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Authors' reply

We thank Mark Abie Horowitz and colleagues for their interest in our Personal View.[1] We agree there is more high-quality evidence for antipsychotics than for psychosocial interventions, probably due to industry sponsorship. In our Personal View, we cited the original US National Institutes of Health (NIH; ie, government funded) trial of around 400 people, and a systematic review that showed conflicts of interest did not differ between antipsychotic and psychotherapy trials in established illness. The UK-based cognitive behavioural therapy (CBT) trials that we cited were also government funded, and we highlighted problems (eg, absence of control group, structured diagnostic interviews, information on substance misuse, and antipsychotic monitoring) are not dependent on funding source.

We are concerned about the misleading language Horowitz and colleagues used to describe antipsychotics; as "sedatives", causing "mental suppression". The citation given to support this language—a letter in response to a review we cited—was comprehensively dealt with by the original authors in their author reply. We cited literature from the 1960s showing sedatives do not exert beneficial effects, similar to antipsychotics, and the suggestion that antipsychotics cause effects through mental suppression belongs to that era and has no place in a clinical research journal. Presumably Horowitz and colleagues would not state CBT causes mental suppression.

We are surprised by the authoritative manner that Horowitz and colleagues assert that withdrawal from antipsychotics "will inevitably worsen outcome in placebo groups", and so be a reason for high relapse rates upon discontinuation; there is no direct evidence to support this statement. We see no harm in individual tapering regimens, but emphasise the hypothetical nature of this premise.

Furthermore, we are bewildered as to why Horowitz and colleagues would expect us to quote selected findings out of context from a randomised controlled trial that was testing feasibility.[2] The numbers are clearly too small to make any inference (n=61 in three groups).[3] Using such logic, one could state twice as many serious adverse events occurred in the psychological therapy group. Furthermore, concordance with antipsychotic medication was less than with psychotherapy. The authors do not appear to have read Francey and colleagues' trial thoroughly,[4] because approximately 40% of the placebo group discontinued and ended up taking antipsychotics. Similarly, around half the placebo group in the original NIH trial ended up taking antipsychotics. Our point regarding allegiance and expectancy effects in psychosocial trials relates to methodology: without a placebo group, expectancy is magnified,[5] and all but one CBT trial has been done by the same group.

Therefore, we reject the argument our piece was unbalanced. We suggest readers appraise evidence, as we have done, before jumping to what we would consider premature and erroneous conclusions.

SJ has received honoraria for educational talks given for Janssen, Sunovian, and Lundbeck. SML declares no competing interests from the past 3 years.

**Sameer Jauhar, Stephen M Lawrie*
sameer.jauhar@kcl.ac.uk

Centre for Affective Disorders, Department of Psychological Medicine, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, SE5 8AF, UK (SJ); Division of Psychiatry, Royal Edinburgh Hospital, Edinburgh, UK (SML)

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Peer support for discharge from inpatient mental health care

We write to express our concern about several aspects of the ENRICH trial as reported in the Article by Steve Gillard and colleagues.[1] We disagree with the Article's strong assertions that "This definitive, high-quality trial addresses uncertainty in the evidence base and suggests that peer support should not be implemented to reduce readmission post-discharge for patients at risk of readmission."[1] The trial studied one model of discharge-related peer support in one national setting. We believe the authors' recommendations not only overreach from this single study but are also simply not justified considering their findings.

By the authors' own definition, only 62% of participants in the intervention group met criteria for engagement, defined as two contacts with a peer support worker, when one occurred post-discharge. For those who met this minimal requirement (per their complier average causal effect analysis) peer support worked; these patients had a significant 12% reduction in the risk of readmission (risk ratio 0·88 [0·76–0·99]), and the point estimate for the effect was even larger for Black participants at 60% (0·40 [0·17–0·94]). The authors' recommendations downplay these results, which is troubling given that guidance on the evaluation of complex interventions

states that "Lack of effect may reflect implementation failure".[2]

Inferring lack of effect without concurrently exploring implementation issues that could have contributed to low engagement is inconsistent with standards for evaluating complex interventions that point to the importance of considering interactions between an intervention and its context (eg, implementation) for decision making.[3] Relationship quality is an essential ingredient in effective peer support and (per this group's systematic review) should be included in an evaluation.[4] Given that the outcome measures were not interpreted in light of an evaluation that included the key factor of relationship quality between patient and peer support worker, these findings seem to be treating the peer support worker–participant relationships like manufactured widgets or pills rather than human interactions. This absence of context around the peer support worker–participant relationship is especially concerning given that the theoretical model underpinning this intervention hinges on "building trusting relationships".[5]

Given these issues, it seems ill-advised to make definitive policy recommendations about post-discharge peer support for the prevention of readmission on the basis of a single trial of one peer-support intervention with unclear implementation. The ENRICH trial shows that peer support offers significant promise for those who use it. We urge decision makers to treat the broad recommendations from the ENRICH trial with caution.

All authors have served as paid and unpaid leaders, advisors, and consultants on projects related to peer support and patient involvement in mental health research. All authors belong to the Advancing User/Survivor Involvement in Research collaborative group.

*Peter Phalen, Rebecca Miller, Barbara Frampton, Nev Jones, Karen Machin, Diana Rose, Hannah Stewart, *Michelle Colder Carras*
mcarras@jhu.edu

University of Maryland School of Medicine, Baltimore, MD, USA (PP); Connecticut Mental Health Center, Department of Psychiatry, Yale School of Medicine, New Haven, CT, USA (RM); Aylmer, ON, Canada (BF); School of Social Work, University of Pittsburgh, Pittsburgh, PA, USA (NJ); Survivor Researcher Network, Birmingham, UK (KM); College of Arts and Social Sciences, Australian National University, Canberra, ACT, Australia (DR); University of Texas Health Science Center at Houston School of Public Health, Houston, TX, USA (HS); Department of International Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD 21205, USA (MCC)

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Authors' reply

We thank Peter Phalen and colleagues for their comments on our Article.[1] When we began enquiries for our study an equivocal evidence base suggested reducing hospitalisation to be the most promising potential effect of peer support. However, many people we spoke to in the peer support community—and in our team—doubted that this would be the case, suggesting that any effects would be more immediately personal or social. Our subsequent systematic review[2] of one-to-one peer support in mental health services did not indicate a significant effect of peer support on hospitalisation (including readmission post-discharge), a finding that was reflected in our trial.[1]

As such, we specifically cautioned against the implementation of one-to-one peer support in the expectation that it will effect psychiatric admissions to hospital. Our review did indicate potential effects of peer support on empowerment, personal recovery, and social network.[2] Future trials might strengthen that evidence and also elucidate the important potential benefits of peer support for Black people using mental health services that we observed.

In the real world, as in trials, not everyone takes up the offer of support, so it is appropriate to base general recommendations on intention-to-treat analyses. Moreover, we do not think that 62% of people taking up a minimum offer of peer support necessarily represents an implementation failure. Our peer support was developed through an extended programme of work with researchers working from an experimental perspective of having used mental health services, peer workers, and people running peer-led services,[3] grounded in a principles framework.[4] One of those principles was choice in engaging with peer support. Additionally, in in-depth interviews peer workers delivering the peer support reported feeling well supported in the role through training, supervision, and a supportive team, at least in part indicative of successful implementation.[5] Nonetheless, implementation questions remain important and our continued research explores, quantitatively and qualitatively, associations between peer-to-peer relationship, engagement with peer support and outcome, and will be published in due course.

We declare no competing interests.

**Steve Gillard, Sally Barlow, Stephen Bremner, Rhiannon Foster, Sarah Gibson, Lucy Goldsmith, Andrew Healey, Mike Lucock, Jacqueline Marks, Akshaykumar Patel, Shalini Patel, Stefan Priebe, Miles Rinaldi, Alan Simpson, Michael Ussher, Sarah White*
steven.gillard@city.ac.uk

School of Health and Psychological Sciences, City, University of London, London EC1V 0HB, UK (SGil, SBa, RF); Department of Primary Care and Public