Best Practice in Peer Support

INTRODUCTION

This document has been based upon information contributed by more than 25 peer support programs across Australia and New Zealand. The programs come from a wide range of organisations, including police, fire, ambulance, SES, hospitals and health services, corrections, welfare and human services, mining, heavy industry, conservation and security. I would like to sincerely thank everyone who contributed with information, suggestions and ideas.

The most successful peer support programs appeared to be those which establish, customise and maintain their program according to the needs of their organisation. The standards I've summarised in this report appear to be the consistent factors which successful programs have in common.

I have basically used four criteria for success. These are the longevity of the program, recognition of the program within the organisation, positive feedback from members of the program and the level of apparent peer support activity. It could be argued that these are a very subjective set of variables, as all information came from self-report. However,this is not a formal empirical study. My purpose was to gather information and put it into a coherent format to assist peer support programs from around Australia and New Zealand to learn from each other.

I will update this document as new information comes to hand. I'm happy to receive feedback and suggestions to enhance the process of establishing a Best Practice for Peer Support. Please send e-mails to michael@emergencysupport.com.au

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Please distribute this document to anyone who you consider would benefit from the contents.

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Michael has specialised in critical incident stress management and peer support programs since 1985. He has trained peer supporters with more than 70 organisations across Australia, New Zealand, and Papua New Guinea. These include all branches of the emergency services, health, education, welfare, justice, mining and petroleum, transport and conservation.

Michael is the co-author of three books, "Emergency Support: A handbook for peer supporters" (1993), "Victim to Survivor" (1994) and "Risky Practices" (2001). He's also the author of "How to Understand and Manage Stress" (1992), "How to Manage the Stress of Traumatic Incidents" (1995), "The Peer Supporters' Pocketbook" (2004) and "The Peer Support Workbook". His new book, "A life in Crisis" will be published in 2007.

Michael continues to provide training and consultancy for a wide range of organisations and is a sessional lecturer in Trauma Counselling at the University of Notre Dame Australia

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Best Practice Standards in Peer Support Programs

AREA OF BEST PRACTICE	STANDARD
1. Description of peer support. Peer support tends to be looked at from two philosophical models. The more traditional model describes a peer supporter as a member of the workplace who has been specially selected and trained to provide a first line of assistance and basic crisis intervention to fellow workers (Robinson and Murdoch, 2003). A second model tends to be much broader, describing a peer supporter as a member of a workgroup who has been trained to assist colleagues affected by stress (Tunnecliffe, 2004). While similar, the second definition outlines a role for peer supporters which may provide for, but is not limited to critical incidents. Most programs have a clear definition of what the concept of peer support meant within their organisation. Only a few limited the focus of peer support activities to front line crisis intervention. Even then, there was no evidence in the information gathered that these limitations were being stricly adhered to.	**Best Practice Standard 1.** ***The program will have a clearly stated definition of peer support and the role that peer supporters will undertake within the organisation. The overview of aims and statement of peer support role will take into account the nature of the industry, or the type of professional service the organisation provides.*** **Evidence may include:** - Training notes on the types of stress covered - Statements of program aims - Descriptions of the role in advertisments for peer supporters - Overall training content reflecting a clear program philosophy - Statements in policies and procedures.
2. Program establishment. It appears the way in which a program is established has a large bearing on the overall success of that program. There have been accounts of program models being transferred from one organisation to another, with limited in-house consultation and little regard as to how that program might work in the second organisation. Two programs reported being mandated by management, without consultation from within various areas of the organisation. Most organisations surveyed adhered, to some degree, to the 8-point program establishment protocol recommended by Robinson and Murdoch (2003). 1. Determine support for the program at all levels 2. Develop a master plan 3. Consult with all sections of the organisation 4. Integrate peer and mental health support 5. Educate the organisation about the program 6. Designate and integrate functions within the program 7. Build in a monitoring and review system 8. Establish and continue to develop a program policy. Four programs reported starting in an ad hoc way, with limited knowledge of what they were doing. These programs became established as they went along, drawing upon the knowledge of existing programs in other organisations. Two programs reported having a poor start, due to lack of expertise, which created a need to fully revise how the program was to operate.	**Best Practice Standard 2.** ***The program will have an establishment plan, which includes a clear set of development tasks, such as those recommended by Robinson and Murdoch.*** **Evidence may include:** - Write up of a needs analysis - Planning documents - Minutes of meetings - Documentation of consultation with key stakeholders and senior personnel - Memos or e-mails of support - Draft of policies and procedures.

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AREA OF BEST PRACTICE	STANDARD
3. Program policies and procedures. All except for three programs maintained a written set of policies and procedures, specific to the peer support role and responsibilities within their organisation. In some cases, these have been incorporated into existing HR, OSH or HSE procedures, while in others they're stand-alone policies, which have little formal recognition within the organisation, as a whole. The programs without a formal written policy document tended to rely either on existing knowledge of peer supporters, or on an ad hoc range of existing practices which had not been formalised into a single document. A number of teams submitted copies of their Policy Document together with the other information being gathered for this project. Most were good examples of a useful Policy & Procedures document, while a few were called a "policy", but were little more than training notes. The written policies and procedures of most organisations covered a wide range of areas, including: - Operational definitions - Role limitations - Membership, recuitment and selection - Training - Role description - Duties and responsibilities - Code of conduct for peer supporters - Terms of service - Confidentiality guidelines - Reporting procedures - Complaint resolution processes.	**Best Practice Standard 3.** ***The program will have a written set of policies and procedures customised to the organisation, covering key areas of peer support functioning. This document will be reviewed and updated, at least every two years, or on a needs basis.*** **Evidence may include:** - Written set of policies and procedures - Provision for, or indication of, periodic review.
4. Selection of peer supporters. All programs reported having some form of selection process for peer supporters. These ranged from highly formal procedures, involving written applications, interviews and contacting referees, to programs, where applications for peer support were called for, then appointments as peer supporters were made by management. The use of a written application and interview, either in person or by phone, were the most common methods. There was little consistency in the style of application form used. Also, it appears the format of interviews varied greatly, with some involving a mental health professional and peers, while others relied on the program co-ordinator and / or supervisory staff. All programs reported attempting to select a peer supporter group which was representative of pertinent features of personnel within their organisation. These included gender, age, rank, location ethnicity, etc. Less than half of the programs reported using an objective inclusion criteria (stating the type of person sought beforehand) in their selection process. Most tended towards a more subjective exclusion criteria (deciding who would not be suitable).	**Best Practice Standard 4.** ***The program will have a clearly defined selection process which looks for suitable personnel based upon a set of desirable criteria (personality, skills and other desirable attributes). This process will also consider the various demographics reflective of the organisation. These may include gender, age, experience, rank, location, ethnicity, etc.*** **Evidence may include:** - Documented selection procedure - Application form - Interview protocol - Written selection criteria - References in the program's policies and procedures.

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5. Training of peer supporters. Peer support training in all programs was a minimum of two days duration, provided by a mental health professional, usually assisted by either a peer supporter or operational member of that service, with training skills and experience. The training duration, methodology and style varied greatly. While the majority provided at least a two or three day course, a few programs had training courses which extended well beyond this. All programs advocated regular follow-up training for peer supporters, however, the consistency with which this was applied or maintained appeared to be sporadic. Training appeared to be divided into areas: core content, non-core content and practical application (e.g. exercises, role-plays and scenario activities). All programs reported provided training in most of the core content areas. These include stress knowledge and information, stress management, critical incident stress, CISM and group support strategies, networking, communication skills, problem-solving, the peer support role, supportive techniques, confidentiality, ethics and referral. A second area relating to the core content was concerned with the program itself. Topics here included the peer support role, peer support program policies and procedures, administration, reporting, EAP and appropriate OSH / HSE requirements. Non-core content tended to range greatly in terms of the topics covered. Depending on the organisation, these included disaster management, suicide identification, grief, burnout and substance abuse. Please note, these are examples only and all programs had some differences in their training content. Not all programs had a consistent mix of knowledge content and practical skills development. A number placed too much emphasis on knowledge content, to the detriment of practical skills development. In most cases, the training was highly customised to the occupational group participating. All organisations indicated that attendees were provided with training materials, which in some cases was accompanied by a text book and / or resource file. A few programs have developed competency-based peer support training reqirements, which meet the accreditation standards for Nationally Recognised Training. The content of this training was similar to that of other non-accredited courses. Three programs reported considering the combining of peer support training with Grievance Contact Officer training. However, this idea has not been acted on. There are a few examples of organisations attempting to combine the roles, to the detriment of peer support, due to potential of conflict of interest issues and the risk of creating role confusion. Most programs used on-going training to maintain peer support skills. This is usually conducted on an annual basis, with peer supporters required to meet an attendance criterion (e.g. annual participation). Some programs used interim contact methods, such as monthly meetings, newsletter or electronic newsletter by e-mail to maintain contact with peer supporters. One program reported a regular phone conference link-up, while another indicated they were considering the use of a peer support website.	**Best Practice Standard 5.** ***The program will have a training course of at least two days duration, with content customised to the types of stress experienced by organisational personnel and specific to the role to be taken by peer supporters. It will exclude other roles, such as grievance or contact officer. The training would be presented by at least one mental health professional and provide an appropriate balance of theory and practice, which emphasises the practical application of the knowledge and information gathered during the training. Initial training would be followed by up-date courses on a regular basis, not less than once per year.*** **Evidence may include:** - Training plans and schedules - Training course notes - Training activities - References in the program's policies and procedures.

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AREA OF BEST PRACTICE	STANDARD
6. Certification of peer supporters. All programs reported that peer supporters receive documented evidence of either their participation or completion of the training. As mentioned in the previous section, a few programs have extended the certification to provide Nationally Recognised Training at Certificate III or Certificate IV level. There appears to be polarised opinion on using this approach to peer support training. Proponents of issuing a formal qualification see it as a means of providing more significant recognition of peer supporters, increasing professionalism and instigating more substantial training by using a competency-based approach. Those opposed to such a move, express concerns about moving peer support into a more formal process which could increase the level of inappropriate activities, such as moving to more of a counselling role, or reluctance to refer to mental health professional when required. However, to date, there are no reports of this happening within programs that issue a formal qualification. Of even greater concern in some organisations are the implications for remuneration for qualifications and the possibility that gaining a qualification becomes the main incentive to become involved in peer support. People from a few organisations also expressed concerns that the implication that qualifications come with increased obligations may deter some highly suitable people from peer support. There was no evidence presented that the use of Nationally Recognised Training for peer support has created any problems for either the program or organisation, where such training is used.	**Best Practice Standard 6.** ***The program will provide each person completing the peer support training with a certificate to state their participation in the course.*** ***A competency-based requirement for certification should not be made mandatory, but be left to the discretion of the organisation.*** **Evidence may include:** - References in the program's policies and procedures - Example of training course certificate.
7. Peer supporter supervision and back-up. Most programs reported supervision of peer supporters by a mental health professional. In the majority of programs, this person also played a major role in training, follow-up and advising peer supporters on issues of concern. Some programs reported a requirement that formal peer support supervisory sessions to take place on at least an annual basis, while others kept the process far less formal. Where the mental health professional was an employee of the organisation, supervision appeared more regular and was consistently used. In some cases, this same person was also the program co-ordinator. Six programs reported supervision being provided by their program co-ordinator, who was not a mental health professional, but in all cases, serious issues, complaints or long-standing problems triggered the involvement of a designated mental health professional or a chaplain. In some situations, assistance was sought from the organisation's Employee Assistance Provider.	**Best Practice Standard 7.** ***The program will provide each peer supporter with access to the co-ordinator and / or chaplain and mental health professionals attached to the program, for advice, supervision and guidance. Supervision and feedback would also form part of the peer supporter's on-going training requirements.*** **Evidence may include:** - References in the program's policies and procedures - Up-date training schedules.

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8. Peer support terms of service. Most programs with documented policies and procedures included written terms of service as a peer supporter. These covered years of service the peer supporter agreed to be involved, agreement with the role requirements and responsibilities and to attend follow-up training. Most terms of service also allowed for peer supporters to leave the program should they wish to do so. In the cases of some programs, these terms of service also covered co-ordination and the involvement of mental health professionals, as clinical directors or advisors. The majority of programs provided peer supporters with written document outlining their role and responsibilities. In some programs, peer supporters are advised of these as part of their selection and sign an agreement at the conclusion of training. Some agreements also clearly state the organisation's obligation to peer supporters in terms of training, co-ordination, supervision and program resourcing. This document tended to be given a range of names, including *Conditions of Service*, *Memorandum of Understanding*, *Code of Conduct* and *Peer Support Agreement.*	**Best Practice Standard 8.** ***The program will provide written information to the co-ordinator and each peer supporter as to the length and terms of service associated with their role. This document would also include the peer support requirements and responsibilities.*** **Evidence may include:** - References in the program's policies and procedures - Example of the program's written agreement with peer supporters.
9. Co-ordination of the program. All programs reported having a designated person who is recognised as the program co-ordinator. The conditions of appointment range from a full-time position to an honorary role that a volunteer peer supporter takes on, in addition to their operational or substantive role within the organisation. In most organisations, the co-ordinator has been appointed or seconded from an operational role, or has an operational background. In a few programs, the co-ordination function is carried out by a mental health professional, with peer supporter involvement in co-ordination duties, while in others this role is the domain of a Welfare Officer or HR or OSH / HSE staff member In general, there's little consistency in co-ordinator, function, role or procedures across the various programs. The key factor seems to recognise that adequate co-ordination has to be funded in terms of an FTE allocation and resourced with financial and administrative back-up.	**Best Practice Standard 9.** ***The program will be co-ordinated by a person with experience and background which relates to the peer support role. This person will be an FTE equivalent according to the needs of the program and will be responsibile for providing guidance and supervision of peer supporters.*** ***The co-ordinator will be responsible for other duties as stipulated in the program's policies and procedures.*** **Evidence may include:** - FTE allocation to the role by the organisation - Co-ordinator's duty statement - References in the program's policies and procedures - Co-ordinator's reports.

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10. Funding of the program. This varies greatly and appears to be linked to how the peer support program articulates into the organisational structure. Successful programs are those incorporated into a branch of the organisation which then provides on-going management of, and funding for, the peer support program. It was evident that the programs given a high profile within their organisation and reporting success in recruiting and mainatining peer supporters, where those provided with a consistent funding allocation.	**Best Practice Standard 10.** ***The program will receive a recurrent funding allocation, adequate to allow its functioning to the degree planned at its establishement. This funding will be reviewed regularly and adjusted according to evidence of need.*** **Evidence may include:** - Annual funding allocation - Organisational budget documents.
11. Promotion of the program. All programs maintain they have some form of program promotion which may include a brochure, posters, employee briefings, reports to Executive and special functions. The degree to which programs are actually promoted, however, varies greatly, with some being highly promoted when established, but with minimal promotion and follow-up in subsequent years. A few programs reported a wide range of promotional activities, with a specific budget allocation to cover the costs.	**Best Practice Standard 11.** ***The program will be regularly promoted throughout the organisation to ensure awareness and clear explanation of the peer supporter role in assisting colleagues.*** **Evidence may include:** - Brochures, posters, etc - E-mails and notifications - Updates at staff meetings - References in newsletters and circulars.

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12. Management support. All programs reported they have some form of management support. What this means in tangible outcomes for the program may vary greatly. The appearance of a CEO, Department Head or Senior Officer to hand out certificates and say encouraging words at the end of a training course is only the start of management support. Endorsement by management requires recognition of the role the program plays by providing funding for co-ordination, administration, training, consultancy and meeting day-to-day expenses.	**Best Practice Standard 12.** ***The program will be endorsed and given tangible support by the mangement of the organisation at all levels.*** **Evidence may include:** - Documents from management endorsing the program - References to the program in executive minutes, etc - Advice from senior management to middle management encouraging assistance to the program - Participation by management to encourage peer supporters at training courses.
13. Program referral policy. All programs were able to articulate a referral policy, with some using an in-house EAP service, while others used only an external provider and a few programs using both. A few programs included referral to a chaplain in their policy. Around two-thirds of the programs reported having documented procedures, outlining a consistent referral policy. All programs reported anonymous referral, however, not all EAPs were available for self-referral by members of the organisation.	**Best Practice Standard 13.** ***The program will have a documented referral policy to guide peer supporters in assisting colleagues with problems which are beyond the peer support role.*** **Evidence may include:** - References in the program's policies and procedures. - Information about referral for professional assistance being included in the peer support training. - EAP documentation issued to peer supporters.

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AREA OF BEST PRACTICE	STANDARD
14. Program evaluation. An overview of peer support programs indicated two forms of evaluation. Firstly, a general statistics reporting by peer supporters and secondly, a more formal program-wide evaluation which looked at the effectiveness of the peer support program within the organisation on a number of levels. Requiring peer supporters to keep non-identifying statistics on their contacts is common practice in the majority of programs. This is understandable in that continued funding of programs often needs the form of justification that contact statistics provide. Many of the organisations surveyed seek "Return On Investment" evidence in their funding considerations. Programs seemed to use a number of methods for collecting statistics, including completion of forms, record booklets and on-line reporting. Most programs appeared to have problems in getting statistics on a regular basis. A few programs had opted for a quarterly or six-monthly review, while nearly a quarter of programs had once sought data from peer supporters, but had now given up on collecting statistics. Comprehensive program evaluations were reported by at least half of programs. A number of these formed the basis of dissertations by university students. Programs generally reported that the findings of these formed the basis for significant program improvements. Two programs reported having major evaluations, but had not incorporated any results of these evaluations into their practices or procedures.	**Best Practice Standard 14.** ***The program will keep a record of peer support activity and engage in some form of periodic evaluation of the program's functioning and effectiveness.*** **Evidence may include:** - References in the program's policies and procedures - Program activity statements and statistics - Program evaluation reports - Reports to manageement
15. Succession planning. Less than half of the programs had details of a workable succession plan incorporated into the policies and procedures. It seemed very few programs considered succession planning when the original program was established. There were a number of indicators that programs with clearly detailed succession plans maintained a high level of recognition and functioning over time.	**Best Practice Standard 15.** ***The program will provide for its on-going functioning with a documented succession plan.*** **Evidence may include:** - References in the program's policies and procedures.

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PEER SUPPORT BEST PRACTICE AUDIT

By reviewing the evidence available for a specific peer support program, each of the best practice standards can be audited using the chart below. Keep in mind the unique needs of the organisation.

The ratings are as follows:

1. This best practice standard is not applicable to our organisation
2. Completely fails to meet the best practice standard.
3. Partially meets the best practice standard
4. Mostly meets the best practice standard.
5. Completely meets the best practice standard.

These ratings can be used to decide on action priorities (Low, Medium or High) which can then be transferred to the planning sheet on the following page.

Best Practice Standard	Rating	Action Priority
1. Peer Support Description	1 - 2 - 3 - 4 - 5	Low Medium High
2. Program Establishment	1 - 2 - 3 - 4 - 5	Low Medium High
3. Policy and Procedures	1 - 2 - 3 - 4 - 5	Low Medium High
4. Selection of Peer Supporters	1 - 2 - 3 - 4 - 5	Low Medium High
5. Training of Peer Supporters	1 - 2 - 3 - 4 - 5	Low Medium High
6. Peer Support Certification	1 - 2 - 3 - 4 - 5	Low Medium High
7. Supervision and Back-up	1 - 2 - 3 - 4 - 5	Low Medium High
8. Terms of Service	1 - 2 - 3 - 4 - 5	Low Medium High
9. Program Co-ordination	1 - 2 - 3 - 4 - 5	Low Medium High
10. Funding of the Program	1 - 2 - 3 - 4 - 5	Low Medium High
11. Promotion of the Program	1 - 2 - 3 - 4 - 5	Low Medium High
12. Management Support	1 - 2 - 3 - 4 - 5	Low Medium High
13. Program Referral Policy	1 - 2 - 3 - 4 - 5	Low Medium High
14. Program Evaluation	1 - 2 - 3 - 4 - 5	Low Medium High
15. Succession Planning	1 - 2 - 3 - 4 - 5	Low Medium High

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PEER SUPPORT BEST PRACTICE PLANNING SHEET

TASK	BY WHOM?	DATE

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