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Mark C. Creamer
University of Melbourne

Tracy Varker
University of Melbourne

Jonathan Visson
Cardiff University

Kathy Darte
Veterans Affairs, Charlettown PEI

Neil Greenberg
King's College London

See next page for additional authors

Authors
Mark C. Creamer, Tracy Varker, Jonathan Visson, Kathy Darte, Neil Greenberg, Winnie Lau, Gill Moreton, Meaghan O'Donnell, Don Richardson, Joe Ruzek, Patricia Watson, and David Forbes

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CE Article

Guidelines for Peer Support in High-Risk Organizations: An International Consensus Study Using the Delphi Method

Mark C. Creamer,[1,2] Tracey Varker,[1,2] Jonathan Bisson,[3] Kathy Darte,[4] Neil Greenberg,[5] Winnie Lau,[1,2] Gill Moreton,[6] Meaghan O'Donnell,[1,2] Don Richardson,[7] Joe Ruzek,[8] Patricia Watson,[9] and David Forbes[1,2]

[1]Australian Centre for Posttraumatic Mental Health, Melbourne, Victoria, Australia
[2]Department of Psychiatry, University of Melbourne, Melbourne, Victoria, Australia
[3]School of Medicine, Cardiff University, Cardiff, Wales, United Kingdom
[4]Veterans Affairs Canada, Charlottetown, Prince Edward Island, Canada
[5]Institute of Psychiatry, King's College, London, England, United Kingdom
[6]Rivers Centre for Traumatic Stress, Edinburgh, Scotland, United Kingdom
[7]Parkwood Operational Stress Injury Clinic-St. Joseph's Health Care, London, Ontario, Canada
[8]National Center for PTSD, VA Palo Alto Health Care System, Menlo Park, California, USA
[9]UCLA/Duke University National Centre for Child Traumatic Stress, Los Angeles, California, USA

Despite widespread adoption of peer-support programs in organizations around the world whose employees are at high risk of exposure to potentially traumatic incidents, little consensus exists regarding even the most basic concepts and procedures for these programs. In this article, consensus refers to a group decision-making process that seeks not only agreement from most participants, but also resolution of minority objections. The aim of the current study was to develop evidence-informed peer-support guidelines for use in high-risk organizations, designed to enhance consistency around goals and procedures and provide the foundation for a systematic approach to evaluation. From 17 countries, 92 clinicians, researchers, and peer-support practitioners took part in a 3-round web-based Delphi process rating the importance of statements generated from the existing literature. Consensus was achieved for 62 of 77 (81%) statements. Based upon these, 8 key recommendations were developed covering the following areas: (a) goals of peer support, (b) selection of peer supporters, (c) training and accreditation, (d) role of mental health professionals, (e) role of peer supporters, (f) access to peer supporters, (g) looking after peer supporters, and (h) program evaluation. This international consensus may be used as a starting point for the design and implementation of future peer-support programs in high-risk organizations.

Peer-support programs have emerged as standard practice for supporting staff in many high-risk organizations—that is, organizations which routinely expose their personnel to potentially traumatic events such as emergency services and the military (Levenson & Dwyer, 2003). Although peer-support models are also used in other settings such as addiction or psychiatric populations, the focus of this article is restricted to the use of peer support in organizational settings. The rationale for provision of peer-support programs often includes the goals of meeting the legal and moral duty to care for employees, as well as addressing multiple barriers to standard care (including stigma, lack of time, poor access to providers, lack of trust, and fear of job repercussions).

Despite their increasing popularity and implementation across a range of these high-risk organizations, the published literature mostly comprises descriptive studies, often with small samples and cross-sectional designs, or longitudinal designs without comparison groups (Campbell, 2005; Solomon, 2004). Little consensus exists around how peer support in high-risk organizations is defined, its goals, how they should be implemented, and how effective they are on a range of outcomes. A recent review of police peer-support programs, for example, concluded that more research is needed on programs that utilize trained peers in partnership with professional mental health practitioners (Grauwiler, Barocas, & Mills, 2008). One reason for the paucity of rigor is that traditional randomized clinical trial methodologies, widely considered to be the gold standard in determining effectiveness, can be difficult to implement in real-world peer services, which are consumer driven and voluntary (Resnick & Rosenheck, 2008). The use of random

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Correspondence concerning this article should be addressed to Tracey Varker, Australian Centre for Posttraumatic Mental Health, Level 1/340 Albert St, East Melbourne, Victoria 3081, Australia. E-mail: tvarker@unimelb.edu.au

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assignment to condition limits the availability of an intervention, and for peer services built on a philosophy of inclusion, randomization may fundamentally alter the peer service under investigation (Resnick & Rosenheck, 2008).

Although past research findings regarding peer support in high-risk organizations are limited due to the lack of methodological rigor, significant gains have been described by participants of groups offering peer support in areas of self-esteem, better decision-making skills, improved social functioning, decreased psychiatric symptoms, lower rates of isolation, larger social networks, increased support seeking, and greater pursuit of educational goals and employment (Davidson et al., 1999; Froland, Brodsky, Olson, & Stewart, 1979; Humphreys & Rappaport, 1994). Although direct evidence relating to peer-support programs in high-risk services is lacking, there is an emerging body of evidence which shows that boosting and protecting social support can increase an individual's capacity to deal with a potentially traumatic event (Norris & Stevens, 2007). As such, peer support represents one attempt to operationalize social support within high-risk organizational structures.

The alacrity with which peer-support programs have been adopted in the absence of agreed protocols or an adequate evidence base is cause for concern. Using a well-established method of enquiry that canvases opinions of experts in a particular field (the Delphi method; Linstone & Turoff, 1975), this study surveyed an international group of experts and peer-support practitioners to reach agreement on various key aspects of peer support in high-risk services. Once agreement is reached on these key practices in peer support, future research can build upon that framework to evaluate the effectiveness of the approach.

Method

The Delphi Method

The Delphi method of enquiry recognizes the value of experts' opinions, experience, and intuition when full scientific knowledge is lacking (Linstone & Turoff, 1975). A carefully selected group of experts answer surveys in two or more rounds. After each round, a facilitator provides an anonymous summary of the experts' views and comments, allowing all raters to compare these with their own (Bisson et al., 2010). The aim is that, during this iterative process, the range of responses will decrease and the group will converge towards the "correct" response (Skulmoski, Hartman, & Krahn, 2007). The Delphi methodology has been used widely and has resulted in accepted outcomes, including guidelines in the health field (Bisson et al., 2010; Langlands, Jorm, Kelly, & Kitchener, 2008).

Literature Search

The aim of the literature search using PubMed and PsycINFO was to generate statements related to peer support for the expert rater group to consider (see below for a description of this group). This was not a systematic review and no judgment was made about the quality of the evidence or the methods. The literature was used solely to identify key questions, common practices, and intended outcomes.

The search term "peer∗support" was used, and all records for the 20 years leading to the search date were reviewed. Only those addressing peer support in high-risk occupations (e.g., emergency services, military) were selected. Articles were read if they described models of peer support, effectiveness and evaluations of peer support, or if they defined peer support itself or the goals or principles of peer support. Only 18 articles met our criteria and were subsequently used to generate 73 statements in consultation with the working group. A full list of statements for each of the three rounds is available from the corresponding author on request.

Statement and Questionnaire Development

The questionnaire for Round 1 was developed by grouping the 73 statements into four categories: (a) the definition, goals, and principles of peer support; (b) training, personnel, and supervision in peer support; (c) peer-support models and the delivery of peer support; and (d) the evaluation and effectiveness of peer support.

We reviewed each statement to ensure that the questionnaire did not include statements that contained more than one idea, repetition, ambiguity, or other problems that may have impeded comprehension. We made no judgments about the value of the statements; this was the task of the expert raters.

All raters answered the questionnaire using the online Internet survey tool Survey Monkey (www.surveymonkey.com). Raters were asked to indicate the level to which they agreed or disagreed with each statement using the following 9-point scale: 1 = *Completely disagree*, 5 = *Neutral,* and 9 = *Completely agree*. They were also given the opportunity to provide comments for each statement.

Ratings between 1 and 3, 4 and 6, and 7 and 9 were considered as *disagreement*, *neutrality*, and *agreement,* respectively. The nine ratings were collapsed into these three categories to increase the likelihood of obtaining consensus. A statement was considered to have achieved consensus when 70% or more of the raters scored the statement in the same direction (i.e., disagree, neutral or agree; Bisson et al., 2010).

The Round 2 survey comprised those statements that failed to reach consensus in Round 1. In Round 2, a pair of Round 1 statements was deleted due to overlap with other statements and two new statements were created based on feedback from Round 1. In all, raters were asked to rate 32 statements in Round 2. For each statement, they were provided with summary statistics indicating the percentage of raters who had agreed, disagreed or were neutral in relation to that statement in Round 1.

Raters were provided with an Excel spreadsheet containing a deidentified list of all raters' responses (with their own

responses highlighted for easy reading), as well as the mean, standard deviation, and mode for each statement. Raters were also provided with a list of all comments made by fellow raters about each of the statements. As such, they were able to reconsider their responses in light of the comments and ratings provided by other raters. They were also provided with a list of statements that had achieved consensus in Round 1. Raters were told that if they did not wish to rerate statements in Round 2, then their Round 1 scores would be used. The Round 2 survey was sent to the 92 Round 1 respondents and 81 (90%) completed it. Round 1 responses were used for the 11 raters who did not rerate statements in Round 2.

The Round 3 survey consisted of 16 statements. Four Round 2 statements were deleted (due to overlap or redundancy) and two new statements were created. Raters were provided with the same information as in Round 2 (i.e., summary statistics, rater comments, and a list of all statements including those that had already reached consensus). The Round 3 survey was sent to the 92 initial respondents and 82 (91%) completed it. Again, ratings from previous rounds were used for those raters who did not rerate the statements in Round 3.

Expert Raters

Potential raters were identified and selected in a number of ways. First, the author group (experienced researchers and practitioners in the field of trauma or peer support) provided advice about experts and peer-support practitioners to be invited. Second, experts were identified by their profiles and reputation in the field of trauma and peer support (e.g., through published literature, presentation profiles, etc.). Third, key personnel from known peer-support programs in high-risk organizations were invited to participate. Finally, a snowballing approach was employed across all three methods whereby identified raters were also asked to nominate other potential raters, who were then added to the list of invitees.

Criteria were applied to determine eligibility for inclusion as a rater in this study. These included one or more of the following: a publication record in the area of peer support, a national/international clinical or research profile in the area of trauma and/or peer support, or significant experience in the provision of peer support. Users of the programs (i.e., those in receipt of support from peer supporters) were not included as expert raters. This was to ensure the integrity of the Delphi process in ascertaining views of those with significant expertise/experience in the field of peer support. Clearly, consumer involvement would be vital in any attempt to evaluate the acceptability and perceived value of the program for the target population but that was not the goal of this study.

One hundred twenty-three potential raters were invited to take part in the first round and 92 responded (75%), representing 17 different countries. Details of the raters are shown in Table 1

Table 1
Rater Characteristics

Characteristic	*n*	%
Gender		
Male	56	61
Female	36	39
Age		
31–40 years	16	17
41–50 years	34	37
51–60 years	31	34
61 + years	11	12
Country/region of work		
Asia	0	0
Australia/New Zealand	33	36
Europe	18	20
UK	15	16
USA	14	15
Canada	9	10
Other (all reported this as "Middle East")	3	3
Perspective		
A peer-support program within an existing organization	82	90
A peer-support program external to a specific organization for people who have experienced certain types of events	9	10
Profession[a]		
Mental health professional	61	66
Emergency services worker	21	23
Defence force personnel	7	8
Military veteran	6	7
Other (included researcher, nurse, humanitarian aid worker, social worker, air traffic controller, general practitioner, human resources)	14	15
Roles or activities in peer support[a]		
Peer supporter	31	34
Peer-support coordinator	36	39
Academic/researcher	40	44
Trainer/educator	57	62
Manager/administrator	33	36
Policy maker	27	29
Clinician	44	48
Main role or activity in peer support		
Peer supporter	10	11
Peer-support coordinator	16	17
Academic/researcher	19	21
Trainer/educator	21	23
Manager/administrator	9	10
Policy maker	5	5
Clinician	10	11
Years involved in peer support		
<2 years	5	5

(continued)

Table 1
continued

Characteristic	*n*	%
2–5 years	15	16
5–10 years	28	30
10–20 years	24	26
>20 years	17	19
Population that the rater works mostly with[a]		
Paramedics/ambulance officers	30	33
Trauma clients (e.g., motor vehicle accident survivors, ex-police officers)	13	14
Military officers	18	20
Veterans	14	15
Police officers	34	37
Firefighters	22	24
Health/mental health professionals	30	33
Journalists	4	4
Other[b]	20	22

[a]Raters could select as many categories as applied for this statement. [b]Included state emergency services, correctional officers, air traffic controllers, council staff, international aid organizations, security officers, and welfare and legal services.

Analysis

The Survey Monkey software was used to generate basic statistics. SPSS version 17 (SPSS Inc., 2009) for Windows was used to determine statements that reached consensus. The comments were summarized to identify emergent themes to inform the following round and interpretation of the final results.

Consultation

Upon completion of the three round Delphi process, the statements that reached consensus were used to compile draft guidelines. These were circulated to the raters for comment regarding the wording of the guideline recommendations, on the understanding that the content was driven by the consensus statements and was not for discussion at that point. Those comments were consolidated and considered in the final wording of the guidelines.

Results

Forty-one (56%) of the original 73 statements achieved consensus in Round 1. Raters were asked to rate the remaining 32 statements in Round 2, and of these, 14 (44%) statements reached consensus. Raters were asked to rate the remaining 16 statements in Round 3, and consensus was reached for 7 (44%) of these. Thus, 62 of the total 77 (81%) statements were deemed to have reached consensus. A full list of consensus (agree, neutral, or disagree) and nonconsensus statements, along with consensus percentages, and means are available from the corresponding author.

Exploratory analyses of variance (ANOVAs) were conducted with the 15 items that failed to reach consensus to examine whether there were differences of opinion based on the rater's main role. Raters were grouped into five categories: peer supporter/peer-support coordinator, academic/researcher, trainer/educator, administrator/policy maker, and clinician. It was found that there was a significant difference between groups for the item, "There is good research evidence that peer-support programs are effective," $F(4, 70) = 3.76$, $p = .008$. Post hoc tests revealed that academics disagreed that there was good research evidence, whereas peer supporters/peer coordinators believed that there was good evidence ($p = .004$). There was also a trend for academic/researchers to differ from peer supporters/coordinators in their views for the item "Peer support should be available as needed, with the expectancy that it not be used outside of normal hours except in emergency," $F(4, 82) = 2.25, p = .071$. Post hoc testing revealed that this was due to academics agreeing that peer supporters should be available as needed; peer supporters/peer coordinators disagreed ($p = .037$).

Key Areas of Consensus

This section provides a detailed description of the results of the consensus process. These areas of consensus have been summarized to generate the eight recommendations shown in the Appendix.

The consensus on the main goals of peer support was that they are (a) to provide an empathic, listening ear; (b) to provide low-level psychological intervention; (c) to identify peers who may be at risk to themselves or others; and (d) to facilitate pathways to professional help. It was agreed that the goals of peer support do not relate solely to recovery from a traumatic or highly stressful incident, but relate to psychological and physical health and well-being more broadly. Indeed, the use of spontaneous or informal peer support during the course of a day's work was considered an important aspect of peer-support programs. There was also agreement that peer support is not intended as a treatment for psychiatric disorder, although there was disagreement regarding whether encouraging treatment adherence should be a goal. The consensus view was that peer support should not be used for advocating in disputes with management, nor is it primarily designed to improve job performance or organizational efficiency.

There was consensus that to become a peer supporter, the individual should be a member of the target population, with considerable experience within the field of work of the target population, and should be respected by his or her peers. It was agreed that potential peer supporters should undergo a formal application and selection process.

There was strong support for the notion that peer supporters should receive training in the basic skills required to fulfill their role (such as listening skills, psychological first aid, and information about referral options). Equally, it was agreed that they should not receive training in higher level

interventions such as prolonged exposure or cognitive restructuring. There was consensus that potential peer supporters should meet specific standards in their training before commencing their role and that they should participate in ongoing training, supervision, review, and accreditation to ensure maintenance of skills.

Consensus was reached that mental health professionals should occupy the position of clinical director and should be involved in supervision and training. It was agreed that this specialist support should be available when required, but that there was no expectation that the mental health professional would necessarily be consulted on every case.

It was agreed that peer supporters should not limit their activities to high-risk incidents, but rather should be part of routine employee health and welfare—informal peer support as a routine part of a day's work was seen as integral to a successful program. There was recognition that peer supporters should not generally see "clients" on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases. Equally, it was recognized that, in some cases, support will be required for extended periods (especially, for example, in programs for specific populations such as veterans). It was agreed that peer supporters should maintain confidentiality (except when seeking advice from a mental health professional or in cases of risk of harm to self or others).

In terms of access, consensus was reached that peer supporters should normally be offered as the initial point of contact after exposure to a high-risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters. Several aspects of this question did not reach consensus, such as whether peer supporters should be remunerated for their work, whether they should be available whenever required (although it was agreed that not every supporter needs to be available 24 hours a day), and whether personal mobile phone numbers should be made available to the target population. This nonconsensus perhaps reflects a tension between wanting to do the best for those needing support and wanting to ensure some boundaries and protection for those providing support. Although these questions are best decided by the individual program, it is incumbent upon those responsible for the program to ensure the safety and well being of their peer supporters.

There was a clearer consensus recognizing the importance of looking after peer supporters if the program is to be sustainable. It was agreed that peer supporters should be easily able to access care for themselves from a mental health practitioner if required. In terms of fulfilling their role, it was agreed that they should be easily able to access expert advice from a clinician and should engage in regular peer supervision within the program.

The consensus was that peer-support programs should establish clear goals that are linked to specific outcomes prior to commencement. It was agreed that they should be evaluated by an external, independent evaluator on a regular basis and that the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, though not primary goals of peer-support programs, may be collected as adjunctive data as part of the evaluation. The question of whether it is useful and/or viable to administer measures such as simple checklists to monitor progress did not reach consensus. Although this approach has appeal, there was a recognition that it does not fit comfortably with the typical approach to peer support that may involve an interaction as simple as a quick corridor conversation.

On the basis of the consensus statements, eight draft guideline recommendations were developed covering (a) the goals of peer support, (b) selection of peer supporters, (c) training and accreditation, (d) the role of mental health professionals, (e) the role of peer supporters, (f) access to peer supporters, (g) looking after peer supporters, and (h) program evaluation. The Appendix lists the principal recommendations of the final guidelines. The full report is available from the corresponding author.

Discussion

This is the first study to generate a consensus from a group of international experts working in the field of peer support. Given the lack of a consistent approach to implementing peer support, such a consensus is vital to provide the foundation upon which effectiveness research can be built. If organizations are to continue to adopt peer support as a strategy to assist employees following exposure to difficult incidents, it is essential that we agree on the core goals and implementation processes, as well as on how it should be evaluated. To date, no such consensus has existed and peer-support models vary widely across organizations. These guidelines represent an opportunity for organizations to review their existing programs in the context of the current recommendations.

Anecdotal evidence suggests that a wide range of approaches to peer support are adopted in different settings. Programs have evolved in response to idiosyncratic organizational needs. A good example is the Trauma Risk Management (TRiM) program developed in the British Armed Forces. TRiM providers are volunteer nonmedical personnel trained in psychological risk assessment and provided with a basic understanding of trauma psychology. After an event, TRiM peer supporters advise commanders about best-practice guidelines in relation to traumatic stress and carry out structured risk assessments of those exposed. A further structured risk assessment is carried out after a month; personnel who continue to exhibit significant symptoms are referred to formal mental health providers. Although the TRiM program is often referred to as a peer-support program, and is one of the few programs of its kind to have conducted a randomized trial of its effectiveness (Greenberg et al., 2010), it differs from most peer-support programs in that it follows a structured process and has clearly defined goals. Nevertheless, the guidelines developed in this consensus study

may be easily adapted for application to models such as the TRiM program.

Another example of an initiative that is often referred to as peer support is the Vet-to-Vet program (Resnick, Armstrong, Sperazza, Harkness, & Rosenheck, 2004), a group-based peer education and support program for veterans with chronic psychiatric disorder. Again, although the Vet-to-Vet program is not a peer-support program operating within a high-risk organization, several of the principles would still apply. The fact is that all peer-support programs pose different challenges, highlighting the importance of seeing these guidelines as recommendations for practice, not as absolute rules for operation.

Achieving a clear understanding and agreement of the goals of a peer-support program is fundamental for several reasons. First, it sets the context for evaluation—only if we know what we hope to achieve can we design strategies to measure the program's effectiveness. Second, a shared understanding of goals helps to place boundaries around what is, and more importantly, what is not expected of peer supporters. This is important both to direct the training of peer supporters and to ensure that once trained, peer supporters do not interfere with normal coping but do encourage referral to professional sources of help where this is required.

One of the most difficult issues confronting the field of peer support for high-risk organisations at present is the relative lack of empirical data to support its effectiveness. Evaluation of peer-support programs in the area of psychological stress and trauma is challenging, in part because these programs often seek to remain independent from formal mental health care bureaucracies (Mead, Hilton, & Curtis, 2001), and may consider this independence central to their contribution (Barber, Rosenheck, Armstrong, & Resnick, 2008). Often this independence results in a philosophical position that precludes the collection of data that would be required for an evaluation. Of relevance here is the finding that those involved in the delivery of peer support were more likely than those in a research role to believe that peer support is supported by a strong empirical evidence base. These problems may be more apparent in programs with a psychological health focus than, for example, physical health conditions such as diabetes support groups. In all programs, however, those involved at every level should be educated about the importance of evaluation, along with reassurances regarding the goals and confidentiality of the process. It is essential that those involved are able to put their reservations aside and expose the programs to objective scrutiny. Only then will we be able to establish what is genuinely helpful.

Until a rigorous body of research exists upon which to build practice guidelines, the Delphi process is a valuable way of achieving expert consensus. Guidelines developed in a more ad hoc manner are vulnerable to selective use of evidence and the intrusion of personal biases. In the current study, care was taken to systematically identify individuals from a range of backgrounds and nationalities. Our independent group of 92 experts and practitioners from 17 different countries provides a broad representation, thus helping to ensure widespread acceptance of the consensus view. Equally, the fact that 15 statements did not achieve consensus indicates that this was not simply a blind adherence to conforming with the views of others. The high retention of raters across the three rounds was a major positive feature of this study.

There are, however, limitations. Although many statements achieved a consensus in excess of 90% of raters, for some the consensus was only just above the requisite 70% indicating significant differences of opinion. Closer inspection of those items, as well as of those statements that did not achieve consensus, generally reflected differences in the type of peer-support program being offered. This reinforces the importance of seeing these recommendations as guidelines, not as rigid rules. Although we recommend that they be adhered to, we also encourage programs to make exceptions where an alternative approach would better meet the needs of the target population. A second common explanation for low consensus was differing views between researchers and mental health specialists on the one hand, and peer-support providers on the other. The former were more likely to be influenced by evidence-based considerations.

Another caveat in this study was that consumers (i.e., those in receipt of peer support) were not included as expert raters. Thus, these guidelines represent the views of those providing, or working in the field of peer support, rather than those accessing the peer support. We recognize that those receiving peer support would offer an alternative perspective on how such programs should be provided and we would recommend that those views be sought in any evaluation.

The findings of this study are limited to peer-support programs targeted at psychological health in high-risk services. Although it may be possible to apply many of the recommendations in other settings, a few may not translate so readily. Further, it was not possible to cover every area of operation in the consensus statements. For example, not specifically addressed in the statements (although strongly implied) is the need for rapid access to appropriate mental health services delivering evidence-based treatment for those who require it. It is incumbent upon organizations involved with high-risk activities to ensure that these pathways and services exist.

The guidelines presented here represent the current views of experts and practitioners in the field of peer support, but we would expect them to evolve as more research is conducted and knowledge develops. We have tried to ensure that the guidelines are applicable across a wide range of settings and cultures, and we have ensured they are written in a manner that is easy to translate into other languages.

We believe they are acceptable to both experts and practitioners in this field and hope they will be used to guide both the development of peer-support programs and future research endeavors.

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Appendix 1: Key recommendations of the Peer Support guidelines

Eight key domains of recommendations emerged from the project findings. A starting point for these recommendations is the consensus view that all high-risk industries should have a well planned, integrated, and tailored peer support program for their current employees, as well as, for a limited time, once employment with the organization ceases. Each context, however, is different. The following recommendations should not be interpreted rigidly but, rather, should be implemented as appropriate to the specific context of the program. This is particularly important since there is currently an absence of objective empirical evidence for the effectiveness of peer support in improving psychosocial outcomes. Indeed, the authors strongly support the establishment of properly designed and controlled research trials to inform our understanding of the effectiveness of these models.

1. *The Goals of Peer Support:* Peer supporters should: (a) provide an empathetic, listening ear; (b) provide low level psychological intervention; (c) identify colleagues who may be at risk to themselves or others; and (d) facilitate pathways to professional help.
2. *Selection of Peer Supporters:* In order to become a peer supporter, the individual should: (a) be a member of the target population, (b) be someone with considerable experience within the field of work of the target population, (c) be respected by his/her peers (colleagues), and (d) undergo an application and selection process prior to appointment that should include interview by a suitably constituted panel.
3. *Training and Accreditation:* Peer supporters should: (a) be trained in basic skills to fulfil their role (such as listening skills, psychological first aid, information about referral options); (b) meet specific standards in that training before commencing their role; and (c) participate in on-going training, supervision, review, and accreditation.
4. *Mental Health Professionals:* Mental health professionals should: (a) occupy the position of clinical director, and (b) be involved in supervision and training.
5. *Role: Peer supporters should:* (a) not limit their activities to high-risk incidents but, rather, should also be part of routine employee health and welfare; (b) not generally see "clients" on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases; and (c) maintain confidentiality (except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others).
6. *Access to peer supporters:* Peer supporters should normally be offered as the initial point of contact after exposure to a high-risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters.
7. *Looking after peer supporters:* In recognition of the potential demands of the work, peer supporters should: (a) not be available on call 24 hours per day, (b) be easily able to access care for themselves from a mental health practitioner if required, (c) be easily able to access expert advice from a clinician, and (d) engage in regular peer supervision within the program.
8. *Program evaluation:* Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation

should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation.

Not specifically addressed in the consensus statements (although strongly implied) is the need for rapid access to appropriate mental health services delivering evidence based treatment for those who require it. It is incumbent upon organizations to ensure that these pathways and services exist.

