5-year period. Trauma Surgery and Acute Care Open. 2020;5(1):e000363.
121. Boschen KA, Tonack M, Gargaro J. Long-term adjustment and community reintegration following spinal cord injury. International Journal of Rehabilitation Research. 2003;26(3):157-164.
122. Gassaway J, Jones ML, Sweatman WM, et al. Peer-led, transformative learning approaches increase classroom engagement in care self-management classes during inpatient rehabilitation of individuals with spinal cord injury. Journal of Spinal Cord Medicine. 2019;42(3):338-346.
123. Letts L, Martin Ginis KA, Faulkner G, et al. Preferred Methods and Messengers for Delivering Physical Activity Information to People With Spinal Cord Injury: A Focus Group Study. Rehabilitation Psychology. 2011;56(2):128-137.
124. Visser AM, Visagie S. Pressure ulcer knowledge, beliefs and practices in a group of South Africans with spinal cord injury. Spinal Cord Series and Cases. 2019;5:83.
125. Barclay L, Hilton GM. A scoping review of peer-led interventions following spinal cord injury. Spinal Cord. 2019;57(8):626-635.
126. Newman SD, Gillenwater G, Toatley S, et al. A community-based participatory research approach to the development of a Peer Navigator health promotion intervention for people with spinal cord injury. Disability and Health Journal. 2014;7(4):478-484.
127. McAweeney MJ, Forchheimer M, Tate DG. Identifying the unmet independent living needs of persons with spinal cord injury. Journal of Rehabilitation. 1996;62(3):29-34.
128. Sweet SN, Noreau L, Leblond J, et al. Peer support need fulfillment among adults with spinal cord injury: relationships with participation, life satisfaction and individual characteristics. Disability and Rehabilitation. 2016;38(6):558-565.
129. Trezzini B, Brach M, Post M, et al. Prevalence of and factors associated with expressed and unmet service needs reported by persons with spinal cord injury living in the community. Spinal Cord. 2019;57(6):490-500.
130. Coghlan N, Copley J, Aplin T, et al. The experience of wearing compression garments after burn injury: "On the inside it is still me". Burns. 2019;45(6):1438-1446.
131. Shaw RB, Sweet SN, McBride CB, et al. Operationalizing the reach, effectiveness, adoption, implementation, maintenance (RE-AIM) framework to evaluate the collective impact of autonomous community programs that promote health and well-being. BMC Public Health. 2019;19(1):1-14.
132. Divanoglou A, Tasiemski T, Augutis M, et al. Active Rehabilitation-a community peer-based approach for persons with spinal cord injury: international utilisation of key elements. Spinal Cord. 2017;55(6):545-552.
133. Stoddard FJ, Ryan CM, Schneider JC. Physical and psychiatric recovery from burns. Surgical Clinics. 2014;94(4):863-878.
134. Evans M, Daaleman T, Fisher EB. Peer support for chronic medical conditions. Peer Support in Medicine: A Quick Guide: Springer; 2020.
135. Simmons D. Peer support: time to tap the (largely) untapped. European Diabetes Nursing. 2013;10(3):98-103.
136. Powers MA, Bardsley J, Cypress M, et al. Diabetes self-management education and support in type 2 diabetes: a joint position statement of the American Diabetes

Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. The Diabetes Educator. 2017;43(1):40-53.

137. Magasi S, Papadimitriou C. Peer Support Interventions in Physical Medicine and Rehabilitation: A Framework to Advance the Field. Archives of Physical Medicine and Rehabilitation. 2021.

138. Vayshenker B, Mulay AL, Gonzales L, et al. Participation in peer support services and outcomes related to recovery. Psychiatric Rehabilitation Journal. 2016;39(3):274.

139. Acton AR, Mounsey E, Gilyard C. The burn survivor perspective. Journal of Burn Care and Research. 2007;28(4):615-620.

140. McPeake J, Quasim T. The role of peer support in ICU rehabilitation. Intensive & Critical Care Nursing. 2016;37:1-3.

Table 1. Study details (*n*=90)

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Acton et al., (2017)	USA	Summary Article	No study objectives but reports on a scientific meeting that included the burn survivor perspective in relation to community reintegration and future research recommendations.	Burn Survivors	Acute & Community	n/a	n/a	n/a	n/a
Amorelli et al., (2019)	USA	Qualitative evaluation	To examine the content of the Amputees Unanimous (AU) program by participants with limb loss and healthcare	Mixed (military service members, beneficiaries, veterans, local non-military citizens)	Community	n=17	n (age range): 2 (17-26) 6 (26-36) 4 (37-46) 3 (47-56) 1 (57-66) 1 (67+)	n=15 (male) n=2 (female)	n (range): 4 (0-6 months) 1 (7-12 months) 5 (13 months- 3 years) 7 (3+ years)

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			professions. To discover beliefs, opinions, and attitudes regarding the value of AU for the limb loss community.						
Anderson et al., (2017)	USA	Exploratory study	To elicit the past experiences of Deaf individuals with help-seeking and recommendations for improving Deaf trauma services.	Deaf individuals who had one or more experiences of trauma in their life (including traumatic injuries).	Community	n=16	n=3 (range: 21-34) n=2 (range: 35-44) n=11 (range: 45+)	n=3 (male) n=13 (female)	n/a
Arya et al., (2016)	Sri Lanka	Cross sectional	To investigate lived experiences and coping mechanisms	Diagnosis of SCI of traumatic cause	Inpatient rehab	n=23	39.5 years	n=19 (male) n=4 (female)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			among the Sri Lankan SCI population						
Badger et al., (2010a)	USA	Exploratory study	To investigate a) how burn survivors view peer support, b) what are the associations with perceived value of peer support and outcome variables that indicate successful burn recovery, and c) if there are any differences in burn recovery when viewed by burn	Burns	Community	n=324	47years (14.9)	n=133 (male) n=191 (female)	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			survivor groups with low, medium, and high regard for peer support.						
Badger et al., (2010b)	USA	Exploratory study	To learn from the burn survivors whether peer support was important to them in their recovery and why, and secondarily, if they had volunteered as a peer supporter, if there were any negative consequences or advice they would have for others.	Burns	Community	n=30	41 years (10.9)	n=19 (male) n=11 (female)	14 years (13)

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Baily et al., (2018)	Canada	Cross-sectional study	To explore the barriers and facilitators of an anti-inflammatory diet in people with spinal cord injury.	SCI	Community	n=6	n/a	n=3 (male) n=3 (female)	Range: 6-38
Baldwin et al. (2018)	USA	Cross-sectional survey	To identify burn survivors attending support groups or services and identify barriers to participation. To investigate QoL among the region's burn centre population over the past 10 years.	Burns	Community	n=105	n (range) 12 (18-24) 23 (25-39) 42 (40-54) 69 (55+)	n=72 (male) n=33 (female)	n=94 were 2 or more years from injury

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
Barclay et al., (2019)	Australia	Scoping Review	To report on the extent range and nature of the research literature in the field of peer-led interventions for people following SCI.	SCI	n/a	n=21 (articles)	n/a	n/a	n/a
Beauchamp et al. (2016)	Canada	Qualitative evaluation	To examine the nature of effective peer mentoring of adults with a spinal cord injury (SCI) from the perspective of mentees.	SCI	n/a	n=15	47.2 years (12.9)	n=8 (male) n=7 (female)	14.5 years (16)
Best et al., (2016)	Canada	RCT	To evaluate the effect of a peer-led wheelchair training program on	Manual wheelchair use: SCI, 62.5%; Multiple	Community	Experimental group n=16 Control group	Experimental group 49.1 years (18.7)	Experimental group n=14 (male) n=2 (female)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			self-efficacy of manual wheelchair use and to explore influences of the intervention on manual wheelchair skills, life-space mobility, and satisfaction with participation.	sclerosis, 12.5%; Cerebral palsy, 12.5%; other (stroke, Parkinson disease, amputation), 12.5%		n=12	Control group 48.5 years (15.2)	Control group n=8 (male) n=4 (female)	

Boschen et al., (2003)	Canada	Mixed methods study	To examine the factors that influence community reintegration 1 to 6 years after a spinal cord injury.	SCI	Community	n=100 (quantitative sample)
						n=34 (qualitative sample)
							n=40 (quantitative sample)
							n=37 (qualitative sample)
								Male
								n=75 (quantitative sample);
								n=24 (qualitative sample)
								Female
								n=25 (quantitative sample);
									n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
								n=10 (qualitative sample)	
Bradford et al., (2011)	USA	Brief Report	Briefly describe the development and implementation of the Trauma Survivors Network (TSN)	Trauma	n/a	n/a	n/a	n/a	n/a
Bradford et al., (2013)	USA	Implementation	To assess the initial implementation effort of the Trauma Survivors Network (TSN) to inform future efforts to replicate the TSN nationwide.	Trauma: General trauma, specific injury group not specified	n/a	n/a	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Carrougher et al., (2020)	USA	Literature review and case study	To identify significant contributions to the field of burn care from 25 years of National Institute on Disability and Rehabilitation Research funding and to use case study methodology to highlight specific Burn Model System contributions that have had a significant impact for individuals living with a burn injury.	Burns	n/a	n=125 (publications) n=3 (case study)	n/a	Case study: n=2 (male) n=1 (female)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Castillo et al., (2013)	USA	Non-randomized trial	To determine whether the TSN can be successfully implemented in clinical sites and if it can improve patient outcomes, reduce costs, and increase satisfaction with care.	Trauma (upper/lower extremity injury)	Acute	n=125 (control); n=126 (experimental)	38 years (control); 36.9 (experimental)	Male: n=81 (control); n=95 (experimental) Female: n=44 (control); n=31 (experimental)	n/a
Chaffrey et al., (2018)	Australia	Scoping Review	To bring together existing evidence about the various types and content of programs involving peers, aimed at health education for adults with SCI.	SCI	n/a	n=8 (articles)	n/a	n/a	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
Chemtob et al., (2018)	Canada	Cross sectional	To understand SCI peer mentorship through a self-determination theory lens by gathering mentees' perceptions of their experiences with their mentors.	SCI: Traumatic (77%)	Community	n=13	49.3 years	n=9 (male) n=4 (female)	15.3 years
Cimino et al., (2020)	Canada	Cross-sectional study	To explore experiences of perceived social isolation; and, to explore the factors that contribute to perceived social isolation.	SCI	Community	n=30	61.9 (13.9)	n=19 (male) n=11 (female)	26 years (12.9)

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
Coghlan et al., (2019a)	Australia	Cross-sectional study	To gain an understanding of the patient experiences associated with wearing compression garments post burn injury and to identify reasons that patients remove their garments and discontinue their wearing schedules.	Burns	Community	n=15	Range: 24-60	n=8 (male) n=7 (female)	Range: 3-19 months
Coghlan et al., (2019b)	Australia	Cross-sectional study	To explore patient and therapist perspectives on the strategies and recommendations that improve the	Burns	community	n=15	Range: 24-60	n=8 (male) n=7 (female)	Range: 3-19 months

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			experience of and wear of compression garments after-burn and the feasibility of implementing the suggested recommendations.						
Davis et al., (2014)	USA	Exploratory study	To explore how participants make meaning of their experiences in a burn survivor support group.	Burns	n/a	n=6	44 years	n=3 (male) n=3 (female)	n/a
DeMario et al., (2020)	USA	Retrospective database analysis	To measure the impact of trauma recovery services (TRS) on our	Trauma (Penetrating trauma 22.9%)	acute-community	TRS n=362 No-TRS n=149	TRS 46 years No-TRS 34 years	TRS n=238 (male) n=124 (female) No-TRS	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			hospital and health system by examining the relationship between TRS, patient encounters, and hospital charges.					n=112 (male) n= 37 (female)	
Dillon et al., (2019)	Australia	Narrative inquiry	To describe the lived experience of people who have undergone sequential partial foot amputation (PFA) and transtibial amputation (TTA).	Amputees	Rehab	n=10	52.5 years (SD 15.9)	n=8 (male n=2 (female)	6.6 years (SD 9.7)
Divanoglou et al., (2017a)	Australia	Systematic review	To assess consumer perceptions on the effectiveness	SCI	n/a	n=4 (articles)	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			of community peer-based programmes in SCI management.						
Divanoglou et al., (2017b)	Iceland	Prospective cross-sectional study	To explore and describe: 1) the profile of institutions that use components of Active rehabilitation (AR), 2) international variations in the type and focus of AR, and 3) characteristic of the participants and personnel involved.	SCI	Community	n=22 (institutions)	n/a	n/a	n/a
Divanoglou et al., (2019)	Botswana	Single group trial	To measure the effects of the Active	SCI	Community	n=19	31 years	n=9 (male) n=10 (female)	Mean: 4 years

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			Rehabilitation (AR) training program in terms of physical independence, wheelchair mobility and self-efficacy. The secondary aim was to explore the effects on life satisfaction, level of physical activity and community participation.						
Dorstyn et al., (2020)	Australia	Case report	To discuss how peer-based interventions might be used to supplement	Trauma: Cycling accident	Community	n=1	30 years	n=1 female	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			formal return-to-work services and contribute to positive job-seeking outcomes.						
Fitzgerald (2000)	USA	Summary Article	To discuss the development of a peer visitation program for the preoperative amputee patient.	Preoperative amputee	n/a	n/a	n/a	n/a	n/a
Frey (2017)	USA	Dissertation – implementation evaluation	Chapter 4: To identify the barriers and facilitators to implementation of the Trauma Survivor Network (TSN) in six	Trauma: General trauma, specific injury group not specified	n/a	n=37 (clinical staff)	n/a	n/a	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			level I trauma centers.						
Gainforth et al., (2015)	Canada	Feasibility	To test the feasibility of training peers with spinal cord injury to learn brief action planning to promote physical activity to mentees with SCI.	SCI	n/a	n=13	52.77 years (9.16)	n=7 (male) n=6 (female)	18.46 years (14.51)
Gassaway et al., (2017)	USA	RCT	To investigate the effect of intensive peer mentoring on patient-reported outcomes of self-efficacy and unplanned hospital readmissions	SCI	Community	n=77 (experimental); n=81 (non-experimental)	35.38 years (experimental); 39.59 years (non-experimental)	Male: n=62 (experimental); n=59 (non-experimental) Female: 15 (experimental);	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			for persons with spinal cord injury within the first 6 months after discharge from inpatient rehabilitation.					22 (non-experimental)	
Gassaway et al., (2018)	USA	Editorial	To describe the importance of peer mentorship for person with SCI	SCI	n/a	n/a	n/a	n/a	n/a
Gassaway et al., 2019	USA	Multiple-baseline, quasi-experimental design	To determine if patient engagement in self-management education classes could be improved by incorporating several	SCI	inpatient rehab	n=81	36 years (15.6)	n=58 (male) n=23 (female)	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			changes in class format and structure (nurse with didactic instruction vs peer instructor with blended learning approach).						
Goodridge et al., (2015)	Canada	Descriptive qualitative	To identify and classify perceived gaps in access to healthcare and support services and to compare differences in perceptions of access between urban and rural participants.	SCI (traumatic)	Community	n=23	Range: 23-68 years	n=16 (male) n=7 (female)	Range: 1-45 years

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
Grieve et al., (2018)	USA	Cross-sectional survey	To determine the associations of peer group attendance with societal reintegration.	Burns	Community	n=596	40.5 years (15.4)	n=269 (male) n=326 (female)	n=154 (<3 years) n=164 (3-10 years) n=278 (>10 years)
Haas et al., (2013)	UK	Qualitative evaluation	To evaluate the Community Peer Support Officer (CPSO) provided by the Spinal Injury Association UK to patients in general hospitals in the south west UK.	SCI	Rehabilitation (general hospital)	n=14 n=5 (with SCI) n=4 (relatives) n=5 (therapists)	52 years	n=5 (male)	n/a
Hannah (2011)	Canada	Original article	To describe the impacts of a traumatic hand injury from a	Trauma	n/a	n/a	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			psychological perspective.						
Hoffmann et al., (2019)	Denmark	Feasibility	To investigate if organizing a nationwide cross-organizational peer mentoring system for in-patients with SCI in a primary rehabilitation as a supplement to high level professional neuro-rehabilitation would be feasible in a nationwide hospital setting and if it would be acceptable	SCI: Trauma (44.2%)	Rehabilitation	n=52	Median age: 50	n=33 (male) n=19 (female)	Median years since injury: 0.34

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			for patients to becoming mentees.						
Houlihan et al., (2016)	USA	Qualitative evaluation	To develop and assess the feasibility of My Care My Call intervention for individuals with SCI using peer health coaches.	SCI	Community	n=7	Range: 24-64 years	n=4 (male) n=3 (female)	Range: 9-27 years
Houlihan et al., (2017)	USA	Single-blinded RCT	To evaluate the impact of the My Care My Call (MCMC) intervention in adults with chronic SCI.	SCI	Community	n=42 (control); n=42 (intervention)	45.7 years 47.5 (control); 44 years (intervention)	Male: n=32 (control); n=30 (intervention) Female: n=10 (control); n=12 (intervention)	Mean: 9.9 years; Range: 1-66 years

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Jalovcic et al., (2009)	Canada	Qualitative phenomenological study	To capture women's experiences of participation in the Telephone Peer Support Group program and its main characteristics and structure as perceived by participants.	SCI	Community	n=7	48.2 years (5.8)	n=7 (female)	13 years (12.9)
Johnson et al., (2016)	Australia	Qualitative study	To explore the beginnings of emotional recovery after burn injury and describe how people tentatively begin to seek and redefine normality.	Burns	Community	n=9 (patients) n=9 (family members)	Range (21-48 (patients) Range: 23-52 (family members	Patients: n=7 (male) n=2 (female) Family members: n=9 (female)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Jones et al., (2019)	USA	Non-randomized trial	To evaluate effectiveness of peer interventions on self-efficacy, unplanned hospital readmissions, and quality of life for patients with SCI undergoing inpatient rehabilitation.	SCI	Rehabilitation	n=1117	38.2 years	n=860 (male) n=257 (female)	n/a
Kelly (2007)	USA	Mixed-method, multiple case study	To examine how employment as a peer role model at a rehabilitation hospital affects the development of community competence	SCI	n/a	n=20 n=10 (peer employees); n=10 (non-employees)	24 years (peer employees); 24 years (non-employees)	Male: n=9 (peer employees); n=9 (non-employees) Female: n=1 (peer employees); n=1 (non-employees)	6.7 years (peer employees); 7 years (non-employees)

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			among a group of young people with violently acquired SCI.						
Keszler et al., (2020)	USA	Review	To provide an overview of key concepts in rehabilitation of those with traumatic limb loss for clinicians to consider using in clinical practice.	Trauma: Injury group not specified	Pre-operative-community	n/a	n/a	n/a	n/a
Kornhaber et al., (2014)	Australia	Integrative review	To systematically synthesize the literature focusing on personal perceptions and experiences of adult burn	Burns	Rehabilitation	n=14 (articles)	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			survivors' rehabilitation and to identify factors that influence their rehabilitation.						
Kornhaber et al., (2015)	Australia	Cross-sectional study	To explore burn survivors' experiences of providing and receiving inpatient peer support to develop an in-depth understanding of the influence during the rehabilitation journey.	Burns	Community	n=21	44 years	n=20 (male) n=1 (female)	Range: 6 months - 8 years
Lamontagne et al., (2019)	Canada	Sequential cross-sectional design	To a) explore the context in which the implementati	SCI	Community	Objective 1: n=18 (EBPAS)	27% (18-35 years) 33% (36-45 years)	Objective 1: EBPAS n=6 (male)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			on process will be conducted, b) identify barriers and facilitators that influence the implementation process, and c) measure the influence of the implementation process on implementation behaviour of peer mentors.			n=11 (ORCA) Objective 2: n=10 Objective 3: n=34 (DIBQ)	27% (46-55 years) 12% (56-65 years)	n=12 (female) ORCA n= 2 (male n=9 (female)) Objective 2: n=2 (male) n=8 (female) Objective 3: DIBQ n=22 (male) n=12 (female)	
Latimer-Cheung et al., (2013)	Canada	Single group trial	To determine if a peer-mediated, home-based strength-training intervention would	SCI	Community	n=12	42.9 years (15.6)	n=5 (male) n=7 (female)	23.1 years (18.5)

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			increase self-efficacy, action planning, and strength-training behavior.						
Letts et al., (2011)	Canada	Qualitative study	To explore the perceptions of people with spinal cord injury regarding preferred messengers and methods for obtaining physical activity information.	SCI	Community	n=16	52.4 years (13.97)	n=14 (male) n=2 (female)	15.87 years (9.3)
Ljungberg et al., (2011)	USA	Single group trial	To describe the implementation of the peer-mentoring programme	SCI	Rehabilitation	n= 5 (mentor) n=37 (mentee)	34.8 years (mentor) 35.38 years (mentee)	Male: n=3 (mentor) n=28 (mentee) Female:	11.8 years (mentor) < 1 year (mentee)

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			and describe the experiences with the mentoring process, including its effects on self-efficacy beliefs and medical complications.					n=2 (mentor) n=9 (mentee)	
Lucke el at., (2004)	USA	Single group trial	To evaluate patient response to a professional and peer intervention in addition to standard follow-up care.	SCI	Community	n=10	34 years	n=7 (male) n=3 (female)	n/a
McAweeney et al., (1996)	USA	Cross sectional	To explore the unmet needs for independent living	SCI	Community	n=122	31.5 years	n=98 (male) n=24 (female)	3.5 years

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			services that persons experience.						
METRC (2019)	USA	Prospective, multicenter, cluster clinical trial	To evaluate the impact of the Trauma Collaborative Care (TCC) program's early intervention components on 6-week outcomes.	Trauma Motor vehicle - occupant (41%); motor vehicle – cyclist /pedestrian (14%); motor vehicle – motorcyclist (20%); fall (15%); firearm (3%); other (7%)	Acute - rehabilitation	n=896	38.2 years (12.5)	n=585 (male) n=311 (female)	n/a
Mortimer et al., (2002)	UK	Cross sectional	To explore patient experiences and perceptions of the information	Amputees	Community	n=31	70.5 years (3.54)	n=18 (male) n=13 (female)	Group 1: 63 months Group 2: 25 months

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			on phantom pain that they received before and after amputation, and their views on improving this information.						
Munce et al., (2014)	Canada	Descriptive qualitative	To understand the perceived facilitators and barriers to self-management to prevent secondary complications.	SCI (traumatic)	Community	n=7	Range: 39-68	n=6 (male) n=1 (female)	Paraplegia: 5 years Quadriplegia: 2 years
Newman et al., (2014)	USA	Intervention development	To describe a community-based participatory research (CBPR)	SCI	Community	n/a	n/a	n/a	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			approach to the development and pilot testing of an intervention using community-based Peer Navigators with SCI to provide health education to individuals with SCI.						
Newman et al., (2019)	USA	Single group trial	To develop educational content and pilot test the use of tablet computers, online content management platform, and video conferencing	SCI (traumatic)	Community	n=10	Median: 48.5 (range: 36-70)	n=8 (male) n=2 (female)	Median years since injury: 24 (range: 11-46)

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			for delivery of a peer supported, spinal cord injury self-management intervention, using a community-engaged research approach.						
O'Riley et al., (2014)	USA	Exploratory ethnographic design	To identify and categorize themes and concepts related to Internet-based emotional and problem-focused social support for individuals with SCI.	SCI	Community	n=9	n=1 (18-40 years) n=4 (40-59 years) n=4 (60+ years)	n=8 (male) n=1 (female)	n=3 (1-2 years) n=3 (8-12 years) n=3 (20+ years)

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Papadimitriou et a., (2011)	USA	Exercise in empirical philosophy	To enhance researchers' and rehabilitation clinicians' ways of doing and thinking about rehabilitation by revealing and articulating the role of human temporality in recovery and rehabilitation in the case of traumatic spinal cord injury.	SCI	Community	n=24 (SCI participants) n=12occupational and physical therapists)	n/a	n/a	n/a
Papamikrouli et al., (2017)	Netherlands	Cross sectional	To examine the perceived need for peer support, perceived	Burns	Community	n=264	49.8 years (16.09)	n=121 (male) n=143 (female)	n=143 (<10 years)

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			benefits of peer contact, and perceived barriers to participation. Secondary objectives were to examine differences between burn survivors who reported a need for and experienced peer support and those who reported no need and who have no experience with peer support.						n=91 (>10 years)
Payne (1991)	USA	Ex post facto study	To understand if demographic variables	SCI	Community	n=60	39.7 years (11)	n=42 (male) n=18 (female)	12 years (9.3)

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			influence the perception of the contribution of group learning to rehabilitation programs.;						
Reichmann et al., (2018)	USA	Integrative review	To examine the body of evidence regarding amputee peer support and develop a reasonable clinical practice recommendation, based on the totality of the evidence, the potential for harm, and cost.	Amputees	n/a	n=10 (articles)	n/a	n/a	n/a
Richardson et al., (2020)	UK	Cross sectional study	To exploring the experiences	Amputees	Community	n=8	60.6 years	n=3 (male) n=5 (female)	24.9 years

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			of individuals with amputation delivering peer support.						
Rocchi et al., (2018)	Canada	Cross-sectional study	To determine whether participation in peer mentorship programs is related to an increase in the reported use of positive coping strategies for adults with SCI.	SCI	Community	n=63 (non-mentees) n=68 (mentees)	20.1 years (non-mentees) 14.1 years (mentees)	Male: n=46 (non-mentees) n=48 (mentees) Female: n=17 (non-mentees) n=19 (mentees)	n/a
Shaw et al., (2019)	Canada	Program evaluation	To operationalize and apply each dimension of the RE-AIM framework to evaluate	SCI	n/a	n=9 (organizations)	n/a	n/a	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			similar community-based public health programs delivered by multiple, autonomous community organizations and present findings regarding *the impact of Canadian SCI* peer mentorship programs.						
Sherman et al., (2004)	USA	Cross-sectional survey	To compare the impact of two types of social support, past peer-mentoring experience and current live-in	SCI	Community	n=62	30.3 years	n=42 (male) n=20 (female)	11.65 years

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			partner, on adjustment after spinal cord injury.						
Shi et al., (2020)	China	Generic qualitative design	To explore how Chinese adults living with spinal cord injury viewed the prospect of inpatient peer support programs within a rehabilitation setting.	SCI	Rehabilitation	n=6	37.2 years	n=6 (male) n=0 (female)	1.2 years
Simske et al., (2019)	USA	Prospective cohort study	To evaluate patient satisfaction with TSN services and the impact of these services on patient perceptions about recovery.	Trauma: Crush (3.1%), fall (31.8%), gunshot wound (8%), motorcycle collision (14.8%), motor	Acute – community	TSN exposed n=211 No-TSN exposure n=135 Prior to TSN existence	TSN exposed 43 years (17.1) No-TSN exposure 46.3 years (19.9)	TSN exposed n=147 (male) n=64 (female) No-TSN exposure n=91 (male)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
				vehicle collision (32%), pedestrian (8.2%), other (2.1%)		n=139	Prior to TSN existence 44.3 years (17.6)	n=44 (female) Prior to TSN existence n=81 (male) n=58 (female)	
Simske et al., (2020)	USA	Summary and retrospective review	To describe services at our institution and the evolution of programming through time and to report the demographics and injury patterns of patients using available resources, to target services to	Trauma: Assault (1.6%), ATV/ dirt bike/ snowmobile (1.8%), burn (0.7%), crush (3.4%), fall (25.3%), motor vehicle collision (31.8%), other (1.8%),	Acute – community	n=2324	45.4 years (18.5)	n=1453 (male) n=871	n/a

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			populations who may use and benefit from them.	pedestrian struck (5.6%), penetrating (13.9%), sport related (2.1%)					
Sizoo et a;., (2021)	Netherlands	Observational pilot	To investigate the feasibility and acceptability of aquatic exercise therapy in adult burn patients with an indication for supervised exercise therapy beyond discharge.	Burns	Rehabilitation	n=10	44 years	n=8 (male) n=2 (female)	63 days
Skeels et al., (2017)	USA	Process evaluation of a	To a) describe the communicati	SCI (traumatic)	n/a	n/a	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
		clinical trial	on tools and information delivery strategies used by peer health coaches (PHCs), b) describe the PHC roles and identifying the components of each role in relation to the interplay of communication tools and information delivery strategies, and c) examine the pattern of PHC roles during the 6-						

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			month PHC–peer relationship.						
Sproul et al., (2009)	USA	Descriptive study	To determine a) which factors adult burn survivors report as being important to their recovery, b) the perceived importance of participation in a peer support program on recovery, and c) if there is a difference in levels of reported hope between burn survivors who participants	Burns	Community	n=117	71.9% of participants were between 30 and 59 years of age.	n=56 (male) n=60 (female)	71.9% of participants sustained their injury >5 years ago.

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			in peer support programs versus those who did not.						
Standal et al., (2008)	Norway	Qualitative explorative study	To investigate the learning that takes place when people with disabilities interact in a rehabilitation setting.	SCI	Rehabilitation	n=10	42	n=7 (male) n=3(female)	n/a
Stewart et al., (1999)	South Africa	Case study	To describe a brief history of a spinal cord injury group and a description of the process by which the group developed and moved towards assuming	SCI	Community	n/a	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			responsibility for group planning, management and control.						
Suckow et al., (2015)	USA	Cross sectional	To better understand what domains determine QoL in vascular amputees.	Amputees	n/a	n=26	64 years	n=19 (male) n=7 (female)	4.3 years
Sweet et al., (2016)	Canada	Secondary analysis of cross-sectional data	To examine the association among peer support, participation and life satisfaction in adults with SCI.	SCI: Traumatic (73.4%); non-traumatic (26.6%)	Community	n=1549	49.6 years	n=1041 (male) n= 508 (female)	18.5 years
Sweet et al., (2018)	Canada	Static group comparison Study	To examine differences among mentees and non-mentees on	SCI	Community	n=68 (mentees) n=63 (non-mentees)	50 years (mentees) 53 years (non-mentees)	Male: n=48 (mentees) n=46 (non-mentees) Female:	14.1 years (mentees) 20.1 (non-mentees)

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			QoL/participation and to test a self-determination theory (SDT) model where the psychological needs mediate this relationship.					n=19 (mentees) n=17 (non-mentees)	
Thurston et al., (2020)	South Africa	Qualitative descriptive study	To explore how individuals living with paraplegia in South Africa experience sex and intimacy and how they perceive the related health services and support they received whilst adapting to	SCI: Traumatic violence (60%), traumatic road traffic accident (20%)	Community	n=10	25.6 years	n=8 (male) n=2 (female)	12.5 years

Author (year)	**Location**	**Study Design**	**Study Objectives**	**Trauma population**	**Care setting**	**Sample size**	**Mean age (SD)**	**Sex**	**Mean time since injury (SD)**
			life post injury.						
Tolley et al., (2014)	Australia	Scoping review	To conduct a scoping review of one-to-one peer support programs for adult patients with burn injury to identify any impact resulting from participation as either deliverer (peer) or recipient (patient), and to examine, identify, and evaluate the methods of peer-support program delivery.	Burns	n/a	n=15 (articles)	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
Trezzini et al., (2019)	Switzerland	Cross-sectional observational	To investigate how well existing support service systems in a highly developed country meet perceived needs after rehabilitation among people with SCI and what the associated antecedents and consequences of potential gaps are.	SCI (traumatic 76.7%)	Community	n=490	55.4 years	n=348 (male) n=142 (female)	16.5 years
Veith et al., (2006)	USA	Qualitative study	To identify salient dimensions and outcomes of the peer-mentoring	SCI	Inpatient rehabilitation	Mentee: n=7 Mentor: n=6	Mentee: 40.43 years Mentor: 34.17 years	Mentee: n=5 (male) n=2 (female) Mentor:	Mentee: n/a Mentor: 11 years

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			relationship among individuals with spinal cord injury.					n=4 (male) n=2 (female)	
Vincent et al., (2015)	USA	Narrative review	To present the effects of orthopedic trauma on psychological distress, potential interventions for distress reduction after trauma, and implications for participation in rehabilitation.	Orthopedic trauma	n/a	n=84 (articles)	n/a	n/a	n/a
Visser et al., (2019)	South Africa	Qualitative descriptive study	To determine knowledge, beliefs and practices on pressure ulcers (PUs)	SCI: Traumatic (89%)	Rehabilitation	n=71	36.3 years (12.3)	n=61 (male) n=10 (female)	Range: 6 months to 5 years

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			of persons with SCI that received care at a rehabilitation centre.						
Weitzner et al., (2011)	Canada	Secondary analysis of qualitative data	The objectives were a) to identify the different ways in which people living with SCI viewed and/or used their disabilities positively, b) to identify what influences an individual with SCI to view and/or use his or her disability positively,	SCI	Community	n=52	n/a	n=40 (male) n=12 (female)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			and c) to provide best-practice recommendations for rehabilitation professionals to facilitate individuals with SCI to view and/or use their disabilities positively.						
Wells et al., (1993)	Canada	Single group trial	To describe a peer support program implemented by social workers in a rehabilitation hospital and report on a program evaluation to determine which programs	Amputees	Rehabilitation	n=71	60 years	n=40 (male) n=31 (female)	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			elements patients found important.						
Wiechman et al., (2017)	USA	Summary article	To identify research priorities and addressing two questions: "What are the barriers to an acceptable quality of life?" and "What are the gaps in access to services?"	Burns	Community	n/a	n/a	n/a	Range: 6 months - 20 years
Williams et al., (2002)	USA	Single group trial	To describe and evaluate a peer support visit program in a large burn unit.	Burns	Inpatient	n=51	32.5 years	n=39 (male) n=12 (female)	n/a
Young et al., (1999)	Canada	Brief report	To report on the peer	SCI	Rehabilitation	n/a	n/a	n/a	n/a

Author (year)	Location	Study Design	Study Objectives	Trauma population	Care setting	Sample size	Mean age (SD)	Sex	Mean time since injury (SD)
			mentor's facilitation of communication between clients and staff and on two initiatives that promote clients perspectives.						

Table 2. Description of peer support programs (*n*=22)

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
Amorelli et al., (2019)	Amputee	Community	The primary purpose of the Amputees Unanimous program is to help amputees in need, conveying the message of acceptance, courage, and service to others.	In-person group discussions	Not specified. Participants are free to move across the 12 program steps at their own pace.	Program adapted from the Alcoholics Anonymous 12 steps	Created by the researchers	Peers lead participants through the 12 step program of 1) Honesty, 2) Hope, 3) Faith, 4) Discipline, 5) Courage, 6) Willingness, 7) Humility, 8) Compassion, 9) Integrity, 10) Perseverance, 11) Spirituality, 12) Service.
Best et al., (2016)	Mixed (62.5% SCI, 12.5% MS, 12.5% CP, 12.5% other)	Community	The goal of the WheelSee intervention was to improve wheelchair use self-efficacy	Peer trained group of two in-person	1-2 sessions per week, for 6 sessions (90 min each)	Peer-led wheelchair training program	Designed by the researchers	During the first 4 WheelSee sessions, participants selected goals related to performing activities and negotiating the physical environment. The peer trainer guided the selection of specific objectives that may be required to achieve each goal, such as specific skills, skill sequencing, and overcoming barriers.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
								The final 2 WheelSee sessions focused on less tangible skills, including knowledge and problem solving, advocacy, managing social situations, and controlling emotions.
Bradford, et al., (2011)	Trauma	n/a	The TSN program prepares survivors to effectively manage the challenges of trauma recovery.	In-person peer visitation and trauma support group, internet-based peer support	n/a	Peer support	Designed by the American Trauma Society and researchers. Focus groups of patients and families provided feedback and direction for the development of the program	The TSN fosters peer support through peer visitation with TSN-trained peers, attending trauma support groups where participants can share mutual aid, and the TSN web site.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
Castillo et al., (2013)	Trauma	Discharge from acute	The TSN program prepares survivors to effectively manage the challenges of trauma recovery.	In-person peer visitation and trauma support group, internet-based peer support	n/a	Peer support	Designed by the American Trauma Society and researchers. Focus groups of patients and families provided feedback and direction for the development of the program	The TSN fosters peer support through peer visitation with TSN-trained peers, attending trauma support groups where participants can share mutual aid, and the TSN web site.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
Divanoglou et al., (2019)	SCI	Community	The Active Rehabilitation program aims to address issues of physical independence, wheelchair mobility, fear, shame, isolation, networking and peer support.	In-person group training led by a peer	16 hours over 7 days (10 training sessions, 6 workshops)	Rehab training sessions	Designed by the researchers	Participants completed training sessions on wheelchair skills, cardiorespiratory fitness, strengthening, and ball sports.
Fitzgerald (2000)	Amputee	Pre-operative	To provide support and encouragement to a person who will have an amputation.	One-on-one (in-person)	Often a single visit	Peer visit	Designed by the researchers	Peer visitation is structured around three parts: 1) Attempt to establish rapport, 2) respond to the person's feelings, and 3) respond to their questions with factual and practical information.
Gassaway et al., (2017)	SCI	Rehab and community	The goal of peer mentoring sessions is to meet the needs of	One-on-one, in-person while in rehab; by phone or	1 per week (30 minutes per week) for 90 days	Peer interaction	Designed by the researchers	Peers opened conversations with open ended questions or asked about concerns from previous sessions. Participants were

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
			each individual participant; mentors are more interested in what a participant is thinking or concerned about than what is on their official rehabilitation schedule	email while in the community or in-person if they were on-site for post-discharge services				encouraged to participate in monthly peer team sponsored activities. Post-discharge telephone or email communication with peers were led by the participant and often included adjustment issues in returning to community living or frustrations with equipment delivery and services
Haas et al., (2013)	SCI	Rehab	The Community Peer Support Officer (CPSO) visited people in general hospitals who had a recent diagnosis of SCI.	In-person, peer supporter visited people in the hospital	n/a	n/a	n/a	n/a

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
Hoffmann et al., (2019)	SCI	Rehab	n/a	In-person, one-on-one peer mentoring	3 sessions; more sessions available with permission from project staff anytime during rehab period	Peer mentoring	Designed by the researchers	Mentors were instructed not to provide medical advice, whereas they were encouraged to share their personal experiences with the mentees.
Houlihan et al., (2016)	SCI	Community	The My Care My Call peer health coaches support participants with chronic SCI in meeting their	Peers telephoned survivors (one-on-one)	2 calls per week for 2 weeks	Peer health coaches	Designed by the researchers	Sessions with the peer health coaches involve supporting skill development, facilitate motivation using consumer-centered goal setting, coaching, resource referral, and support network building.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
			health care needs to prevent secondary conditions.			Consumer workbook	Compiled by the researchers	A resource list of essential, comprehensive informational, and local resources
Houlihan et al., (2017)	SCI	Community	The My Care My Call (MCMC) program is designed to empower adults with chronic spinal cord injury (SCI) in the self-management of their primary health care needs to prevent secondary conditions.	Peers telephoned survivors (one-on-one)	8 weekly calls, followed by 4 bi-weekly calls, and then 2 monthly calls; Program duration is 6 months	Peer health coach	Designed by the researchers	Peer mentors tele-coach participants on self-management and health care needs. Calls focused on self-management and unmet health-care needs, peers chose conversation topics and peer mentors had the flexibility to use specific tools and strategies to facilitate and focus conversations.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
Jalovcic et al., (2009)	SCI	Community	To provide women with SCI, access to the latest health resources and with peer support.	Phone-group teleconference	11 Peer support sessions and 12 guest lectures over 11 months.	Peer support and education	Co-designed by researchers and stakeholders with SCI.	A peer support program with a two components: 1) teleconferences with guest lecturers to support health and well-being on a range of topics (e.g., Long-term SCI, Recent developments in SCI research, Menopause and women with SCI) and 2) Peer support teleconferences. Peer support teleconferences were moderated by an experienced facilitator.
Jones et al., (2019)	SCI	Rehab	To improve patients' self-efficacy in care management and reduce unplanned hospital readmissions	One-on-one peer mentoring (in-person and telephone)	Peer support: 1 visit per week for up to 90 days. Peer education program:	One-to-one peer mentoring	Designed by the researchers based on previously collected stakeholder feedback	Patients received an initial introduction to peer support by a member of the peer support team and were assigned a peer mentor.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
					Four 1-hour sessions	Peer-led patient self-management education	Designed by the researchers based on previously collected stakeholder feedback	Peer led classes focused on self-management of conditions associated with SCI, bowel, bladder, skin management, and special concerns. A nurse educator was present as a medical content expert.
						Peer support team assistance	Designed by the researchers based on previously collected stakeholder feedback	Clinical staff would request the assistance of mentors to demonstrate self-management activities or to join patients on community outings.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
Latimer-Cheung et al., (2013)	SCI	Community	To strategically address barriers and increase self-efficacy and strength-training behavior	In-person home visit with a personal trainer and a peer.	Single visit	Peer-delivered exercise program	Created by the researchers	The session began with an introduction to strength training and setting a goal. Next, the peer modeled a set of seven exercises and the participant tried each exercise. Finally, the trainer designed a personalized strength training program.
Ljungberg et al., (2011)	SCI	Rehab	The NRH SCI Peer Mentoring Program was designed to address the prevention of secondary conditions such as pressure ulcers, urinary tract infections, respiratory problems, general health maintenance	One-on-one peer mentoring (in-person and telephone)	1 per week for the first 3 months, 2 per month for the next three months, and 1 per month for the remaining 6 months; program duration is 1 year	Peer mentoring	Developed with the SCI Network	Peer mentors were trained to monitor medical complications, secondary conditions, health risk behaviours, emotional well-being, and general health status.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
			and community living. The goal of the programme is for peer mentors to pass along knowledge, demonstrate and model skills and initiate referrals to the professional rehabilitation team as needed.					
Lucke et al., (2004)	SCI	Community	The Professional + Peer Intervention was an intensive individualized intervention, designed to facilitate	Peers telephoned survivors (one-on-one)	From 6 weeks to 6 months post-rehab	Peer interaction	Designed by the researchers	Peers provided social interaction and shared experiences including but not limited to: role changes, equipment, transportation, activities, recreation, sexuality, adjustment, interactions with friends and strangers, and working with an attendant.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
			knowledge acquisition and problem solving while providing interpersonal interaction.			Workshops	Designed by the researchers	The workshop covered the topics of anatomy and sequelae of SCI; bowel and bladder function and management; pressure ulcers; fertility, sexuality and relationships; health promotion and lifestyle; and the Convention on the Rights of Persons with Disabilities.
METRC (2019)	trauma	Acute-rehab	The TSN program prepares survivors to effectively manage the challenges of trauma recovery.	Peer visitor, support group, self-management course (telephone, in-person, online)	n/a	Peer support	Designed by the American Trauma Society and researchers. Focus groups of patients and families provided feedback and direction for the developme	The TSN fosters peer support through peer visitation with TSN-trained peers, attending trauma support groups where participants can share mutual aid, and the TSN web site.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
							nt of the program	
Newman et al., (2019)	SCI (traumatic)	Community	The Peer-supported Health Outreach, Education, aNd Information eXchange (PHOENIX) telehealth intervention is designed to promote self-management after SCI.	Peer education (online)	6 online education modules	Education modules	Designed by the researchers in collaboration with the South Carolina Spinal Cord Injury Association	Online education modules that cover 1) Introduction to PHOENIX & SCI 101, 2) Getting what you need: Being an empowered consumer, 3) Getting out there: Engaging community resources, 4) Staying healthy: Skin care and preventing pressure ulcers, 5) Staying healthy: Preventing UTI, 6) Staying healthy: Bowel Management
Simske et al., (2019)	Trauma	Acute-rehab	The TSN program prepares survivors to effectively manage the challenges of trauma recovery.	Peer visitor, support group, self-management course (telephone, in-	n/a	Peer support	Designed by the American Trauma Society and researchers. Focus groups of patients and	The TSN fosters peer support through peer visitation with TSN-trained peers, attending trauma support groups where participants can share mutual aid, and the TSN web site.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
				person, online)			families provided feedback and direction for the development of the program	
Skeels et al., (2017)	SCI (traumatic)	Community	The My Care My Call (MCMC) program is designed to empower adults with chronic spinal cord injury (SCI) in the self-management of their primary health care needs to prevent secondary conditions.	Peers telephoned survivors (one-on-one)	8 weekly calls, followed by 4 bi-weekly calls, and then 2 monthly calls; Program duration is 6 months	Peer health coach	Designed by the researchers	Peer mentors tele-coach participants on self-management and health care needs. Calls focused on self-management and unmet health-care needs, peers chose conversation topics and peer mentors had the flexibility to use specific tools and strategies to facilitate and focus conversations.

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
Wells et al., (1993)	Amputee	Rehabilitation	The goal of the AMP Reach program was to provide a personal view of how to live effectively with a disability.	In-person, peers visited survivors (one-on-one)	n/a	Peer visits	Designed by the researchers	Peers promoted a more hopeful attitude by providing a positive role model, reduce patient anxiety by providing information about the rehab program and anticipated life experiences, and to increase patient morale by sharing feelings of concern and fear.
Williams et al., (2002)	Burns	Inpatient	To provide an unstandardized, informal, and personalized form of psychosocial support.	In-person peer consultant met with survivors one-on-one	One 15-60 min visit per week for as many weeks as the inpatient was interested	Peer support	Designed by the research Team and burn survivors	The peer consultant accomplished at least one of six program objectives: 1) Allow survivor to ask questions about the peer consultant's recovery experience, 2) Allow the survivor to discuss burn-related questions, 3) Inform the survivor of community resources, 4) Encourage survivors to contact the Peer Consultation Service for support after hospitalization, 5) If the survivors discusses concerns that should be

Author (year)	Population	Care setting	Program objective	Format	Frequency and duration	Content type	Content creator	Content details
								brought to the attention of burn care professionals, the peer consultant asks the survivor for permission to pass that information to appropriate staff members, and 6) identify a staff liaison for survivors who have concern about the peer consultant program.

Table 3. Quantitative Results (*n*=12)

Author (year)	Quantitative domain	Outcome measure	Results
Best et al., (2016)	Self-efficacy (wheelchair use)	WheelCon for MWC users version 3.0	• Intervention group had greater wheelchair use self-efficacy scores post-intervention (p<.05).
Castillo et al., (2013)	Self-efficacy	Modified Self-Efficacy Scale; Patient Activation Measure	• There was no significant difference between groups for any of the outcomes (p>0.10) except depression.
	Social support	Family, friends, and significant other subscales of the Multidimensional Scale of Perceived Social Support	
	Patient activation	Patient Activation Measure	
	Health status	Physical Components Summary (PCS)and Mental Components Summary (MCS) of the Short Form 12(SF-12) Version 2	
	Anxiety	Anxiety subscale of the Brief Symptom Inventory	
	Depression	Patient Health Questionnaire	• The experimental group had a lower odds of depression (p=.02) at 6 months.
Divanoglou et al., (2019)	Self-efficacy	Moorong Self-efficacy Scale	• There were no significant changes to the total score, the general subscale, and the social construct subscale. • Significant improvement were seen in the personal function subscale at post-intervention (p=.004) and follow-up (p=.04).

	Physical independence	Spinal Cord Independence Measure self-report	• Significant increase post-intervention (p=.019). • Greatest improvement was in the mobility subscale at post-intervention (p=.011) and changes were maintained at follow-up (p=.005).
	Wheelchair skill and confidence	Queensland Evaluation of Wheelchair Skills practical test; Wheelchair Skills Test Questionnaire version 4.3	• Significant improvement at post-intervention (p=.001). Specifically, improvements were made to their ability to maintain balance on the back wheels (p=.003), ascend and descend a gutter (p=.045), and cover longer distances during a 6 minute push (p=.003). • Improvements to wheelchair skill capacity was reported at post-intervention (p=.014) and at follow-up (p=.021). • Wheelchair skill confidence increased at post-intervention (p=.092) and at follow-up (p=.003).
	Life satisfaction	Life Satisfaction Questionnaire-11	• There was no significant difference between baseline and follow-up for life satisfaction (p=.109).
	Rehab participation	Utrecht Scale for Evaluation of Rehabilitation Participation	• There were no significant differences between baseline and follow-up for rehab participation frequency (p=.083) and rehab participation restrictions (p=.365).

Gassaway et al., (2017)	Self-efficacy	General Self-efficacy Scale; project-developed community integration questions	• Growth curve estimates revealed that group assignment significantly affects self-efficacy growth over time (p=.002). Experimental growth rate was greater than the control group.
	Hospital readmission	Percentage of patients readmitted to the hospital; cumulative number of days rehospitalized during targeted time intervals	• No statistically significant differences between groups for percent of patients rehospitalized at 30 days (p=.0808), 90 days (p=.095), and 180 days (p=.182). • There were significantly more cumulative days rehospitalized for the control group at 30 days (p=.018), 90 days (p<.001), and 180 days (p<.001).
Hoffmann et al., (2019)	QoL	International SCI QoL Basic Data Set; items 9a–9i from the Short Form SF-36 v1	• SF-36 items showed significant improvement for five of nine depression items: o Did you feel full of pep? (p<.01) o Did you have a lot of energy? (p=.01) o Did you feel worn out? (p=.03) o Have you been a happy person? (p=.02) o Did you feel tired? (p=.01). • All three International SCI QoL subscales were significantly different post-intervention, life and personal circumstances (p=.01), physical health (p=.01), and psychological health (p=.01).
	Pain	Pain score numeric rating scale (11-NRS)	• Reported pain was not significantly different post intervention (p=.86) and reported pain frequency was not different post-intervention (p=.48).

Houlihan et al., (2017)	QoL	SCI standard dataset	• No significant differences between groups at 6 months.
	Health self-management	Patient Activation Measure	• There was a significant difference between groups at 6 months. • Scores improved and estimated 1 level of improvement in activation for intervention group at 4 and 6 months.
	Quality of primary care	Communication With Physicians Scale; Patient Satisfaction Scale	• No significant differences between groups at 6 months.
	Activity limitation	Social/Role Activities Limitation	• Intervention participants reported significantly greater decrease in social/role activities limitations compared to controls (p=.039).
	Awareness of services and resources used	Global Rating of Change	• Intervention participants reported significantly greater service/resource awareness (p=0.25) and services used (p=.024).
Jones et al., (2019)	Self-efficacy	General Self-Efficacy scale	• Significant relationship between self-efficacy and fewer hospital readmissions at all three time points (p<0.001) for peer intervention.
	Hospital readmission	Number of patients readmitted to the hospital; number of days rehospitalized during designated time intervals	• Significant change in level (p=.002) and slope (p=.048) for number of patients readmitted • Statistically significant change in level (p<0.001) but not slope (p=0.087) for number of hospital days. • The average number of patients readmitted each month decreased from 1.75 pre-intervention to 1.46 post-intervention.

			• There were also significantly more months with no unplanned readmissions post-intervention (p=0.01).
	Depression	Patient Health Questionnaire	• No significant association was found with depression and satisfaction with life.
	Life satisfaction	Satisfaction with Life Scale	
Latimer-Cheung et al., (2013)	Intentions	Three items assessing intentions to engage in at least 30 mins of moderate to heavy intensity physical activity	• Significant improvements at post-test (p=.007).
	Action planning	Four items evaluating whether participants had a detailed plan regarding when, what, where, and how to engage in strength training over the next 2 week	• Significant improvements at post-test (p=.003).
	Goal-setting self-efficacy	Four items assessing confidence over the next 2 week	• Pre-post differences were not significant.
	Scheduling self-efficacy	Four items assessing participants confidence to fit 30 mins of moderate to heavy intensity strength training into their weekly schedule	• Pre-post differences were not significant.
	Barrier self-efficacy	Five items evaluating participants' confidence to overcome barriers to home-based strength training	• Significant improvements at post-test (p=.027).
	Task self- efficacy	Nine items evaluating participants' confidence to physically do moderate and heavy intensity strength training	• Significant improvements at post-test for task frequency self-efficacy (p=.023) but not for duration self-efficacy.

	leisure-time physical activity	Leisure Time Physical Activity Questionnaire for People with SCI – modified to only measure strength training	• Significant improvements to the frequency (p=.011), duration (p=.023), and volume (p=.012) of physical activity post-intervention.
	Intervention fidelity	6-item health care climate questionnaire	• Deviations from the study protocol were related to shortening exercise cool down (4 visits) and not distributing the end of visit survey (5 cases) due to time constraints.
	Acceptability	Six-item questionnaire	• Participants were satisfied with the exercises (average 6.5/7) and felt they could relate to the peer, having a peer at the home visit was helpful, and the visit would help them meet their strength training goals (averages > 6.49/7).
Ljungberg et al., (2011)	Self-efficacy	Generalized Perceived Self-Efficacy Scale	• Score improvements were seen at 6 months but were not significant. • Significant differences observed at 6 months between participants with low education (≤12th grade) and higher education (>12th grade) p=.013.
	Medical complications	Medical complications tracking form	• Rates of secondary medical complications and doctor visits decreased significantly between 0–6 months and 7–12 months. • Decreases were seen in urinary tract infection (p=.001), pain (p=.001), depression (p=.004), pressure ulcers (p=.046), hospitalizations (p=.002), and ER visits (p=.004).

Lucke et al., (2004)	QoL	Life Situation Survey; MOS SF-36	• Most scores remained stable from 6 weeks to 6 months. • There was a non-significant improvement to the mental health subscale score over 6 months. • Vitality and role function due to emotional health subscales did not improve over 6 months. • Regression analysis revealed a significant change in social functioning over 6 months (p=.036).
	Hope	Miller Hope Scale; Herth Hope Scale	• Increased largely at 6 weeks and then declined slightly. • Regression analysis revealed a significant change in hope over 6 months (p=.024).
	Adjustment	Positive and Negative Affect Scale	• There was an upward trend for adjustment over six months.
METRC (2019)	Self-efficacy (return to work and managing financial challenges of injury)	Two 10-point self-efficacy scales	• The odds of high self-efficacy increased by 14% for return to work and decreased by 2% for managing finances.
	Pain	11-point pain intensity numerical rating scale	• The intent to treat analysis revealed that odds decreased for pain (18%), depression (23%), and PTSD (12%) compared to the control.
	Depression	Patient Health Questionnaire	
	PTSD	PTSD Check-list, civilian version	
Simske et al., (2019)	Self-efficacy	Two-item, 6-point self-efficacy scale developed by the research team	• Participants in the experimental group reported a higher likelihood of recovery (p=.05) and of returning to

			daily activities (p=.003) compared to controls.
	Satisfaction	Two-item, 6-point question	• All participants reported high satisfaction with their hospital experience. Participants in the experimental group were satisfied with the program.
	Helpful recovery tools	Select up to 5 program elements that are perceived as helpful to recovery	• The tools that were perceived as the most helpful were an online community (reported by 38.8% of all participants), followed by peer relationships (26.3%), counseling (22.5%), support groups (17.5%), and education materials (6.3%).
	Tool utilization	Select program elements that were used	• Participants in the experimental group reported peer visitation as the most commonly used tool (52.6% of participants utilized this service) followed by the TSN handbook (42.1%). • Participants in the experimental group were more likely (p<.001) to use the TSN handbook (education material) compared to controls. • Participants in the experimental group used peer relationships (52.6% vs 26.3%) and support groups (26.3% vs 17.5%) more than controls, however, these relationships were not significant.

Table 4. User Experience Outcomes (*n*=6)

Author (year)	User Experience Outcomes	Results
Castillo et al., (2013)	Usability/Use of services Patient satisfaction – Perceived helpfulness of program and program elements Whether the participant would recommend the services	• Use of Trauma Support Network resources was low, 6% attended a support group and 10% met with a peer visitor. • Of participants who used peer resources, helpfulness was scored ≥7 pts on a 10pt scale by 50% of participants who attended a support group and 79% of participants who met with a peer visitor. • 86% of participants would recommend the support group and 85% would recommend meeting with a peer visitor.
Hoffmann et al., (2019)	Number of meetings Patient satisfaction the number of meetings Topics discussed Patient satisfaction with mentor match	• 22% of participants attended one meeting, 26% attended two meetings, 38% had three meetings, and 14% attended four or more. 64% of participants found the number of meetings to be appropriate while the remaining 34% would have preferred more meetings. There was no association with the number of meetings and satisfaction with the number of meetings. • The most commonly discussed topics were “life after hospitalization” by 81%, “practical problems” by 73%, “accessibility aids” by 62%, and “the disease accident that caused my SCI” by 60%. • 94% of participants would recommend meeting with a peer mentor and 6% did not know.
Houlihan et al., (2016)	Satisfaction Perceived appropriateness Intent to continue use Actual use	• High satisfaction with each peer health coach and high performance ratings for the peer health coaches. • Generally agreed the intervention would be beneficial. • Participants and peer health coaches expressed reluctance at study end and planned to continue using support materials.

	Perceived demand/need Expressed interest to use Degree of execution Success or failure of execution Type of resources needed to implement Factors affecting implementation ease or difficulty Efficiency of implementation Positive effects on target participants	• Participants demonstrated high levels of engagement and completed almost all their scheduled calls. The resource list was found to be more helpful than the workbook. • Participants felt the intervention would meet a real need. • Every participant would definitely recommend the intervention to their peers. • Peer health coaches made 19%more call attempts than the protocol required and completed nearly all online tracking forms documenting that they fully executed calls. • Peer health coaches successfully completed three quarters of attempted calls and completed brief action planning goal setting with all but 1 participant. Peer health coaches reported building skill in offering support materials over time. • Peer health coaches focused much more than anticipated on creating personal support packages after each call. Although somewhat time intensive, this proved critical to participant engagement. • Peer health coaches and participants reported that peer health coach's use of texting and flexible call scheduling facilitated engagement. Participants and peer health coaches found that using the resource list separate from the workbook was confusing. Peer health coaches found team calls to be important for problem-solving and ongoing support. • Peer health coaches estimated 1 hour of time, including preparation beforehand, documenting call content, and compiling personal support packages. Call length was found to be reasonable.

		• Participants reported three benefits, increased confidence towards achieving their goals, feeling supported by their peer health coach, increased connection to available resources.
Newman et al., (2019)	Usability/Use of services General feedback	• 90% of participants preferred the iPad Air 2 due to the larger screen size. • Participants with impaired hand function were able to tap the screen with their knuckles and when they were unable to apply enough pressure, an adaptive ring stylus could be used. • Results from the Systems Usability Subscale indicated favorable levels of usability and acceptability of the iPad, mean total score 4.47/5. The lowest scored item was “I could use the iPad without having to learn anything new”, mean score 3.9/5. • Two participants suggested an introductory video to learn how to navigate an iPad. • Participants were largely able to navigate the iTunes U platform and were able to move between and within the content modules without difficulty. • The majority of participants expressed satisfaction with the online and multimedia aspect of the content and valued the focus on prevention of secondary conditions and found the video length of <5 minutes to be acceptable. • Suggestions for improvement included larger font size, more actors in the videos, and having the actors talk directly to the viewer. • Holding iPads was difficult during video chat and wheelchair mount recommended. • Participants living in rural environments experienced connection issues.

		- Favorable levels of usability and acceptability for the FaceTime platform. - Participants appreciated the opportunity to talk to peers and none reported apprehension to talk to someone remotely.
Wells et al., (1993)	Patient satisfaction with the program General feedback Satisfaction with the information provided Hopefulness before and after the program	- Many participants rated all aspects of the intervention highly. - Participants reported that the type of amputation, age, and interests of the mentor were important for matching. - All program elements were found to be beneficial, information about the rehabilitation process, opportunities to discuss current concerns and life in the future, and emotional support that validated their feelings. - Participants reported that the information they received was useful and they were comfortable sharing their fears and anxieties. - Although not significant, people aged under 39 reported the least hope for the future and a higher proportion reported that they were not satisfied with their visit, felt they were not helped with their concerns, and were not satisfied with the way their questions were answered. - 51% of participants reported wanting another visit, and of those, 50% would have liked another visit during their rehabilitation.
Williams et al., (2002)	Patient satisfaction	- Overall, burn survivors were satisfied with the peer support program. Mean scores for the four-item (1 to 7 Likert) questionnaire were 5.81 (approached appropriately), 6.2 (visit was useful), 6.3 (questions were answered), and 6.18 (like to see again). Higher scores represent stronger agreement.

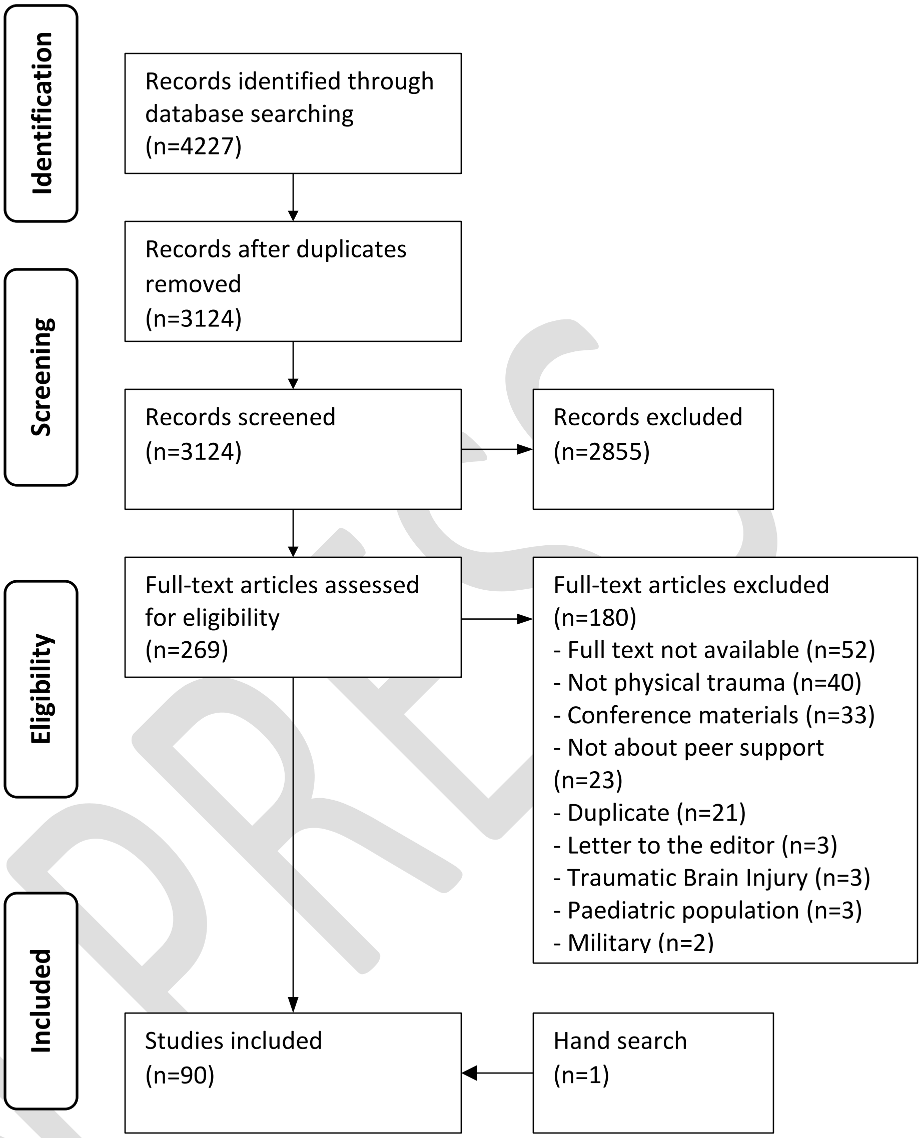

Figure 1. PRISMA diagram

PRISMA diagram displaying the number of articles identified through screening and the number that were excluded. Of 4,227 articles identified through database searching, 90 were included in the scoping review.