WORKPLACE
SUICIDE PREVENTION

"HELPING THE PEOPLE WHO HELP PEOPLE"

Mental Health Providers Working in Crisis, Disaster and Trauma Response Environments

A Peer Support Manual

Developed by
Sally Spencer-Thomas, Psy.D.
Sarah Gaer, MA
Robert Macy, Ph.D.
Eduardo Vega, M.Psy.
Jordan Fox-Kemper, LICSW
Jessie Channell, LCSW

In Partnership with MassSupport Network
A program of Riverside Community Care

ACKNOWLEDGEMENTS

This Peer Support Manual is a collaborative project among:

HUMANNOVATIONS
Empowering the Global Mental Health Revolution

humannovations.net

SallySpencerThomas.com

INTERNATIONAL TRAUMA CENTER ITC

internationaltraumacenter.com

UNITED SUICIDE SURVIVORS INTERNATIONAL

unitesurvivors.org

Riverside Trauma Center
A SERVICE OF RIVERSIDE COMMUNITY CARE

riversidetraumacenter.org

WORKPLACE SUICIDE PREVENTION

WorkplaceSuicidePrevention.com

Suggested citation:

Spencer-Thomas, S., Gaer, S., Macy, R, Vega, E., Fox-Kemper, J. & Channell, J. (2021). *"Helping the People who Help People"—Mental Health Providers Working in Crisis, Disaster and Trauma Response Environments: A Peer Support Manual.* MassSupport Network: Massachusetts.

Designed by: Brielle Killip, Blue Linen Creative

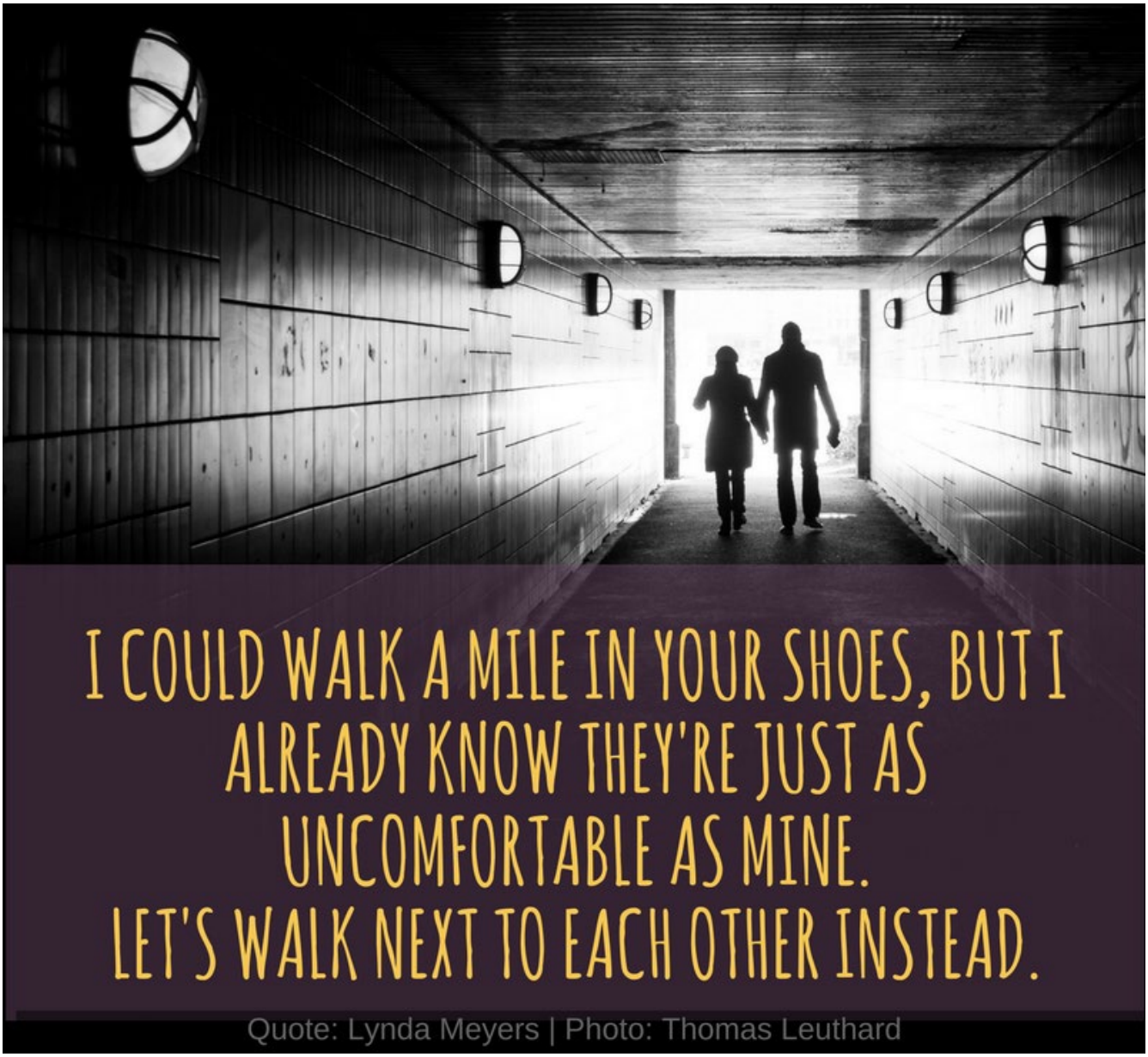

I COULD WALK A MILE IN YOUR SHOES, BUT I
ALREADY KNOW THEY'RE JUST AS
UNCOMFORTABLE AS MINE.
LET'S WALK NEXT TO EACH OTHER INSTEAD.
Quote: Lynda Meyers | Photo: Thomas Leuthard

TABLE OF CONTENTS

PART 1:
JUSTIFICATION AND OVERVIEW

INTRODUCTION

Peer Support as a concept proceeds from the belief that there is no one better to recognize struggle, understand and support someone than another who is in the trenches with them.

When the Helpers Need Help

Mental health professionals, like other helping professionals, can experience high levels of burnout[1] with 21%–67%[2] of providers endorsing excessive burnout. This is not surprising given that individuals who work to provide mental health services are often exposed to intense suffering, trauma, and suicide while also enduring the organizational stressors of many aspects of complicated mental health systems and other distressing intersecting processes. The mental health sector also frequently feels strain from limited resources, job instability and understaffing, and yet is expected to maintain an emotional state that does not interfere with the services they are providing.

Burnout impacts the provider's wellbeing, the quality of services they provide and the organizational viability due to turnover and other costs, and yet since the 1980s burnout interventions for mental health providers that have been implemented and evaluated only show a small reduction in burnout maintained over time.[3] The conclusion of a meta-analysis of 35 years of research on mental health provider burnout is that person-directed interventions were more effective than organizational interventions at reducing emotional exhaustion. Interestingly, of 27 studies included in that meta-analysis only 5 had an aspect of peer group support. Instead, most focused on trainings and stress-reduction workshops.

Beyond just burnout, as a group, mental health professionals are also at higher risk of mental health conditions and even suicide.[4] A selective review concluded that counselor self-care is an ethical imperative, and we must help mental health

[1] Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. Journal of Occupational Health Psychology, 23(1), 18–30. https://doi.org/10.1037/ocp0000047

[2] Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research, 39*(5), 341-352. doi: 10.1007/s10488-011-0352-1

[3] Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. Journal of Occupational Health Psychology, 23(1), 18–30. https://doi.org/10.1037/ocp0000047

[4] Thomsen S, Soares J, Nolan P, Dallender J, Arnetz B. Feelings of professional fulfilment and exhaustion in mental health personnel: The importance of organisational and individual factors. *Psychotherapy and Psychosomatics* 1999;68(3):157-164.

providers develop an ability to feel at ease in identifying and acknowledging their distress and in asking for assistance to support themselves.[5]

Many mental health providers, especially those with increased exposure to suicide and trauma work, experience vicarious trauma and subsequently feel isolated from their peers due to their symptoms.[6]

Despite experiences of vicarious trauma, burnout, anxiety and even suicidal thoughts, many care providers do not seek any formal treatment. Reported barriers to treatment include lack of time, cost, and concerns regarding confidentiality, stigma, potential career implications and exposure to unwanted intervention. Thus, mental health workplace environments, especially those responding to crises must cultivate a culture where the acknowledgment and resolution of work-related distress is validated without the negative impact of secrecy or shame.[7] One way to normalize these experiences is through formal and informal peer support at work.

Definition of Peer Support

The Mental Health Foundation (UK) simply defines peer support "….when people use their own experiences to help each other."[8] Many additional thought leaders[9] have attempted to define what "peer support" means; the key elements of peer support are highlighted in the graphic below.

A process of reciprocal help-giving and receiving in an effort to overcome a common challenge

Deeply felt empathy, encouragement and assistance between equals

A foundation of key principles of respect, shared responsibility, and collaboration

Shared meaningful lived experiences related to similar hardships

An alignment more with empowerment and recovery orientation

5 Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol. (2014). (TIP) Series 57. HHS Publication No. (SMA) 13-4801. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved on October 15, 2021 from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4816.pdf.

6 Mahoney, M. J. (2003). Constructive psychotherapy: A practical guide. New York: Guilford.

7 Kumar, S., Hatcher, S. & Huggard, P. (2005). Burnout in Psychiatrists: An Etiological Model. *International Journal of Psychiatry in Medicine, 35(4) 405-416.*

8 Mental Health Foundation (2021). *Peer support.* Retrieved on October 15, 2021 from https://www.mentalhealth.org.uk/a-to-z/p/peer-support.

9 Shalaby, R. & Agyapong, V. (2020). Peer Support in Mental Health: Literature Review. JMIR Mental Health, 7(6). 10.2196/15572

Unique Needs of Mental Health Providers in Crisis, Disaster and Trauma Response Environments

Mental health providers who work with trauma survivors in a variety of settings are often vicariously traumatized from secondary effects of exposure to that trauma. Working in high stress environments like disasters and suicide interventions may compromise the wellbeing of the providers. For example, most providers consider suicide-related statements made by people they are working with to be a highly stressful part of their work, and 67% report that discussing suicide risk with clients is anxiety provoking.[10]

Offering peer support after critical incidents is not new. Peer support programs have long existed in many of our major municipal law enforcement and fire service organizations. However, there are marked differences between peer support for first responders and for mental health workers.

While all peer support programs are designed to offer support, compassionate listening, and resources, first responders do not have it as their main role to be an expert in mental health support. Mental health workers may find the role of Peer Supporter counter to their professional training and have to be mindful to not fall into the role of clinician when acting as a Peer Supporter. Specifically, mental health workers may be more likely to slip into a more clinical approach to support–e.g., diagnosing and directive treatment advice–that they will need to be very aware of in a peer support situation.

Ad Hoc Crisis/Trauma Teams and Long-Standing Crisis/Trauma Teams

Sometimes crisis teams are long-standing, like those that work in crisis call centers answering the calls coming in through established hotlines and warmlines. These coworkers often have years to develop relationships and policies. Other times, crisis response teams are built quickly on an ad hoc basis to respond to a regional or time-limited disaster. In these instances, the peer support development work needs to be nimble and will need to prioritize the steps outlined in this manual.

When Crisis Counselors Are Impacted Parties

Being present during the disaster or crisis is also a differentiator. Sometimes the crisis counselor is living through the crisis they are responding to. This was certainly true for most crisis counselors after the attacks on the United States on 9/11 and during the COVID-19 pandemic. In these situations, the crisis supporter is simultaneously living through their own reaction to the disaster, adjusting to the crisis and supporting their own family while, at the same time, trying to help others. This situation of multiple roles and multiple impacts adds complexity to the crisis counselor's experience and increases the risk of burnout and trauma exposure as they work to sort out boundaries and maintain patterns of self-care.

[10] Mitchell, S. M., Taylor, N. J., Jahn, D. R., Roush, J. F., Brown, S. L., Ries, R., & Quinnett, P. (2020). Suicide-related training, self-efficacy, and mental health care providers' reactions toward suicidal individuals. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 41*(5), 359–366. https://doi.org/10.1027/0227-5910/a000647

Peer Supporters and Pre-Existing Relationships

Supporting people already known to the crisis counselor also adds complexity to the role of being a peer counselor. In many crisis or trauma response cases, crisis counselors arrive post-disaster to support people that are not known to them (e.g., victim's assistance response to homicide, suicide postvention, counseling for sexual assault or a crisis counselor's telephonic support for an anonymous stranger). With peer support for crisis workers, Peer Supporters are often showing up before, during and after the event (a dying family member, a diagnosis of serious health problems, the COVID-19 pandemic) and have a pre-existing relationship with the people they are supporting as a Peer Supporter. This timing and complexity of relationship can create a different intensity, which can be challenging.

OVERVIEW OF THE PEER SUPPORT MANUAL

Goals

The goals of this "Peer Support Manual" are:

1. To create awareness about the psychological risks to mental health providers working in crisis, trauma and disaster support roles.
2. To make the case that peer support provided to mental health providers by mental health providers in a peer support role makes sense.
3. To empower mental health providers working in crisis/trauma response work to improve their psychological capital by developing a peer support program.

Who is this Manual For?

Crisis and Disaster Responders

There are many settings where crisis response teams are mobilized to provide psychological support after a critical incident. These situations may include natural or human-made disasters, financial crises, sexual trauma, and so on. Similar elements of these crises are:

1. A threat to the person or community
2. The element of sudden onset or surprise leading to a brief window of reaction
3. Due to the instability caused by crisis, it often becomes a turning point for transformation

Suicide Crises and Crisis Counselors

Many crisis care workers provide support to people who are recently bereaved by suicide as well as people who have survived attempts or are living with suicidal intensity (in other words thoughts and feelings)[11] in the short or long-term. Hearing the stories of suicide attempts or deaths can be traumatic and activating for providers.

When crisis counselors have their own prior lived experience with suicide, their experiences often give them key insights on how to approach the person they are trying to support. However, in some instances they situation might hit too close to home and ignite distressing memories or thoughts related to the counselor's own experience with suicide that has not been fully processed. In other circumstances, the crisis counselor may be experiencing personal, undisclosed suicidal intensity and may over identify with the person they are trying to support. Still, in other circumstances they may be supporting someone in their personal life who is fighting to stay—a child or a partner, for example—and they may struggle to find objectivity.

Client suicide death and suicide attempts are an acknowledged occupational hazard for all mental health providers, but especially for people who

[11] Spencer-Thomas, S. & Vega, E. (2019). "Suicidal Intensity": An Emerging Preferred Term to Describe Experiences with Suicidal Thoughts and Feelings. Retrieved on October 15, 2021 from https://www.sallyspencerthomas.com/dr-sally-speaks-blog/suicideintensity.

are working with high risk populations. The death of a client can have intense impacts on a provider, compounding secondary traumatic stress (STS) or other trauma with grief and possibly, shame or self-doubt. Providers often report a sense of responsibility for a client's suicide death and experience alterations in their self-esteem.

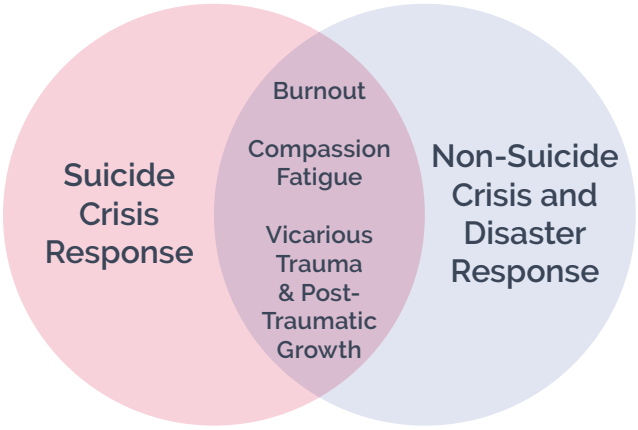
Thus, crisis counselors responding to the crisis of suicide play a particular role in crisis response that may increase their need for peer support, but rarely has this service been offered formally in crisis call centers or urgent mental health care settings.

Types of Crisis Specializations

Specialized forms of mental health services offered in crisis and disaster environments include but are not limited to:

- On-scene crisis and disaster response (e.g., mass shootings, natural disasters, domestic violence, sexual assault, death notification, suicide)
- Crisis call centers, hotlines and warmlines
- Mobile crisis-care teams and Victims Assistance response
- Emergency room or mental health urgent care psychological support
- Refugee response
- Community support after catastrophe (short- and long-term)
- FEMA Funded Crisis Counseling Programs
- Employee Assistance Crisis Response teams
- Critical-incident first responder support teams
- Dispatchers facilitating mental health emergency calls
- Crisis and disaster intervention specialists

Thus, this manual is designed to advance peer support for crisis counselors, disaster responders, and psychological emergency workers. Given the specific roles listed above, many of these providers will be supporting people in suicide crises, while others may be responding to non-suicide related crises and disasters. These mental health specialties experience similar and divergent challenges that primarily fall somewhere in these overlapping domains.



What makes peer support among mental health professionals challenging?

When a peer has mental health expertise...

1. **...there is a power dynamic.**

Fear of professional judgment: Recipients of peer support may wonder, "are they judging me for not being able to manage my mental wellness?" "Will this hurt my chances of promotion?"

Concerns about clinical reflexes: Recipients of peer support may be concerned, "Will they diagnose me?" "Are they going to conduct an assessment with me?" or "Will they force treatment on me by involuntarily hospitalizing me—something that might jeopardize my career?"

2. **...boundaries are blurry.**

Challenges of being a wounded healer: Part of the shared experience is having expertise as mental health providers with knowledge, skills and tools.

This boundary confusion may present the challenge of humility for some who think, "We are the helpers, not the ones needing help."

Worry about being a burden: Highly compassionate mental health providers may be worried that they might add stress to their colleagues by asking for peer support or that they might take a resource away from someone more deserving of care.

Complexity of the ethical dilemma: When Peer Supporters know what treatment might help their peer, how do they refrain from providing these services? How do they stay as equals?

3. **…people experience compassion fatigue.**

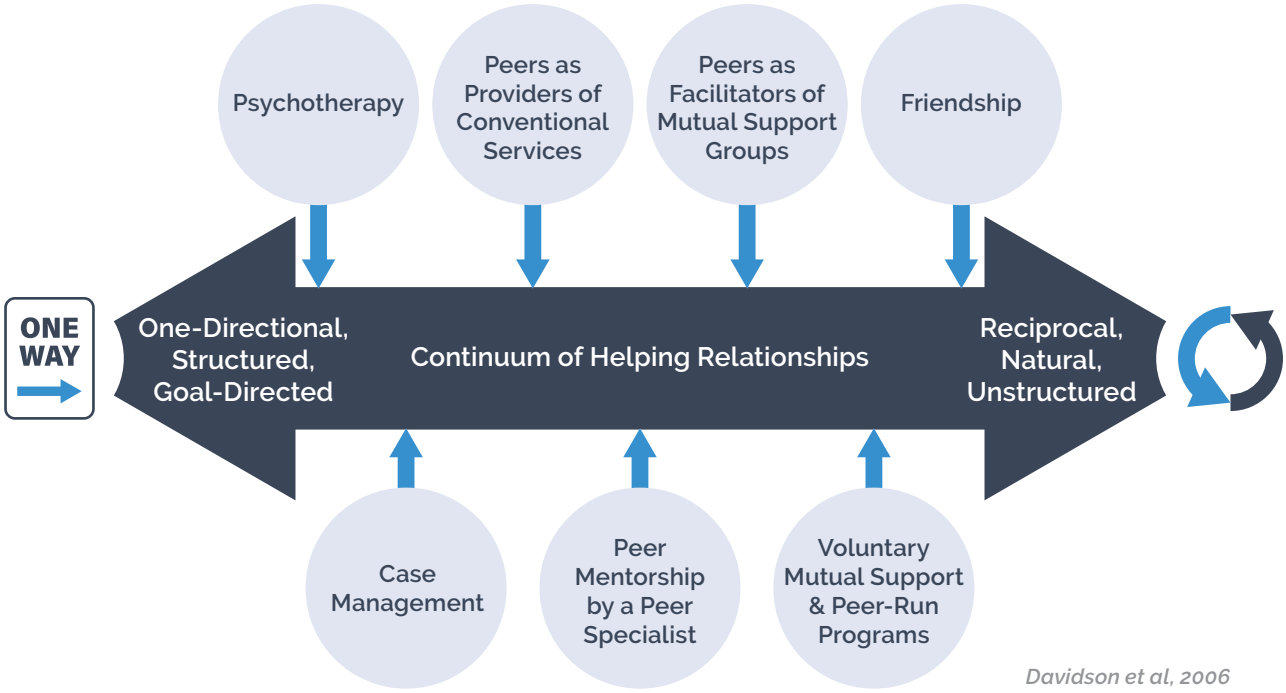
Sometimes the emotional tank is low: When crisis counselors give emotional support all day without adequate refueling, burnout and compassion fatigue are genuine occupational hazards. Finding the reserve tank to additionally support one's peers may feel like a daunting task.

DEEPENING OUR UNDERSTANDING OF PEER SUPPORT

Peer support is arguably the oldest form of providing help in nearly every area of human existence. On a fundamental level, it includes any situation in which a person is sharing their experience and knowledge with another on the level of equals. This can be as simple as a neighbor helping another replace the air filter in her car, a friend consulting with another on a family problem, or a high schooler assisting their peer in creating a website.

Peer support is especially valuable in areas of personal struggle and challenge, either in adjunct to or instead of professional counseling-style services. Beyond the most informal type of peer support, which occurs naturally in break rooms and happy hours everywhere, access to skilled peers in the workplace has great potential to reduce mental health impacts including depression and anxiety. Connecting on a peer basis eases healing connection and can 'normalize' experiences that would be unfamiliar to those outside the workplace.[12]

A Spectrum of Peer Support



Davidson et al, 2006

Illustration above adapted from Davidson et al (2006).[13]

Like almost every form of care, the *most central beneficial aspect of peer support for people at hard*

[12] Adapted from "Understanding and Implementing Peer Support" Vega, E. (2020) Available at https://e7e6aa01-d58e-4b78-a613-daedf98ce824.filesusr.com/ugd/aead11_712a9e71042c42f6a315e9c3eb4465e2.pdf

[13] Davidson L, Chinman M, Sells D, Rowe M. (2006). Peer support among adults with serious mental illness: a report from the field. Schizophrenia Bulletin; 32(3):443-450.

times is the quality of the relationship between the individuals. The psychology of peer support is distinct from professional counseling services in two significant ways:

1. Equality of status, and
2. Shared meaningful experience including work experience.

Peer support is non-clinical and recovery-focused. Non-clinical means peers do not offer professional services, make assessments or dispense expert opinions. Peer support is not a replacement for psychotherapy, psychiatric services or even quality self-care. Rather, Peer Supporters assist their peers as they explore help-seeking options and personal coping strategies to find the mix of services and supports that work best for them.

Unlike external professional counseling, peer support can readily happen adjacent to or within the workplace environment, if trained peers are available at the site.

Peer Specialist vs. Peer Supporter

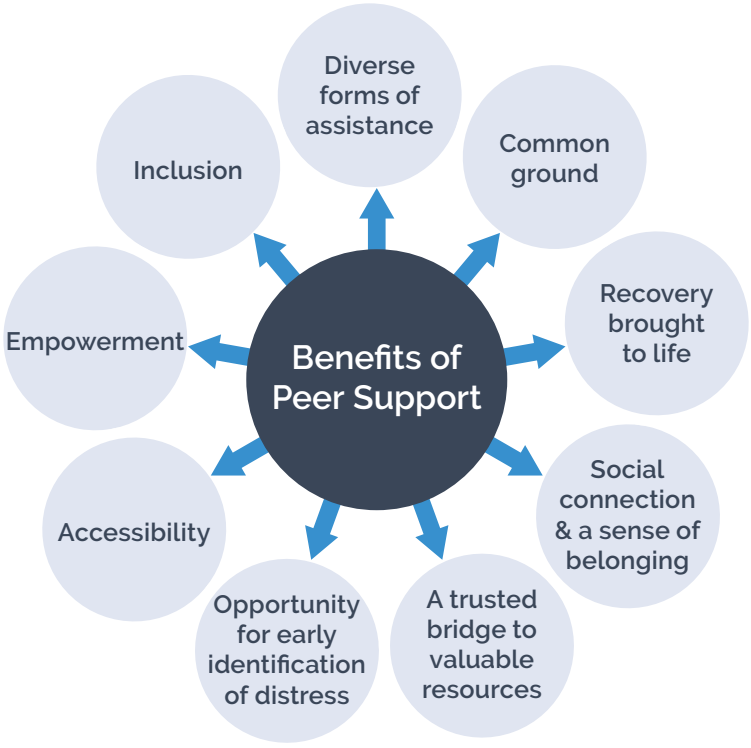
Peer Specialists are trained (often certified) mental health specialists who use their lived experience of struggle, disability, recovery and service usage to support others. Peer Specialists are employed in many mental health settings including inpatient, community care, mobile crisis, and so on. Their certification can require more than sixty hours of training, along with substantial work experience, and they are often considered a paid staff member where they provide peer support services to incoming clients.

For the purposes of this manual, *Peer Supporters* are coworkers offering peer support to other crisis workers. This role is an additional, voluntary duty above and beyond their usual job duties.

Benefits of Peer Support

For many people, most of the time, a skilled Peer Supporter can make a tremendous difference through hard times and recovery. As someone who can naturally relate to their situation, Peer Supporters provide their peers with a strong antidote to despair and isolation—genuine caring connection to ensure that one feels heard, cared for and valued.

The benefits of peer support are many. Peers offer:



- ***Diverse forms of assistance:*** social, emotional, practical
- ***Common ground:*** shared experiences and shared language
- ***Recovery brought to life:*** by role modeling healing, their example becomes a roadmap to hope
- ***Social connection and a sense of belonging:*** enhanced by the power of storytelling and engagement peers increase individual and team wellbeing
- ***A trusted bridge to valuable resources:*** their firsthand testimony builds credibility
- ***Opportunity for early identification of distress:*** because they are "boots on the ground" they are often the first to know that a peer is struggling and can offer permission to disclose vulnerability
- ***Accessibility:*** by eliminating cost and other administrative barriers to help-seeking
- ***Empowerment:*** because peer support is focused on strengths and self-agency
- ***Inclusion:*** by embracing everyone, peers build community and engagement

Peer Support and the Helper Effect[14]

An added benefit to peer support also occurs through the 'helper's effect'—those that provide support to others feel empowered and valued in this role, bolstering a sense of leadership and enabling a renewed and positive relationship to 'work life' as well. In other words, being a Peer Supporter helps the Peer Supporter. This "Helper Effect" is a well-established phenomenon where people use the wisdom they have gained through living with a problem to help others with the same or similar problem, and in return their own recovery is strengthened. There are many reasons why this is so:

Makes meaning and affirms recovery.

When Peer Supporters apply the insight from their own experience while helping others, they can sometimes think, "Well, I wish I never had to go through my hard time, but now that I have, I can use my inner wisdom to help another in a way I wouldn't have been able to without the experience."

Feelings of social value and respect.

Helping others is an honorable role—even when Peer Supporters feel like imposters—they can feel a boost when others have confidence in their abilities and knowledge. Meaningful social roles are significant protective factors for addictions, suicide and related mental health impacts.

Being a Peer Supporter helps keep the helper accountable to wellness.

When Peer Supporters find themselves in a position of supporting another person, they often think, "I need to take care of myself for me AND because now I am a role model for someone else." OR "You are like a lifeguard—you can't be tired if you are saving the lives of others; you need to be strong enough for two."

Reciprocity.

When Peer Supporters "have each other's backs" and are willing to be vulnerable with one another, they develop high trust relationships; their safety net for emotional crises is strengthened.

It feels good to do good.

When Peer Supporters connect in positive ways their bodies release endorphins such as oxytocin that helps them feel bonded and improves self-image.

[14] Spencer-Thomas, S. (2019). Peer Support & The Helper Effect—When Doing Good Feels Good. https://www.sallyspencerthomas.com/hope-illuminated-podcast/29

Culture and Guiding Principles of Peer Support

Guiding Principles

The culture of any successful peer support program needs to be centered on trust and respect. Drawing from *SAMHSA's Core Competencies for Peer Workers*[15], *The Way Forward: Pathways to Hope, Recovery and Wellness with Insights from Lived Experience*[16], and the *National Guidelines for Workplace Suicide Prevention*[17], basic guiding principles include:

Guiding Principles of Peer Support

A recovery orientation (growth mindset)— envisioning a meaningful and purposeful life based on strengths and personal goals

Person-centered—focused on personalization for the person being supported

Self-agency—through choice and empowerment

Collaborative—the relationship is built on empathy and partnership

Trauma-informed—with a deep appreciation of the historical and environmental determinants of wellbeing

Dignity Protection—through defying prejudice, advocating for justice, and protecting human rights.

Empowered Connection—peers compassionately link others to qualified supports.

---

[15] Substance Abuse and Mental Health Services Administration. Core Competencies for Peer Workers. https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers/core-competencies-peer-workers. Updated December 19, 2018. Accessed February 11, 2021.

[16] National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force. (2014). The Way Forward: Pathways to hope, recovery, and wellness with insights from lived experience. Washington, DC: Author. Accessed February 11, 2021 from https://sprc.org/sites/default/files/resource-program/TheWayForward.pdf

[17] Workplace Suicide Prevention and Postvention Committee (2019). A Report of Findings to Direct the Development of a National Guidelines for Workplace Suicide Prevention. Accessed February 11, 2021 from https://workplacesuicideprevention.com/.

What makes a good Peer Supporter?

When it comes to recruiting and selecting the individuals who will provide the core peer support services, of whatever model, certain essential qualities are recommended.

COMPASSION. Compassion has been defined as the willingness to be present with another's pain. Regardless of the setting or role a Peer Supporter must have the ability, and be ready to relate with and support another's situation.

THE SPIRIT OF SERVICE. Put simply, this means someone enjoys supporting their peers through 'thick and thin'. A good Peer Supporter is a person who wants to give back to others by listening and learning about their situation, without the desire to be in a 'superior' or advisor role. (NOTE: "Advising" is not considered good peer support practice and should be avoided except in special circumstances.)

CURIOSITY AND EFFECTIVE LISTENING. When someone is genuinely curious and compassionate, they can help a peer feel heard and seen and therefore truly cared about. Connecting in a non-judgmental way with someone else requires a kind of humility and the desire to understand by listening and authentic curiosity.

LIVED EXPERIENCE. Peer support is not about having the answers to another's problems but walking along a journey with them. This does not mean that Peer Supporters have been in the precise situation at hand. It does mean that they have lived experience related to these issues and the willingness to share them.

COURAGE. It is not easy to be with another's pain and struggle. Sometimes it means facing one's own fears as well including the fear that one doesn't know how to help.

Training can provide confidence and skills but people who shy away from emotional struggles or challenges, for whatever reason, may not be the best choice to support others at hard times.

Research Supporting Peer Support

One of the challenges of research on peer support is the heterogeneity of the intervention across modalities. Nevertheless, the findings thus far seem to show that not only is peer support effective in improving outcomes, it is often better than traditional mental health services on a few fronts. According to research reported by Mental Health America[18]. Peer support improves the following outcomes:

- Reduce symptoms and hospitalizations
- Increase social support and participation in the community
- Decrease lengths of hospital stays and costs of services
- Improve wellbeing, self-esteem, and social functioning
- Encourage more thorough and longer-lasting recoveries

[18] Mental Health America. Peer Services. https://www.mentalhealthamerica.net/peer-services. 2019. Accessed February 11, 2021.

Other meta-analyses and systematic reviews[19] on the effectiveness of peer support have concluded that peer support:

- Is a significant benefit to recovery
- Has a significant impact on empowerment
- Improves the working alliance in the help-giving partnership
- Seems to have a modest impact on reducing the need for inpatient service use and crisis services

Thus, in many ways peer support appears to be equivalent to health professionals in improving a host of mental health symptoms and quality of life for people living with mental health conditions.[20] In support of the work of this manual, emerging evidence exists that peer support as a tool shows positive results for helping healthcare providers who specifically experience vicarious trauma.[21]

The current research indicates that mental health providers derive most support from informal contacts with team members, and family and friends, versus more formal support structures such as psychotherapy or Employee Assistance Programs. This is a further recommendation for peer support for providers, when it can be relevant and thoughtfully distinguished from the service provision modality.[22]

In summary, the literature reveals medium to very large positive effects with peer support in the reduction of compassion fatigue and burnout and an increase in compassion satisfaction among those in the helping professions [23]. Furthermore, a study on vicarious trauma and mental health providers concluded, "Best practice for mental health providers working with traumatic material necessitates access to peer support services to mitigate work-related sequelae of VT [vicarious trauma] and ultimately contributes to provider retention through support of professional quality of life." p. 24 [24]

For additional research on peer support and mental health see Appendix G.

---

[19] Bellamy C, Schmutte T, Davidson L. An update on the growing evidence base for peer support. Mental Health and Social Inclusion. 2017;21(3):161-167.

Fuhr DC, Salisbury TT, De Silva M, et al. Effectiveness of peer-delivered interventions for severe mental illness and depression on clinical and psychosocial outcomes: a systematic review and meta-analysis. Soc Psychiatry Psychiatry Epidemiol. 2014;49:1691-1702.

White, S., Foster, R., Marks, J. et al. The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis. BMC Psychiatry 20, 534 (2020). https://doi.org/10.1186/s12888-020-02923-3

[20] Bellamy, C., Schmutte, T. & Davidson, L. (2020). An update on the growing evidence for peer support. *Mental Health and Social Inclusion, 21(3), 1-7.*

[21] Vinson, A. E., & Randel, G. (2018). Peer support in anesthesia: turning war stories into wellness. Current Opinion in Anesthesiology, 31(3), 382–387. https://doi-org.silk.library.umass.edu/10.1097/ACO.0000000000000591

[22] Foley, S. R., & Kelly, B. D. (2007). When a patient dies by suicide: incidence, implications and coping strategies. Advances in psychiatric treatment, 13(2), 134- 138.

[23] Kendrick, A. (2020) "Peer Support to Reduce Vicarious Trauma in Mental Health Providers" . Doctor of Nursing Practice (DNP) Projects. 231. Retrieved on October 15, 2021 from https://scholarworks.umass.edu/nursing_dnp_capstone/231

[24] Kendrick, A. (2020) "Peer Support to Reduce Vicarious Trauma in Mental Health Providers". Doctor of Nursing Practice (DNP) Projects. 231. Retrieved on October 15, 2021 from https://scholarworks.umass.edu/nursing_dnp_capstone/231

SECONDARY TRAUMATIC STRESS (STS) ANDVICARIOUS POST-TRAUMATIC GROWTH (VPTG) IN DISASTER WORK[25]

By Robert D. Macy

Crisis and Disaster Mental Health Response & Secondary Traumatic Stress

Disaster response is difficult work. Frequently, the people who are doing this work are also impacted by the crisis at hand. This reality increases the need for disaster behavioral health workers to (1) understand, develop and sustain psychological capital (PsyCap) and (2) to be trained in and practice toxic stress reduction protocols and compassion care programs as a means of professional development, competence and a reflection of the values that Peer Support Teams uphold.

Psychological trauma may be defined as overwhelming demands placed upon the physiological system that can result in a profound sense of loss of control, immobilization, betrayal, and sometimes helplessness and hopelessness as well as increased threat detection behaviors and appraisal skills. Exposure to potentially traumatic events may occur directly, when the event impacts a person or their loved ones, or indirectly, when people are witness to a survivors' narrative.

[25] Aafjes van-Dorn, K, Hoffman, L & Prout, T.A. (2020) Psychotherapist's vicarious traumatization during the COVID-19 Pandemic. Psychological trauma theory research practice and policy. Volume 12 No. S1 (pp 148-150)

Benuto, L., Singer, J., Cummings, C., & Ahrendt, A. (2018). The Vicarious Trauma Scale: Confirmatory factor analysis and psychometric properties with a sample of victim advocates. Health & social care in the community, 26, 564–571

Calhoun, L. G., & Tedeschi, R. G. (1999). Facilitating posttraumatic growth: A clinician's guide. Mahwah, NJ: Lawrence Erlbaum Associates.

Calhoun, L. G., & Tedeschi, R. G. (2001). Posttraumatic growth: The positive lessons of loss. In R. Neimeyer (Ed.), Meaning, reconstruction and the experience of loss (pp. 157–172). Washington: American Psychological Association.

Calhoun, L. G., & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), Posttraumatic growth: Positive change in the aftermath of crisis (pp. 215–238). Mahwah, NJ: Lawrence Erlbaum Associates.

Dar, I. A., Iqbal, N. (2020). Beyond linear evidence: the curvilinear relationship between secondary traumatic stress and vicarious post traumatic growth among health care professionals. Stress and Health. 2020;36:203–212. John Wiley & Sons.

Kessler, R. C., Aguilar-Gaxiola, S., Alonso, J., Benjet, C., Bromet, E. J., & Cardoso, G. (2017). Trauma and PTSD in the WHO world mental health surveys. European Journal of Psychotraumatology, 8, 1353383

Vigra, D., Baciu, E. L., Lazar, T.A., Lupsa, D. (2020) Psychological capital protects social workers from burnout and secondary traumatic stress. (pp 1-16) Sustainability 2020, 12, 2246;

Xiao, H., Zhang, Y., Kong, D., Li, S., & Yang, N. (2020). The effects of social support on sleep quality of medical staff treating patients with coronavirus disease 2019 (COVID-19) in January and February 2020 in China. Medical Science Monitor, 26, e923549

Studies continue to indicate that 30%-70% of populations are exposed to potentially traumatic events in their lifetime. Outcomes from these exposures can include post-traumatic stress injuries which may lead to ill health and also include post traumatic growth which may lead to positive psychological changes beyond pre-trauma levels.

As a crisis counselor, indirect exposure to potentially traumatic events can lead to vicarious trauma or secondary traumatic stress (STS). Likewise, research demonstrates that indirect exposure to potentially traumatic events can also lead to vicarious post traumatic growth (VPTG).

STS can become a condition whereby a healthcare worker begins to experience traumatic stress symptoms very similar to post traumatic stress disorder as a result of being witness to survivor accounts of traumatic events, which in many cases include repeated exposures to the most stressful parts of the trauma. Higher levels of STS are associated with increased mental health challenges, poor relationship quality, and negative worldview which in turn can potentially have a negative impact on the effectiveness of treatment and counseling. Furthermore, higher levels of STS are associated with deep exhaustion and a growing sense of being less able to emotionally connect to clients. Higher levels of STS appear to be most present among less experienced, younger crisis counselors and crisis counselors with very little to no training. STS negative impacts can increase substantially when the crisis counselor and the client are simultaneously experiencing the same disaster or potentially traumatic event.

Crisis Support and Vicarious Post Traumatic Growth

It has been shown over the last 20 years that counselors exposed to and struggling with stressful events of survivors may also experience positive psychological changes as a result of their work with survivors. "These positive changes can occur in five distinct ways: an improvement in relating to others, greater personal strength, positive spiritual change, a greater appreciation of life, and discovering new possibilities"[26].

Current studies are indicating that VPTG and psychological distress among crisis counselors can coexist, and in fact, VPTG is dependent on a crisis counselor's appraisal that the event and the counseling experience is moderately stressful while simultaneously the client-survivor believes in their ability to recover, or put another way, when the client survivor and the crisis counselor believe that the goals of recovery are attainable. This threshold of potential VPTG is fostered and even protected by peer support relationships and consistent utilization of peer support sessions. This is a critical dynamic for peer support effectiveness in preventing high levels of STS while supporting the co-occurrence of VPTG.

[26] Calhoun, L. G., & Tedeschi, R. G. (1998). Posttraumatic growth: Future directions. In R. G. Tedeschi, C. L. Park, & L. G. Calhoun (Eds.), Posttraumatic growth: Positive change in the aftermath of crisis (pp. 215– 238). Mahwah, NJ: Lawrence Erlbaum Associates.

Building Psychological Capital

One other fundamental component that can protect and maintain VPTG in the face of low to moderate STS involves the workplace environment and staff relationships that support the ongoing development of psychological capital (PsyCap) which tends to preserve the wellbeing of employees. PsyCap consists of four primary domains: hope, efficacy, resilience, and optimism. Peer support programs are potential unique contributors to the development and growth of PsyCap in crisis counseling programs and health care organizations.

What has been referred to as "self-care" over the last decade does not capture the dynamics of PsyCap or of obtaining professional training to understand toxic stress reduction and how to monitor levels of stress, especially when in the field under disaster circumstances that can create very high levels of STS.

The science of STS accumulation and reduction is focused on the reality that crisis counselors are exposed to varying degrees of STS. This comes with the territory for sure and could occur as an active peer support team member as well. On the other hand, peer support may be a truly effective tool to counter STS, along with personal self-care strategies.

The trick is to adopt daily and weekly practices that allow the peer supporter to appraise and reduce their own levels of secondary stress, so they do not end up in the territory of higher STS levels. In other words, low and moderate STS levels are associated with vicarious post traumatic growth and higher levels of STS are directly correlated to developing PTSD, and possibly ill health and medical compromises.

Successful toxic stress reduction programs begin with acknowledging that STS is real, is measurable and reducible, and can be prevented from building to high levels. An effective toxic stress reduction program includes disaster and crisis workers putting together a personal compassion care team of people they can depend on when they need connection and support. This team should minimally include a peer support contact, a primary care physician, a spiritual guide, counselor or therapist, a body healer, and first circle social connections who they know, trust and love. A final critical component for maintaining lower levels of STS and fostering

VPTG will be obtaining training that allows the crisis counselor to acquire the skills to have some mastery over your autonomic nervous system by practicing consistent self-regulation protocols.

PsyCap, toxic stress reduction and compassion care is an ethical obligation for crisis support workers. If the goal of a crisis response program is to enhance the stabilization and wellness of the communities served, crisis responders must also engage in activities that foster these goals for themselves.

Peer support can be an essential part of helping a program or agency reduce toxic stress and compassion fatigue through both individual and group activities. These activities can include, but are not limited to, individualized support and regular self-care activities that promote social connection and joy. Whether one-on-one via direct peer support connections, or through facilitated peer support groups, service providers can gain much from their peers, including as an adjunct to traditional services or a broader array of self-care activities. Exploring one's stress management and self-care options with a fellow provider, for example, is an excellent use of peer support.

PART 2:
PEER SUPPORT MANUAL

KEY CONSIDERATIONS WHEN DEVELOPING A PEER SUPPORT PROGRAM FOR CRISIS COUNSELORS

Developing a quality peer support program takes planning, dedication and resources. A peer support program for mental health providers takes extra thoughtfulness. Below are some key considerations and steps in the process. Training and consultation on these items are widely available and are often best facilitated by an objective third party.

TRAINING, COMPETENCIES and DEVELOPMENT

Clinicians will benefit from training regarding what "peer support" is and how it differs from counseling. On-going training may include the following topics:

- Active listening skills
- Reflection of feeling and meaning
- The ability to know when further supports are needed
- How to use self-disclosure appropriately
- Cultural humility
- How to identify strengths and connect them to coping skills and self-care.

VALUES, ETHICS, SELF-CARE

At the heart of what makes peer support work is trust. Thus, understanding the significance of confidentiality and role clarity is essential. In order to build trust, Peer Supporters must be able to "walk the talk." On-going discussion about modeling self-care and ethical decision-making is essential to building a credible peer support program.

For a Self-Care worksheet, see Appendix A.

ROLE CLARIFICATION

Providing peer support to a fellow service provider is quite different from providing a professional/ clinical service. It must be clear at the outset that the 'mode' of peer support is unique and (as above) closer to a friendly interaction than a mental health or crisis intervention. Similarly, the role expectations for "provider peer supporters" differ from those that apply to the services of their 'clients'. For example, sharing personal experience and openly disclosing one's life challenges is expected in peer support, while it may be frowned upon or even prohibited in a crisis or mental health 'professional' role.

COMPENSATION

While grassroots peer support programming often begins through a volunteer effort, sustainability and perceived value of the role are enhanced when the service is rewarded through compensation and other benefits. Even if time is not compensated directly, recognition of Peer Supporters' dedication and contribution to the cause is valuable. Recognition and reward can come in the form of special apparel (e.g., hats or t-shirts) peers can wear as an outward symbol of their role, a certificate they can add to their leadership portfolio, or shout-outs from their supervisors at team and organizational meetings or publications.

REPORTING, CONFIDENTIALITY, SAFETY AND EMERGENCY STANDARDS

Unless a worker is deemed in imminent danger to self or other, is "gravely disabled" or if the worker reports to the peer some form of abuse of child, disabled person or elder abuse, what is discussed between peers is deemed confidential. Should these issues arise, having a licensed mental health supervisor on-call will help peers determine what steps are needed. This confidentiality aspect is crucial especially where issues related to the job challenges, client interactions or coworker relations are concerned—precisely the types of job-related stressors that impact service providers and are a natural fit for peer support conversations. The only

additional reporting that can be useful is tracking the peer support services used—e.g., number of contacts, hours of service and presenting issues.

When it comes to situations that require an emergency response (e.g., the exceptions to confidentiality mentioned above) developing clear protocols on when and how to bring other experts into peer conversations is essential. If Peer Supporters are unsure whether or not to break confidentiality, they can raise hypothetical questions (e.g., "a Peer Supporter experienced XYZ, what might be the best course of action?") to get clarity.

ACTION STEPS

NOTE: Given the Ad Hoc status of many crisis response teams, groups may not have the time or resources to go through all of the steps outlined below. This icon is next to the most important steps for teams that need to set up their peer support program quickly.

Step 1: Getting Started—Establish a Peer Support Program Steering Committee, EAP Support & Advisory Council

Steering Committee

Begin by establishing an internal Steering Committee to help organize the initial processes and oversee the implementation. It's often best if this committee is relatively small (3-7 members), representative of the larger team, and not motivated by personal political gain. The group needs to be able to work together well and have a balance of skills, perspectives and roles. Usually, someone in a position of influence and resource management is necessary to facilitate decision-making. If available a person who has experienced peer support previously (either providing or receiving) can offer good insights.

Involve the Employee Assistance Program

If the crisis support organization has an Employee Assistance Program (EAP), it is helpful to engage the EAP in the development of the peer support program. An EAP representative can share their policies and procedures with the Peer Support team in order to best collaborate and clarify roles.

External Advisory Council

Additionally, a small group of outside expert advisors are needed to give input. These experts often require compensation for their time, so this is a consideration in the early stages of planning. Types of expertise:

- Building peer support teams
- Peer support skills training
- Trauma-informed care
- Crisis worker challenges (e.g., vicarious trauma, exposure to suicide)
- Evaluation

Step 2: Seek to Understand

Rationale

Before undergoing change, one is always advised to "seek first to understand." Thus, the listening process–even if brief–is essential to its likelihood of future success for the peer support program.

Conducting a "needs and strengths" assessment prior to implementation allows the program's Steering Committee:

- To gain buy-in by listening to the needs of different stakeholders.
- To better understand the resources that already exist to support workplace emotional health.
- To identify champions and storytellers who can share their lived experience of recovery, help-seeking and help-giving while at work.
- To gather baseline data against which future changes can be benchmarked.
- To develop a comprehensive strategy and identify best practices (upstream, midstream, downstream) for crisis counselor wellbeing.

NOTE: By listening intently to the crisis counselors, integrating their voices in the strategy, and enrolling their participation in the implementation of changes, the emerging Peer Support Program will feel that the program is by them, about them, and for them.

Anonymous Survey

A brief, on-line (e.g., Survey Monkey) anonymous survey sent to all of the crisis counselors in the workplace, can help implementers put their finger on the pulse of what is working and what is not working in the development of a peer support program. Sample questions might include:

- Demographic information and role description
- Tenure as a crisis counselor
- Short list of "drivers of distress" (e.g., Exposure to Others' Trauma, Sleep Disruption, Long Hours, Personal Challenges on Top of Crisis Work, etc.—then add "Other" category for additional input)
- What are the impacts of these stressors? (e.g., insomnia, burnout, cynicism, depression, vicarious trauma, anxiety, etc.)
- Short list of responses to "What helps to buffer the stress of the work?" (e.g., Camaraderie of Co-Workers, Connection to Meaningful Mission, Self-Care, etc. and "Other")
- How supported by your coworkers do you currently feel?
- [Open-ended] What would make a formal peer support program for crisis counselors effective?
- [Open-ended] What are some barriers to the successful implementation of a peer support program?
- [Open-ended] Anything else you'd like to share with us?

Focus Groups and In-Depth-Interviews

Focus groups and in-depth interviews can help program implementers better understand the crisis counselors' emotional wellness at work, and the key roles, values, needs, barriers, and communication strategies that will be vital in developing the program. Focus groups often involve 8-14 people and are conversations revolving around key questions related to the development of a peer support initiative. Sometimes, organizations seeking input in this way will offer two focus groups—one for managers and another for non-managers, so people feel more comfortable in speaking freely. Having a good cross-section of representation of workers also helps ensure the conversation will represent diverse perspectives.

In-depth, 1:1 interviews should include top leaders, key influencers, "nay-sayers" and people with lived experience of personal challenges and recovery.

Sample Discussion Questions.

1. What are drivers of distress?
2. What are strengths of the team and protective factors for crisis counselors' mental wellbeing?
3. What gaps exist for supporting the well-being of the workforce?
4. In what ways would a peer support program help fill the gaps?
5. What barriers or challenges do you foresee in building a peer support program?
6. Any additional ideas for making peer support implementation successful?
7. Final thoughts?

Groups with more time and resources may consider recording and transcribing these listening sessions; however, if that is not possible, a skilled note-taker is often sufficient. As people are talking, capturing direct quotes can give important clues and subtle insights.

Step 3: Develop a Mission Statement, Vision, Goals and Core Values

A mission statement should succinctly summarize the aims and values of the proposed peer support program. Here, the Steering Committee reviews the inputs of the listening strategies and clarifies what the program hopes to accomplish and related values. Peer support teams should always reflect the cultural norms of the community they serve.

Step 4: Determine Organizational Structure

Reporting Structure

Strong administrative leadership supporting the vision and mission and commitment to Peer Supporters is essential, and thus, where the peer support program sits within the larger organization's framework is an important consideration. Some find that reporting directly to leadership elevates the status of this vital program, enabling its representative(s) to avoid the complications and potential conflicts of interest that arise when employee issues are channeled through a performance management structure. The clinical supervisor (next section) and administrative supervisor can be the same person or two different supervisors, with one focusing on clinical issues, skills training, and ethics and the other on administrative duties like tracking, scheduling and resource allocation.

Peer Support Supervision

One key question to answer early on is who will provide consultation and answering questions that may arise during the peer supporters' service. When difficult issues arise like ethical dilemmas or safety concerns, having an established consultant or supervisor available is reassuring for all. Advanced supervision by a mental health professional helps to ensure that the peer provides the highest standard of service delivery in the best interest of the recipient. The best supervisors are champions of peer support and familiar with the particulars of peer support work while also having advanced degrees in mental health, which may be needed if advanced care decisions are warranted. Often, these supervisors have served as peers themselves. Best practices for supervision are that supervision contact is "regular, accessible and meaningful" and focuses on peer empowerment and self-care (See Appendix B).[27]

Staff

A program coordinator is often needed to help organize program logistics, assist with referrals, manage tracking and training, and more.

Step 5: Establish Timeline and Budget

Establish resource needs of time and money. Ad hoc groups will need to move quickly, whereas long-standing groups can take more time to fine tune programmatic components and evaluation.

[27] National Association of State Mental Health Program Directors (2014). Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention. Retrieved on September 25, 2021 from https://www.nasmhpd.org/content/enhancing-peer-provider-workforce-recruitment-supervision-and-retention

Common expenses include:

- Training consultants and materials
- Meeting space and refreshments (where applicable)
- Team-building activities
- Rewards and recognition efforts
- External evaluators
- Marketing materials (e.g., flyers, stickers, postcards)

Step 6: Draft Policies & Procedures

All Policies and Procedures should be reviewed with the organization's Human Resources and Legal teams to ensure compatibility.

Common challenges[28] in peer support programs for mental health providers include:

- Staff attitudes that foster bias towards people providing peer support, receiving peer support or toward the entire peer support program
- Role shifting/managing multiple relationships
- Lack of clarity about confidentiality and when to seek consultation
- The role of supervision

Because of the above challenges, policies developed at the outset can help mitigate these challenges. Policies and procedures may include:

- Code of Ethics (Sample in Appendix C)
- Confidentiality & Role Conflict
- Program tracking metrics
- Supervision Practice (on-going meet-ups, individual/group, emergencies, any documentation that needs to occur, mentoring/coaching)
- Critical incident protocol

Limits to confidentiality should be consistent with state and federal laws as well as any organization policy. For example, recipients of peer support are advised that there is usually no confidentiality for threats to self, threats to others, and child, elder, and vulnerable adult abuse. Generally speaking, the fewer confidentiality restrictions, the more confidence participants will have in the program.

Crisis care providers are mandated reporters and because of this, they must complete a mandated reporting training to serve as a Peer Supporter. Peer Supporters are required to follow the mandated reporting laws of their state. These guidelines vary and can be found on each state's website.

Step 7: Recruitment, Selection & De-selection

Selecting the right people for the peer support role is essential in building a strong peer support program. Peer support team members should reflect the range of roles within the workplace, as well as a wide representation of ethnic, racial, gender, sexual orientation and physical abilities.

Position Description

The first step in the recruitment process is developing a position description. The description should include essential tasks, expectations for numbers of hours of service and length of commitment, voluntary/paid, and so on. Another point of clarity needed in the position description is whether or not the work is voluntary. If the position is paid, what is the hourly rate or stipend?

Ideally, Peer Supporters are workers currently in good standing with their organizations and can include, but are not limited to, previous education and training in mental health; resolved traumatic

[28] National Association of State Mental Health Program Directors (2014). Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention. Retrieved on September 25, 2021 from https://www.nasmhpd.org/content/enhancing-peer-provider-workforce-recruitment-supervision-and-retention

experiences; and desirable personal qualities such as maturity, judgment, personal and professional ethics, and credibility.

Peer Supporters should see themselves, and be seen by their peers, as 'one of them". This means using common language and natural non-clinical terms, meeting in places that are familiar and comfortable, and understanding cultural norms of the community.

In addition to selecting for the qualities of personality and experience, the application, interview and on-boarding processes are critical steps in ensuring that the applicant is a good match to the needs of the organization.

Recruitment Process

[See Sample Recruitment Materials Appendix D]

The recruitment/nomination process can take one of several forms, or a combination. There are pro's and con's to each, so a combination approach might be beneficial.

- **Leadership-nominated**: this can be helpful because it can feel very validating to be recognized for compassion by a supervisor. This approach may also give credibility to the program; however, it can create an appearance of favoritism or confusion regarding the program's fit within management.
- **Peer-nominated**: peers can nominate others through an anonymous survey or by writing a letter to the Steering Committee. The advantage of this approach is the confirmation that the individual is indeed highly regarded and trusted by their peers. The downside is that it can feel like a popularity contest.
- **Self-nominated**: on one hand, people who self-nominate often have "fire in the belly" and may be more ready to make this service a priority than others who have been tapped on the shoulder by leadership or peers. On the other hand, people who self-nominate may hold self-gain motivations rather than altruistic ones. Or they might not be emotionally ready, have the right skills or credibility with the team.

One thing to consider at the outset of program development is when and how to terminate a Peer Supporter's service. De-selection criteria might include a breach of confidentiality, failure to attend training or supervision, or loss of one's good standing with the organization[29].

Interview

Once the nominations have been submitted, a small selection committee should review each and evaluate against a guiding matrix of prioritized qualifications. Members of the selection committee should then interview candidates and evaluate them on pre-established criteria while assessing the fit and motivation. Thought should be taken on how to notify those who were selected and those who were not.

Step 8: Identify Training Needs

While training is highly recommended, it should not be clinical. The ability of peers to connect in ways that feel natural and have supportive conversations that do not feel like 'treatment' is essential. Most crisis support workers are naturally good at basic peer support skills; however, sometimes they need training to differentiate between operating in the "peer zone" in contrast to the "therapy zone." Learning to shift into the role of peer support may be a challenge for those who are accustomed to

[29] International Association of Chiefs of Police (2016). Peer Support Guidelines. Retrieved on October 15, 2021 from https://www.theiacp.org/resources/peer-support-guidelines.

a traditional service provision mode. Peer support training that is specialized is essential to learning this different role and way of interacting.

Peer support training focuses most often on a combination of values and techniques which in practice are tightly intertwined. The values of peer support focus on empowerment, transparency, authenticity and humility. They are expressed in practices that are at once ethical and aspirational, and which most commonly pertain to communication. [30]

For professionals in the human service, mental health and related fields, peer support communication techniques might appear quite similar to skills they have learned such as reflective listening. Put into the context of peer support values however, these have a very different 'feel' -one that distinguishes them from clinical interviewing, psychotherapy etc. This is because relating as a peer provides for a different understanding of the use of self and professional boundaries.

Active listening, for example, is central to peer support because the primary goals of peer support are 1) to help a peer to feel truly heard and, 2) to reinforce that others share something of their experience—i.e., that they are not alone. By contrast, communication that seems too prescriptive or professional can raise concerns about authenticity and equality in the peer relationship.

It will be obvious to most that the above outcomes are desirable in any support modality. In peer support, however, they take on a special primacy because *peer support is not about providing advice, resources, or clinical intervention*.

This is to say that *a Peer Supporter seeks only to listen with compassion and get as close as possible to the experience of their peer, acknowledging where that experience might intersect with their own and also, importantly, where it does not.*

Essential Training Topics

- Values and ethics of peer support
- Role conflict
- Sharing meaningful personal lived experience
- Understanding and responding to vicarious trauma

Additional Training Topics

- Burnout and psychological safety
- Engaging/Active listening with peers vs. community
- Crisis support and referral/suicide prevention for peers vs. community
- Peer support practice parameters/ role management
- Avoiding advice-giving and the psychotherapy zone
- Understanding where therapy is needed/appropriate
- Confidentiality—federal and state laws as well as organizational policies
- Peer Supporters are encouraged to advance their skills through on-going training as scheduled by the program coordinator. Four hours of training per quarter is ideal to keep Peer Supporters up-to-date and sharpen skills.
- Additional Training Best Practices in Appendix E

[30] https://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf

Step 9: Create an Evaluation Process for Quality Improvement & Measuring Impact

Monitoring progress to course correct as needed is essential in any good program management plan. If you have the resources, hiring an external evaluator can provide some objectivity and more reliable data. A good evaluation plan will follow a logic model flowing from inputs to outputs and connecting to short- and long-term anticipated impacts.[31] See sample logic model in Appendix F.

Evaluation outcomes should assess impact as well as quality assurance. For instance, data collected should address areas that need improvement as well as critical processes in sustaining strengths of the program.

[31] Center for Innovation and Health (2009). Evaluating Peer Programs. Boston University School of Social Work. Retrieved on September 25, 2021 from https://ciswh.org/wp-content/uploads/2016/04/7._EvaluatingPeerProgramsComplete.pdf

MASS SUPPORT

A SERVICE OF
RIVERSIDE TRAUMA CENTER

PART 3:
CASE STUDY—MASSSUPPORT PEER SUPPORT NETWORK

History

From 2020 to 2021, the MassSupport Network was developed as a Crisis Counseling Program (CCP) managed by Riverside Trauma Center, a program of Riverside Community Care. The intention of the Network was to support Massachusetts residents experiencing hardship after the onset of the COVID-19 pandemic. MassSupport Disaster Counselors offered an array of services and resources (often in multiple languages), including anonymous, confidential and free help to all Massachusetts residents, organizations and communities. Participants were able to:

- Receive fact-based, credible, up-to-date information to help inform decisions.
- Take stock of needs, options and gain awareness of resources.
- Understand your current situation and reactions.
- Reduce stress.
- Develop and use coping strategies.
- Connect with other people, agencies and resources.
- Get 1:1 short-term, confidential support for individuals and families.
- Psycho-educational presentations on a range of topics.
- Consultation and group supports to schools, business and organizations.

MassSupport was organized into seven teams: Eastern Mass., Western Mass., Boston Area, Southeastern Mass., Northeast Mass., Worcester Team. and a team supporting the Mass 2-1-1 call center. In the early phase of development the teams deployed outreach counselors (Bachelors level) and clinicians (Masters level) to provide Psychological First Aid in the form of basic education and counseling around issues related to the pandemic, while assessing high-risk individuals for additional referrals. A nine-month extension of the project through the spring of 2021 built on that work to provide more crisis counseling for the lasting effects of the pandemic, community education on coping with ongoing stress and building emotional resilience, and assistance for people applying for services to relieve crisis-related burdens.

Co-Designing the Peer Support Program

Knowing that input from the mental health teams would be an important feature throughout the process of building the peer support program, the project lead began the work by "seeking first to understand."

Before the peer support team launched, a "peer support committee" was established. Their initial charge was to conduct a series of listening sessions across the different regions of the state and assure them that their participation in the co-design was critical to its success. From October to December 2020, these listening sessions lasted about 30 minutes and involved a representative sample of the Statewide Crisis Counseling team. The interviewees completed an informed consent form and then the interviews were conducted virtually and recorded so that themes across participants could be identified. If participants declined to be recorded, the interviewer took detailed notes. Once the data collection period ended, only de-identified notes were kept.

We would like to acknowledge following people as the peer support team/design contributors:

Senior Team Leader
Sarah W. Gaer

Peer Support Team Lead: (Extension)
Jessie Channell

Peer Support Team/Design Contributors
Yaminette Diaz-Linhart
Sarah DiGregorio
Jennifer Matoney
Sand J Butter
Lia Simonds
Jordan Fox-Kemper

MassSupport In-Depth-Interview Questions

- Who is a peer?
- What is peer support and what is it not?
- Where does peer support happen?
- What are the essentials of a peer support program?
- What makes a peer support program successful?
- What are the goals of a peer support program?
- What qualities and skills should Peer Supporters possess?
- Why is a peer support program important?
- What are the benefits of a peer support program?
- How does a peer support team be effective?
- What values should a peer support program have?
- What are the ethical considerations?
- When is peer support at its best?
- What barriers to help seeking should we be aware of and how do we attempt to overcome them?
- What should a team of future Peer Supporter know when starting a program?
- What should organizations know before starting a peer support program?
- Can you share any stories of peer support successes/ anecdotes/and/or what you have seen it accomplish?

Results of Listening Sessions

The listening sessions explored participants' ideas on what peer support looks like and how it might benefit crisis support workers. Over a three month period, program leaders conducted four key stakeholder interviews, five interviews with clinicians and counselors and one focus group. The Peer Committee reviewed recordings and notes and discussed themes across all the interviews.

When asked "what is peer support?" one interviewee stated:

> *Peer support for me would be having a more informal connection with someone and engaging in the mutual aid aspect, we are both living through this pandemic and we are helping people living through this pandemic and being able to talk openly about it, and the struggle about it. Having someone there to talk about it, it is just tough hearing all the different stuff going on with people, and you want to be able to commiserate in a helpful way, a way you are able to vent a little bit, and you can back and say the work we are doing is helpful. Being a positive person of the good stuff you are doing, sort of like let you air it all out, that is what it would mean to me.*

A second responded:

> *I think peer support means having an open and welcoming environment for everyone. Co-workers who you feel like you can come to with an issue or problem and they will listen, offer suggestions or just say, "yeah, that is really hard." Just having those folks who get it available to you. You can talk about work stuff with people in your life, but they just don't know what it is like.*

When asked "what ideas would you have to increase support?", one interviewee suggested:

> *Each person needs the option to choose which peer supporter they would like and whether or not they want someone within the same team or not. This is especially important for people who have different cultural backgrounds.*

When asked, "What role might peer support have in supporting wellbeing at work?", one interviewee expressed:

> *I think checking in with people—as clinicians and counselors we are used to helping other people and are really bad at saying, I need help, outside of our assigned supervision, and no one asks us how we are doing. No one says, are you doing okay, are you using these? So having folks available and making effort to reach out to people and making sure they are okay, checking in with them, making that space available and drawing people in, needs to be a conversation for us. Beyond being available and accessible—deliberately checking in and making space for that in people's work life. That space can broaden.*

Themes across all of the listening sessions were then identified by the Peer Support Leadership Committee.

Theme	Stakeholder	Notes	Questions and Next Steps
Power	Key Experts Peers	Equalizing power Being present and listening are more important than what is actually done	Is there an inherent problem in our program around power dynamics because of the clinician-counselor different? Do clinicians and counselors experience power differtials in teams?
Culture of Care and Connection	Key Experts Peers	Developing a workplace where the culture is caring Respect, humility, partnership Spaces for connection	Underscore that a core value of our program: it is ok to not be okay
Shared Experience/ Identity	Key Experts Peers	Support is based on shared experiences Support based on potential shared identities	How comfortable are peers accessing support through shared identities?
Logistics and Getting started	Key Experts	NOT therapy Confidentiality needs to be explicit	Consider training on peer support in particular to help facilitate process
Community-building on shared interests	Peers	Opportunities to get to know each other Affinity groups More informal opportunities to get to know each other Create a form to get to know each other and hot to best support each other (playing games, talking etc.)	Create more informal opportunities to get to know each other
Working support through team	Peers	There is current support in teams, overall peers report feeling supported Being able to talk about systems, not just individual needs of clients	How do we expand this support between teams?
Promotion/ Well-being	Peers	Lighthearted support Support beyond reaching out when something is wrong	Move beyond "something being wrong" towards a culture of caring

In summary these themes included:

Power Balance: is there an inherent problem in our program with power dynamic of doing peer support in a mental health setting. How will our approach equalize power?

The Culture of Care and Connection: A crisis support team is centered around partnership and care. Thus, a core value of our program emerged that it's okay to not be okay.

Shared Experience and Identity: Interviewees recognized that support is based on potential shared identities and experiences.

Community Building: Informal opportunities for team members to get to know each other are important.

Existing Support on Teams: There is current support on teams, as peers report feeling supported by their coworkers. We thought about how we might expand this strength.

Mission Statement of MassSupport Peer Support Program

Subsequent to the listening sessions, this mission statement was formed:

> *Our mission is to create a culture of caring, safe mutual support, wellbeing, and permission to be vulnerable with the knowledge that team members have both shared and unique experiences.*

MassSupport Peer Support Structure

Peer Support Team & Advisory Council

The peer support team was made up of two Peer Supporters per regional team and the Senior Team leader. The team was advised and trained by experts in vicarious trauma, peer support and workplace mental health.

Recruitment, Selection, De-Selection & Training

Recruitment. The MassSupport Peer Support Network recruitment process identified various qualities needed to create a successful team of Peer Supporters. Peer supporters needed to represent various roles and diverse backgrounds. For example, Peer Supporters did not all have the same educational nor professional background, but they should identify as helpers. It was deemed helpful if Peer Supporters had lived through and experienced what they aim to help their peers with and that they strive to be transparent, person-driven, compassionate, and present.

The recruitment process was also intentional about role modeling self-care and wellness. Further, the committee sought peers who believed in a culture of permission—those who could demonstrate to others in the field "it's okay to be vulnerable." Finally, the recruitment priority was to seek Peer Supporters who could identify the need for support

for the team of crisis support workers and who could demonstrate their understanding of the importance of confidentiality.

Selection. Through use of an anonymous survey, each MassSupport Network regional team nominated two of their team members to be part of the peer support team. They chose not to have Peer Supporters selected by team leaders or other management but rather be chosen by the teams. There were a few "pros and cons" of this approach. Initially, the team that was nominated by team members was composed of only women. Some concern was raised around representation and whether or not this would keep men from accessing peer support. When the organization received an extension in Spring 2021, the team was composed of three White women. Some concern was raised again about representation and a plan was created to recruit additional Peer Supporters. The team went to their prospective Regional team members and let them know Peer Support was looking for new members. Team members answered questions and spoke about the commitment associated with being a Peer Supporter. The team then offered to hold informational sessions for any interested parties. After doing so, the team was able to recruit a male member to the team.

De-Selection. The Peer Network determined that removal of Peer Supporters from the team was a two-way street. Peer Supporters may choose to withdraw from their role at any time with notice. Serving in the peer support role is voluntary. Peer supporters may also be removed from their role within the program for conduct violations.

Training & Psychoeducation. MassSupport provided appropriate resources to develop and maintain the peer support program including regular and ongoing training for peer support members. All peer support members were previously trained in suicide assessment, Skills for Psychological Recovery, and Psychological First Aid as part of the Crisis Counseling Program. Specific Peer Support training was also provided to the team.

Ethics, Policies & Procedures

General Policies & Procedures

Goals of the MassSupport Peer Network were two-fold:

1. Disaster work often leads to great emotional distress. With the disaster of the COVID-19 pandemic, staff are experiencing it both at work and at home. In an effort to support and preserve the team during this difficult time, MassSupport developed, in conjunction with Riverside Trauma Center, a Peer Support program for crisis support members.
2. In addition to serving crisis support workers through the COVID-19 pandemic, the MassSupport peer support team wanted also to broadly consider Peer Support for the national crisis behavioral health workforce and develop a standardized Peer Support program to help them.

The Peer Support Team member expectations:

There was difficulty fusing a peer support model within the mental health field. Specifically, most Peer Supporters who serve other populations are not qualified to provide mental health information or have highly technical skills in mental health services. Due to the reality that all of the MassSupport Peer Supporters had some background in mental health, this policy had to be adapted to Peer Supporters with mental health skills as it felt irresponsible to not share insights with a peer who may be struggling with a mental health condition, etc. We remained clear that Peer Supporters must never allow themselves to fall into the role of therapist or to perform assessments on peers. We still found that it was incredibly difficult for individuals who had a background as clinicians to entirely remove their clinical hat and it raised concerns around ethical obligations and providing clinical advice recommendations.

DO	DON'T
Provide support to their fellow MassSupport team members	Perform crisis assessments or respond in-person to the emergency at hand.
Attend weekly team meetings, peer working groups, and ongoing trainings	Disclose identifying information during check-ins with other Peer Supporters or team meetings.
Make referrals as appropriate and as needed (create a resource list)	Do not pathologize or diagnose peers
Protect the confidentiality of those who seek support	Do not create treatment plans or formal safety plans
Practice self-care, wellness and creativity	Do not seek case supervision internally (external supervisors were identified)
Offer on-on-one peer support as needed—a one-time interaction or on-going	
Respond to a request for support within 24 hours, unless the situation seems more urgent, then as soon as possible.	
Lean on other members of the peer support team as needed, but preferably not a member of their own regional team to protect the confidentiality of the staff person reaching out.	
Consult with their supervisor or another Peer Supporter if they have concerns regarding a peer's feelings of suicidal intensity.	

Accessing Peer Support

Peer Supporters either organically reached out to members of their regional teams, or team leaders recommended peer support to a team member when they became aware of a team member struggling. Accessing peer support was not ever to be a part of a disciplinary action in any way. The team leader may ask the team member if they are comfortable with a Peer Supporter reaching out to them.

Team members also reached out to Peer Supporters directly when seeking support for themselves. Staff could access contact information and availability for all Peer Supporters in a common workplace portal. There, brief bios of each Peer Supporter highlighted any areas of interest or expertise. This process allowed team members to be empowered to reach out to a Peer Supporter with whom they believed they shared the most life experiences or identities.

Peer Supporters then provided support via zoom, texting, email, or telephone given the restrictions of physical distancing during the pandemic. The general expectation was that Peer Supporters would respond to team members as quickly as they are able, taking no longer than 24 hours to reach out.

Initial Contact

Upon first contact Peer Supporters will clarify their role to provide one-time or short term support and assistance to team members. Peer Supporters assured team members that their information would be kept confidential and that no notes were being taken during their video conversation or phone call. However, it was also the responsibility of the Peer Supporter to advise the team member that the conversation was not exempt from mandated reporting laws. Peer Supporters were instructed to notify the peer support team lead if a conflict of

interest arose or if they needed consultation about an ethical dilemma without violating confidentiality of the peer. When appropriate, Peer Supporters shared referral information within the scope of their knowledge and training.

Hypothetical Example of MassSupport Peer Support Process (case example)

A Peer Supporter received an email from a supervisor stating a team member had expressed interest in peer support after a family member died suddenly. The Peer Supporter called the team member an hour later. The team member was already aware of peer support so no additional information or introduction was needed. The Peer Supporter listened to the team member and validated all feelings expressed. Because the Peer Supporter did not have a significant similar experience the Peer Supporter stated, "I can't even imagine what you're going through."

The Peer Supporter and staff member discussed a self-care plan for the evening and the weekend where the team member would connect with friends and family and engage in activities that have helped relieve anxiety in the past.

The Peer Supporter and staff member made a plan to talk again and did so two days later. The staff member reported that the self-care plan was effective in decreasing distress and expressed gratitude for the support.

In the subsequent supervision check-in, the Peer Supporter reported the call felt more casual than a clinical interaction due to the pre-existing relationship as peers.

Confidentiality

Confidentiality was emphasized to the MassSupport Peer Supporters an ethical duty provided to fellow team members that should be maintained. Privacy should be an expectation of team members who disclose information to Peer Supporters.

Peer Supporters communicated that contact is confidential, as well as the limits of this confidentiality, with team members at the start of each call.

Limits of Confidentiality.

Bill S.2633 "An Act Relative to Critical Incident Intervention by Emergency Service Providers" was originally passed in December 2018 as a tool to help first responders seek support without fear of stigma. In Massachusetts, "certified emergency service providers" are emergency service providers certified by the Massachusetts Peer Support Network or International Critical Incident Stress Foundation, Inc.

Information provided to Peer Supporters is confidential under this law and these providers are not required to testify or share any information to a third party. The limits of this law are a disclosure of harm to self or others, a crime, or need for mental health treatment.

Because the MassSupport Peer Support Network program was not certified and their Peer Support Team members were not trained and certified by either the Massachusetts Peer Support Network or International Critical Incident Stress Foundation, Inc., there was concern that the program's confidentiality policy might not hold up in a court of law.

Ethical Practices for MassSupport Peer Network

The Peer Network established the following guidelines to help them navigate ethical challenges:

- If a team member called about a work-related stressor, a Peer Supporter would provide peer support and suggest reaching out to the agency's human resources department, if appropriate, but will not contact anyone themselves.
- If a Peer Supporter reached out directly to an individual who they have observed possibly having a difficult time, the Peer Supporter will identify themselves as a Peer Supporter as a means of providing informed consent.
- Peer Supporters will not pursue interacting with a peer who has expressed not wanting it.
- Peer Supporters will not provide psychotherapy.
- Peer Supporters will not take gifts nor money in exchange for peer support.
- Peer Supporters will not impose their personal views upon team members.
- Peer Supporters will not share personal information with team members unless beneficial to the encounter and with permission from the team member.

Emergency Policy and Procedures

The MassSupport Peer Network developed the following emergency protocol:

> *The Peer Support Network is a program with universal precautions that does no harm. In an emergency situation, the role of a Peer Supporter is to support the team member experiencing severe distress in an effort to decrease the distress or resolve the emergency situation. When appropriate, the Peer Supporter may guide the team member in viewing the situation as a possible opportunity for growth and personal development. It is not the Peer Supporter's role to perform crisis assessments or respond in-person to the emergency at hand. Peer support, through the culture of caring, aims to provide upstream suicide prevention, providing protective factors that mitigate risk. Peer Supporters should consult with their supervisor or another Peer Supporter if they have concerns regarding a peer's feelings of suicidal intensity.*

Documentation.

The MassSupport Peer Network determined that confidentiality would be maintained by limiting documentation to minimal tracking. They kept a record of how many calls or contacts they had per day, but did not record who took the call nor what it was regarding. They did not ask for or document any identifying information of the caller.

Role Clarity & Conflict of Interest.

At MassSupport, many Peer Supporters were also clinicians. This can pose a challenge in regards to providing peer support rather than counseling. The team solved this dilemma by creating the following agreements:

- MassSupport clinical service providers who are engaged for peer support will be mindful to come to peer support calls with a focus on shared experience and empowerment of their peers and will intentionally avoid engaging their peers as if they were providing a clinical consultation.
- *With permission, a Peer Supporter can provide clinical psychoeducation.*
- *Clinicians will not assess or diagnose a peer.*
- *Peer Supporters are welcome to provide clinical advice with the permission of the peer.*
- *Peer support is not terminated formally in a clinical manner.*

Training

The MassSupport Peer Support Team went through two days of training (total 12 live session hours) facilitated by Eduardo Vega and Dr. Robert Macy. This training included presentations on trauma-informed care and an in-depth training onPeer Support. Peer Support topics included: how to explore shared meaningful experiences, developing allyship and mutuality, and how to avoid the "Therapy Zone." Specifically, trainees worked on developing their 'peer ally' mode, which involved moving away from a psychodiagnostic/ intervention framework, connecting as equals, identifying 'sympathetic stress' rather than seeking fixing stress by finding a solution.

Communication skills within the Peer Support training, while similar in form to the fundamentals of reflective listening or motivational interviewing, focused on creating a 'peer ally' relationship as opposed to a treatment provision model. Shifting roles to do this is often a challenge for clinician-identified individuals, even when they are clearly speaking with peers in their field. Sharing one's personal experience, for example, a fundamental aspect of peer support, is a radical departure from traditional clinical boundaries.

Dr. Macy's training involved the exploration of three fundamental components for the practice of peer counseling. The first component asked peer counselors to define "who are we" in this work, "what is our intention for the work", and "how do we drop into the zone of 'the authentic self'"?

The second component involved designing and refining a practice for peer counselors to be able to manage their emotional arousal. This is sometimes referred to as reactivity or autonomic arousal. The peers practiced a specific sequence of activities which allows the peer counselor to lower their heart rate, ground themselves and become fully present in the immediate moment.

The third component explored the conceptual framework "saving and rescuing" a peer. Trainees explored the idea that it is not their role nor mission to save and rescue somebody from something that's already happened to them. And if they are not saving and rescuing then what are they doing? Their role is actually to assist the peer in feeling safe, comfortable, and connected enough to tolerate their own vulnerability so that they can access their resiliency.

Team-Building and Self-Care Activities

Self-care was considered a professional imperative and foundation for the Peer Support Network. The Peer Support Team regularly discussed the importance of wellness, for both staff members and Peer Supporters. They mailed caring cards to staff members with supportive notes, reminding them that they were crucial members to the mission and that they were doing great work.

They explored posing self-care challenges, where teams could compete with each other completing self-care tasks, such as drinking 8 cups of water every day for a work week. They implemented wellness activities, such as yoga classes and a weekly Coffee Chat.

The Peer Support Team was offered activities to enhance social connection, spark joy, and promote stress relief. These activities include yoga, journaling workshops, cooking classes, show and tell, and a regularly scheduled Coffee Chat. The ideas for these activities are generated from the team members themselves. Activities were led by both Peer Supporters and staff. All of these activities were designed to increase staff members' comfort with accessing Peer Support.

Cultural Responsiveness & Humility

MassSupport Network had a wide diversity of staff including multiple languages, ethnicity and professional backgrounds. The composition of the original Peer Support team was representative of the diversity found in the program staff; however, when the program downsized after receiving a contract extension the broad diversity and reflection of the workforce was lost. . The MassSupport Peer Support Network did find that organic peer support occurred within the special committees that were designing outreach for the Spanish speaking community (Cafe Con Leche) as well as the Black Community (Soul Food).

Lessons Learned from MassSupport Peer Support

There are several lessons learned from the MassSupport Peer Support Network case example. The pandemic stripped the team of their organic opportunities to sit at the lunch table or stop by one another's office, causing it to be especially imperative that they were mindful of the need for support.

In some ways the MassSupport Peer Network case study may be unique in that the Peer Supporter was a member within the same agency as the staff member they were supporting and experienced the same disaster (i.e., the COVID-19 pandemic) at the same time. Furthermore, the nature of the pandemic necessitated that peer support be provided virtually. Because this particular crisis care need was built ad hoc in response to the COVID-19 pandemic, the Peer Support Network needed to be built quickly and responsively.

It is important to be mindful during the nomination process to not only nominate clinicians with advanced degrees as the program benefited from a wider range of Peer Supporters (gender, race/ethnicity, age, professional background, SES, etc.).

Integrating a second group of Peer Supporters into the program at a later time negatively impacted group cohesion and a sense of ownership among new members. The MassSupport Peer Support Network foresees this being a challenge for future crisis counseling programs serving disaster situations because of the hiring pattern during the transition from the Immediate Service Program (ISP) to the Regular Service Program (RSP) and again if there is an extension of the program.

Other lessons learned shed light on what other peer support programs for crisis services organizations might anticipate. For instance, nearly all of the calls came in through a supervisor referral and nearly all of the calls were prompted by personal life experiences and not work-related.

Benefits for the program overall: Having a peer support team has allowed supervisors to separate their supervisory role from a nurturing, supportive role while enabling staff members to get the support they need from a Peer Supporter rather than a supervisor.

CONCLUSIONS

Mental health providers are often at risk for burnout, and those who provide crisis support/trauma response services are at additional risk for vicarious trauma. These counselors are often holding stories of terror and tragic loss. Peer support is a highly effective way to mitigate these risks in crisis counseling programs. Implementing quality peer support programs for clinically-trained specialists requires specialized knowledge, training and collaboration, and benefits from a well-planned methodology.

This manual provides key considerations and tools to help crisis services organizations build a peer support program.

ABOUT THE AUTHORS

Jessie Channell

Jessie Channell is a licensed social worker, certified Trauma-Focused Cognitive Behavioral therapist, and certified Telemental Health provider. She has a Bachelors in Sociology from Bard College and a Masters of Social Work from Boston University. She has a great deal of experience in the fields of domestic violence, sexual abuse, and child welfare. She has worked in several roles at Riverside Community Care: as a Clinician for MassSupport, the FEMA-funded crisis counseling program, a clinician for the behavioral health line, and a critical incident responder for the Trauma Center.

Jordan Fox-Kempler

Jordan Fox-Kemper is a licensed clinical social worker. Her areas of expertise include crisis intervention, individual and group counseling, clinical supervision and teaching. Jordan has worked in multiple roles at Riverside Community Care including as a Team Leader for a FEMA-funded crisis counseling program named MassSupport, a critical incident responder for Riverside Trauma Center and a behavioral health consultant for Mindwise Innovations. She is also a lecturer in the Human Services program at Northeastern University.

Sarah Gaer, MA

Shortly after accepting her first job in the mental health field when 20 years old, Sarah lost her third friend to suicide within a three-year period. She was so devastated by those losses she informed her new employer that she didn't think she would be able to work with youth in crisis.

A couple of decades later, Sarah is a crisis response leader, speaker, trainer and author who has worked with many populations ranging in age from youth to the elderly, with challenges ranging from trauma to chronic mental illness, developmental disabilities, substance use related disorders, and suicidality. She has worked

in a wide variety of settings including residential treatment, outpatient, substance abuse treatment crisis, and outreach.

Sarah earned her Associates Degree at Holyoke Community College (1998) and her master's degree in Clinical Mental Health counseling at Antioch University New England (2009). She has been part of the Riverside Trauma Center, a Program of Riverside Community Care, based in Needham, Massachusetts. In her role there, she has been providing trauma response, suicide prevention training, and trauma training to public safety and Massachusetts communities.

She is a board member for United Suicide Survivors International and has presented at the World Congress of the International Association for Suicide Prevention, among many other national and regional conferences. She is the author of *The Price,* a novel about the aftermath of suicide and first responders, and is the co-editor of the *Guts, Grit & The Grind* book series, an anthology on men's mental health. More: https://sarahgaer.com/.

Robert Macy, Ph.D., DMT
Founder and President of the International Trauma Center

Dr. Robert Macy is the Founder and President of the International Trauma Center. He was trained as a theatre artist, Taoist martial artist, dance movement therapist (DMT), traumatologist, and neuroscience researcher with over 30 years practice in the field of body-based psychological trauma interventions, disaster medicine and the design, development, dissemination and implementation of trauma informed care assessment and intervention service delivery systems in the United States and overseas.

Dr. Macy and Dicki Johnson Macy, BC-DMT, LMHC, M.Ed., have devoted the last two decades to the design, development and implementation of DMT-based interventions for youth and communities exposed to violence and extreme stress events. Dr. Macy is also the Co-Founder, with Dicki Macy, and Executive Director of The Boston Children's Foundation. Dr. Macy is a member of the SAMHSA Disaster Technical Assistance Center (DTAC) and works nationally to assist SAMHSA in disaster response and recovery.

Dr. Macy is a founding member of the National Child Traumatic Stress Network (NCTSN), where he is a primary content provider for the development of Psychological First Aid, (PFA) and Skills for Psychological Recovery (SPR), and was instrumental in the design and development of NCTSN network products during its first 8 years. He has co-chaired the NCTSN Terrorism and Disaster Network Committee and led numerous response and behavioral health recovery teams during national and international disasters.

Sally Spencer-Thomas, Psy.D. President & Co-Founder, United Suicide Survivors International

Clinical psychologist, inspirational speaker, podcaster, and impact entrepreneur, Dr. Sally Spencer-Thomas sees the world of mental health from many perspectives. She began her innovative work in suicide prevention after her brother Carson died of suicide in 2004. After his difficult battle with a bipolar condition ended in tragedy, she searched for bold, gap-filling strategies to prevent what happened to Carson from happening to other people.

Now known nationally and internationally as an innovator in social change, Spencer-Thomas has helped start multiple large-scale, gap-filling efforts to remove bias around mental health and ensure more people have access to the tools and assistance they need to thrive and stay alive. These efforts include:

- The award-winning Man Therapy campaign
- Lead author of the National Guidelines for Workplace Suicide Prevention
- Co-founder and current president of United Suicide Survivors International, a non-profit dedicated to lifting up the voices of people with lived experience to effect systems and culture change
- Past Executive Secretary for the American Association of Suicidology
- Leadership positions with:
    - The International Association for Suicide Prevention
    - The National Suicide Prevention Lifeline
- Co-editor of *Guts, Grits & the Grind*, a book series about men's mental health

Spencer-Thomas has won multiple awards for her advocacy work, including:

- The 2014 Survivor of the Year from the American Association of Suicidology
- The 2014 Invisible Disabilities Association Impact Honors Award
- The 2012 Alumni Master Scholar from the University of Denver
- The 2015 Farbarow Award from the International Association for Suicide Prevention
- The 2016 Career Achievement Alumni Award from the University of Denver's Graduate School of Professional Psychology

In 2016, Spencer-Thomas was honored to accept an invitation to speak about men's mental health at the White House. In her TEDX talk, Stopping Suicide with Story, she shares her goal of elevating the conversation to make mental health promotion and suicide prevention a health and safety priority in our schools, workplaces, and communities.

Her degrees include:

- Doctorate in Clinical Psychology from the University of Denver
- Masters in Nonprofit Management from Regis University
- Bachelors in Psychology and Studio Art with a Minor in Economics from Bowdoin College

She lives with her partner and three sons in Conifer, Colorado.

Connect with Dr. Sally via:

- Her website
- Facebook
- Instagram/Twitter (@sspencerthomas)
- LinkedIn
- Her *Hope Illuminated* podcast

Eduardo Vega, M.Psy.
Humannovations Founder, CEO and Principal

An internationally recognized thought leader in mental health systems, programs and policy, consumer/patient engagement, stigma reduction, men's health and suicide prevention, Eduardo Vega's work continues to drive the forefront of change for mental health worldwide. A former Fulbright Specialist and California State Mental Health Commissioner, he has spearheaded progressive social and public health change at local, national and international levels.

For over twenty-five years, Vega has worked for the improvement of lives and systems of care in behavioral health. A suicide attempt survivor who experienced serious mental health conditions himself since childhood, Vega has served as counselor and/or manager in virtually every psychosocial and clinical mental health service setting, as well as performing executive roles in government, business and non-profit administration. As President and CEO of Mental Health Association of San Francisco from 2010 to 2016, he drove organizational expansion near one-thousand percent in three years, focusing on innovation in consumer-run services and community empowerment. Simultaneously, as Director and Principal Investigator at the International Center for Dignity, Recovery and Empowerment Vega spearheaded leading-edge research, TA and training projects in suicide and stigma and discrimination reduction, community integration, self-help and peer support. Previously, he served at the executive management level of the Los Angeles County Department of Mental Health, one of the world's largest public mental health authorities.

APPENDICES

APPENDIX A

Self-Care Plan[32]

Answer these questions as a guide to developing your self-care plan:

1. What I am like when I am feeling well:

   _____

2. Who is on my "A-Team":

   _____

   » Who has my back?

   _____

   » Who do I trust?

   _____

   » Who brings out the best in me?

   _____

   » Who comes to support me, even when it's inconvenient for them?

   _____

3. What specifically do you need from members of my "A-Team"?

   _____

4. Exercise choice:

   _____

5. Favorite self-talk statement:

   _____

6. Food/snacks for wellbeing plan:

   _____

7. Meditation/ relaxation practice that works for me:

   _____

8. Favorite sources of spiritual replenishment:

   _____

9. Where can I find humor:

   _____

My Self-Care Commitment

I value my health and my service to the community so much that I do not want to compromise my wholeness and potentially, hurt myself or others. I take my social and emotional health very seriously and commit to making my self-care a priority:

Signature

_____

[32] Adapted from Kendrick, Alina, "Peer Support to Reduce Vicarious Trauma in Mental Health Providers" (2020). Doctor of Nursing Practice (DNP) Projects. 231. Retrieved from https://scholarworks.umass.edu/nursing_dnp_capstone/231

Example of Self-Care/Team-Building Activity from MassSupport

Creative Show & Tell

Drawing, painting, photography, knitting or other fiber arts, origami or other 3D art, jewelry making, soap making, woodworking - come share your creative outlet with others at MassSupport

Show us something you've made or are still working on, tell us about the new technique you're learning, show us examples of the kind of art that inspires you, or just come chat about your favorite materials to use

Wednesday, Feb 24th 5:30-6:30pm

Pop in when you can!

https://us02web.zoom.us/j/85453771723

APPENDIX B

Peer Support Supervisor Best Practices[33]

- Supervisors are champions of peer support work, and often have given or received peer support in the past.
- Supervisors complete the same trainings and orientations as the Peer Supporters.
- Supervisors are actively involved in the peer selection process.
- Supervisors are licensed mental health professionals or a peer in recovery with experience as a peer provider who meets the State's Medicaid standards for a competent mental health professional can provide clinical supervision of peer providers.
- Supervisors offer regular, scheduled check-ins (one-on-one or group) and are also available for consultation at all times by phone or text.
- Supervisors review any needed documentation.
- Supervisors are trauma-informed and aware of cultural differences between them and the Peer Supporters.
- Supervisors are respectful, honest, kind and fair. They are calm and calming.
- Supervisors encourage self-reflection and empowerment by asking questions and eliciting solutions.
- Supervisors model and promote self-care.

Example of a Supervision Session:

1. Start with accentuating the positive. Ask for examples of something that is going well. Give specific feedback (observations/assessment).
2. Ask for Peer Supporters reactions to #1
3. Focus on the Peer Supporters' needs: "What kinds of questions do you have for me?"
4. Offer assistance: "Is there anything you need from me right now to help you do your best in your work?"
5. End with a statement of appreciation for the Peer Supporters.

[33] Adapted from National Association of State Mental Health Program Directors (2014). Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention. Retrieved on October 15, 2021 from https://www.nasmhpd.org/sites/default/files/Assessment%201%20-%20Enhancing%20the%20Peer%20Provider%20Workforce_9-15-14.pdf

APPENDIX C

Sample Ethics Code[34]

Ethical considerations look at the balance of self-determination, power dynamics within teams and within the organization as a whole, and confidentiality.

The following principles guide Peer Supporters in their various professional roles, relationships, and areas of responsibility.

1. Peer Supporters believe that every individual has strengths and the ability to learn and grow.
2. Peer Supporters respect the rights and dignity of those they serve.
3. Peer Supporters openly share their personal recovery stories with colleagues and those they serve.
4. Peer Supporters seek to role-model recovery.
5. Peer Supporters respect the privacy and confidentiality of those they serve.
6. Peer Supporters never intimidate, threaten, or harass those they serve; never use undue influence, physical force, or verbal abuse with those they serve; and never make unwarranted promises of benefits to those they serve.
7. Peer Supporters do not practice, condone, facilitate, or collaborate in any form of discrimination on the basis of ethnicity, race, gender, sexual orientation, age, religion, national origin, marital status, political belief, or mental or physical disability.
8. Peer Supporters maintain high standards of personal conduct.
9. Peer Supporters conduct themselves in a manner that fosters their own recovery, maintaining healthy behaviors.
10. Peer Supporters do not enter into dual relationships or commitments that conflict with the interests of those they serve.
11. Peer Supporters never engage in sexual/intimate activities with colleagues or those they serve.
12. Peer Supporters do not accept gifts of significant value from those they serve.
13. Peer Supporters keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their colleagues and those they serve.

Additional reading:

Values and Ethics of Peer Support

https://na4ps.files.wordpress.com/2012/09/nationalguidelines1.pdf

http://nisa.on.ca/wp-content/uploads/2016/06/NISA-Core-Values-of-Peer-Support.pdf

[34] Adapted from DBSA (2004) Peer-to-Peer Resource Center.

APPENDIX D

Peer Support Recruitment and Selection Tools

SAMPLE Recruitment Language for Peer Support

- Do you have a desire to help fellow other crisis support providers through hard times?
- Have you lived through depression, anxiety, addiction or suicidal crises and have insight into what it takes to survive and thrive through these experiences?
- Do you have what it takes to be a Peer Supporter?
- Peer Supporters are needed at [XYZ company] to offer empathic understanding, mental health education and help to other crisis support workers who are going through hard times. The goal of peer support is to break down the isolation that often comes with suffering and empower others to rekindle a passion for living through effective listening and connecting to the right resources.
- If this sounds like something you'd like to do, please, fill out and submit an application to [AGENCY NAME] either in person or to [EMAIL] with "peer support training application" typed in the email subject line. The peer support team will contact you to set up a time for an interview to assess suitability for the training.

++++++++++++

[SAMPLE RECRUITMENT ANNOUNCEMENT]

[Version 2. Detailed announcement for posting at job sites, through communication channels.]

SEEKING PART-TIME PEER SUPPORT WORKERS

Do you like to help a fellow in need? Can you listen to others who are having a hard time?

XYZ is developing a vital new peer support program to reduce job stress, mental health problems and suicide prevention for our employees and community. We are seeking interested individuals with the following qualities and experiences.

Ideal candidates will:

- Feel committed to the wellbeing and mental health of employees/coworkers
- Demonstrate good listening skills
- Enjoy working with peers in finding solutions to job stress, coping, mental health issues, family and/or substance use challenges
- Have personal lived experience with mental health issues/ life challenges and recovery which may include family/marriage and job-related stress, substance abuse recovery, depression and/or suicidal experiences and be willing to share these
- Be trustworthy and able to observe strict confidentiality on personal issues

- Have the ability to separate work, social and personal items from support of their peers in the workplace, regardless of position
- Have experience with related roles such as ombudsperson, mentor/instructor, crisis support volunteer
- Able to commit an estimated XX hours per week to peer support outside ordinary work hours (XYZ will provide flexibility to accommodate your peer support work where possible).

Please submit a statement of interest in this position to … @. Your application will be treated as confidential.

Peer Supporter Recruitment Part 2

[SAMPLE INTERVIEW OR APPLICATION QUESTIONS]

- Why does working as a Peer Supporter interest you?
- Can you tell me some ways that you might use your personal lived experience of going through hard times to support the people you'd be working with?
- Types of answers: inspiring hope, decreasing isolation, and sharing tools or strategies of recovery
- Think about a time you were experiencing hardship or distress and someone was there for you. What did they do or not do that made a difference?
- Answers to focus on listening, offering support or encouragement, non-judgment etc.
- Flags of concern—Advice giving, doing things for people they could do for themselves, didactic or judgmental language, use of psychiatric jargon, religious spiritual advocacy, racist/sexist or expression of political views
- Talk about your personal and professional background as it relates to this position.
- How would you define a peer support? how would you describe the key role and tasks?
- Part of the role of a Peer Supporter is to model recovery by sharing some of your own experiences when it fits. Would you be comfortable doing so?
- What role has peer support had in your own recovery?
- What questions or concerns do you have about being a peer support program?

APPENDIX E

Best Practices for Training for Peer Support for Crisis Counselors

To ensure that individuals have good experiential learning in the 'art and science' of peer support, and the ways in which it is distinct from more traditional counseling, training is essential.

Fundamental Principles

The core elements of peer support training should include its values and practices, and emphasize the two fundamental principles of peer support: 1)Equality and 2) Shared Experience.

1. **Equality.** A peer support interaction is based on equality of status. Peer support privileges the autonomy, dignity and insight of the peer as an equal against any role or hierarchical difference. This emphasis on this crucial distinction from other service approaches in mental health and human services.

   » When it comes to helping professionals working as Peer Supporters it is valuable to affirm the fact that status differentials are not a factor—ie that one's training/education, job title or community position has no effect on the relationship or the conversation to be had.

An example of this is using clarifying statements such as:

» *As a Peer Supporter I am here to listen and learn how I can support you.*

» *Peer support is about us meeting as equals regardless of job title or position.*

» *Even though I'm a manager, I don't have any authority over you when it comes to peer support. Just here to help if I can.*

» *Our ranks at the agency don't apply here.*

» *If you want to discuss something with a supervisor, I'm glad to help you think about how to do that. I would never talk to your supervisor or anyone else about your situation.*

» *I'm not here to tell you what to do or give you any advice.*

2. **Shared Experience.** Peer support presumes some degree of 'peerness' in terms of life, work, community or other shared experience. While such things may be a given in certain situations, peer support values meaningful shared experience a core asset and also something to be intentionally explored. It is important to note that all people share experience in some ways, and no two people do in every way.

In practice this can look quite different from a traditional service provider conversation. To establish affiliation and shared meaningful experience a Peer Supporter might say things like:

» *I'm a crisis counselor just like you and I know how hard it can be.*

» *I've been really stressed recently too.*

» *Just like you I've experienced difficulty with life and this job/field etc.*

» *I can really relate to struggles with divorce.*

» *I've been there.*

Other Key Training Considerations

Shifting from Coworker or Clinical Mode to Peer Support Mode: as above it is crucial to program success that Peer Supporters distinguish their personal peer support style or mode of interaction from that which they employ in the service provider role. This can be tricky, especially when the outreach or connection feels similar.

Introductory affiliation statements such as the above, a more casual peer tone, even a different physical orientation can help the Peer Supporter remember that they are operating in a distinct mode, striving to create and maintain a relationship grounded in peerness.

Training can help peers develop ideas on how to create a different position or point of focus from normal 'service' contacts to peer mode contact. For example, peers can place the phone at the other ear, or move a different part of the room when they are doing a peer contact. Through this change they can physically associate the peer support mode as distinct from day to day work mode.

Managing 'The Therapy Zone'

Here training helps Peer Supporter focus on providing space for peers to share and be heard when they encounter struggles in life while being mindful of not crossing into "The Therapy Zone." Sometimes emotional struggles may be related to a history of trauma, current legal, domestic or relationship problems, addiction, violence or abuse. Such issues may emerge in the context of a peer support conversation but when they do, they must be handled thoughtfully.

Being alert to items that fall into the 'therapy zone' and working with the peer to identify appropriate resources is key to good peer support practice. A Peer Supporter should not shy away from difficult issues but they should never be in the position of providing professional therapeutic interventions, recommendations or advocacy to a peer.

In any circumstance in which a professional service may be needed or helpful, a Peer Supporter thoughtfully collaborates with the peer in exploring and accessing those, never in providing it themselves.

Useful phrases to consider when the therapy zone appears:

- This sounds like emotionally intense stuff. Have you ever discussed these things with a professional?
- As your Peer Supporter I would definitely not be able to provide legal advice. Should we look into finding someone that can?
- Recovery from trauma is a serious thing. What has helped you deal with it?
- I have done some work in this area but as your Peer Supporter it's not my role to provide that. Let's see if we can identify another professional that could help.

Example of Clinical Advice Versus Peer Support

Peer/Clinical Advice Model

Peer: I'm feeling so anxious I can barely focus for five minutes. I just want something to make it stop.

Supporter: That sounds intense. Can I give you some clinical advice as a fellow professional?"

Peer: Okay

Supporter: Anti-anxiety meds help a lot of people and you can get a prescription through our health plan with your primary care physician online.

Peer: Yeah I thought about that but I get addicted to benzos really fast…

Peer Support Alternative

Peer: I'm feeling so anxious I can barely focus for five minutes. I just want something to make it stop.

Supporter: That sounds intense. You're looking for some relief and I don't blame you. What kinds of things have you thought about for that?

Peer: Well, I used to take Xanax but I got addicted and the withdrawal was so bad. So I don't want to do that again.

Supporter: Can I ask you something as a peer professional?

Peer: Sure.

Collaboration on Safety

The only exception to the above relationship considerations arise is if an issue of personal safety is involved or perceived to be involved. Such things occur quite infrequently in peer support contacts and fear of them should be met with context, lest it affect the quality of the peer support relationship.

If risk of harm or abuse (including self-harm or threats of suicide) arises in the context of a peer support conversation, the Peer Supporter should feel confident to discuss safety concerns and engage positively with the peer to prevent or reduce those risks.

Training here reinforces the following best approaches:

Express authentic personal feelings/concern

- *When you mentioned that I felt scared for the safety of your mother*
- *I'm really concerned about your safety now*

Inquire about the risk/intensity.

- *Do you think there is a real risk she could be abused by her caregiver?*
- *Are you actively considering a suicide attempt today?*

Reflect Urgency

- *This sounds like something we need to respond to right away.*
- *This is an emergency.*

Petition Collaboration

- *Can we work together to reduce any risk to her?*
- *What kinds of resources could we engage to help us?*
- *How about we connect you to crisis services resources?*

Clarify Role limitations and responsibility

- *As a Peer Supporter I want to be here for you any way I can, but I also feel a responsibility when there is a threat of abuse*
- *I can't provide resources for this myself but will work with you to make sure your family gets what it needs.*
- *I'm here for you as a peer but I'm not able to provide what this situation requires.*
- *In this risky situation I need help to help you*

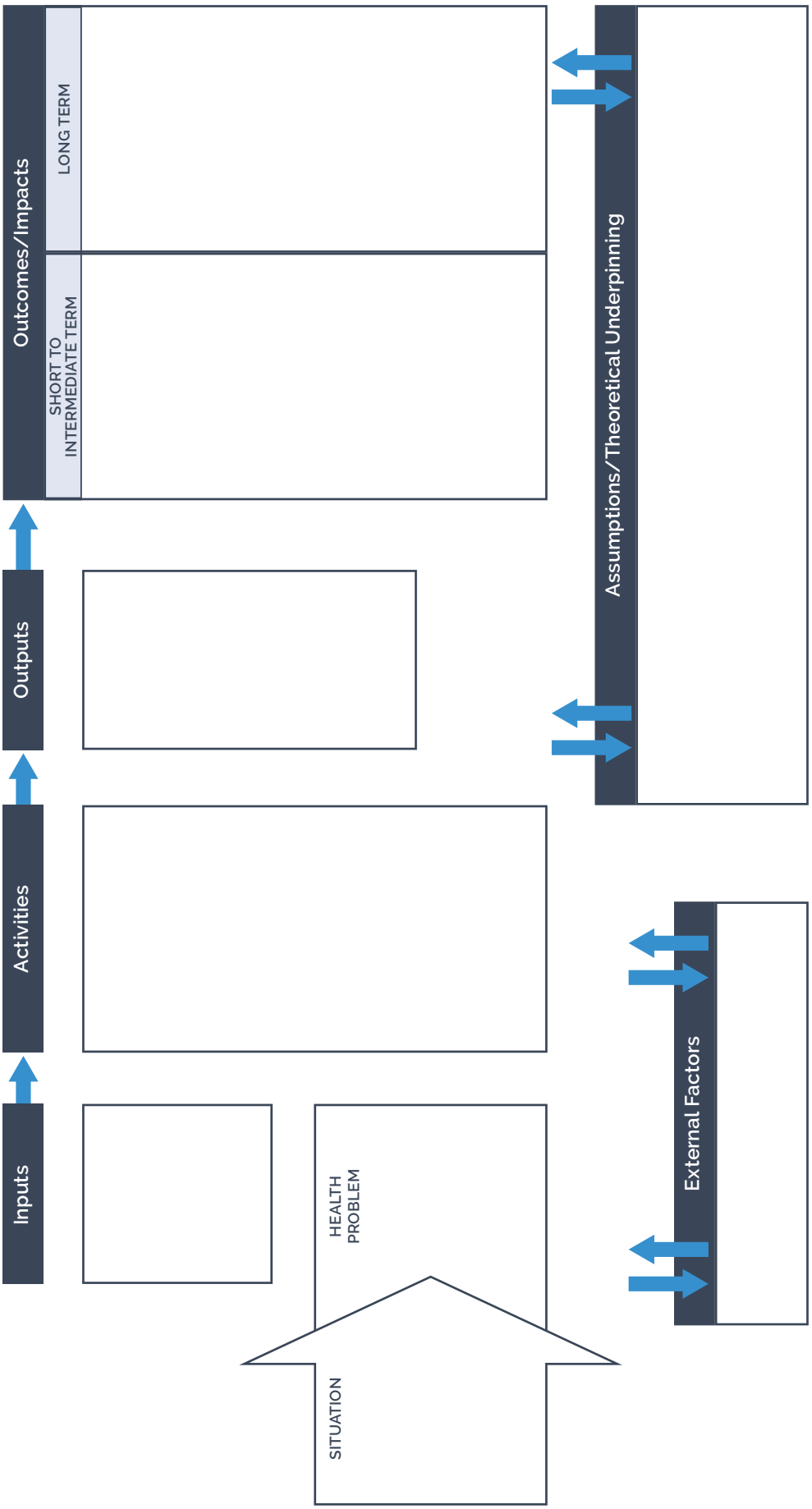
Specify actions and reasons (ONLY If Collaboration cannot happen.)

- *I'm going to have to call Adult Protective Services because it's my ethical duty. I hope it will not affect our peer support relationship*
- *I never want to do anything without your consent but I see this as a life and death emergency I have to respond to.*
- *I'm reaching out to emergency services because your safety is the most important thing to me*

APPENDIX F

Logic Model

Logic Model for Building and Evaluation Plan for Peer Support Program



APPENDIX G

Additional Research

Summary research literature on effectiveness of peer support:

Acker GM. Burnout among mental health care providers. *Journal of Social Work.* 2012;12(5):475-490. https://journals.sagepub.com/doi/10.1177/1468017310392418

Bellamy, C., Schmutte, T. & Davidson, L. *MENTAL HEALTH AND SOCIAL INCLUSION VOL. 21 NO. 3 2017, pp. 1-7,* https://www.researchgate.net/profile/Timothy-Schmutte/publication/316533906_An_update_on_the_growing_evidence_base_for_peer_support/links/5f3e91d3299bf13404d48338/An-update-on-the-growing-evidence-base-for-peer-support.pdf

Benson, J., & Magraith, K. (2005). Compassion fatigue and burnout: the role of Balint groups. Australian Family Physician, 34(6). https://search.informit.org/doi/10.3316/informit.368101015009896

Gidugu, V., Rogers, E.S., Harrington, S. et al. Individual Peer Support: A Qualitative Study of Mechanisms of Its Effectiveness. *Community Ment Health J 51*, 445–452 (2015). https://doi.org/10.1007/s10597-014-9801-0

Corrigan, P. W., Mueser, K. T., Bond, G. R., Drake, R. E., & Solomon, P. (2008). Peer Services and Supports. *Principles and practice of psychiatric rehabilitation: an empirical approach* (pp. 359–378). New York: The Guilford Press.

Solomon, P. (2004). Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Rehabilitation Journal, 27*(4), 392–401. https://doi.org/10.2975/27.2004.392.401

William H. Sledge, M.D., Martha Lawless, B.A., David Sells, Ph.D., Melissa Wieland, Ph.D., Maria J. O'Connell, Ph.D., and Larry Davidson, Ph.D.

Psychiatric Services. Published Online:1 May 2011 https://ps.psychiatryonline.org/doi/full/10.1176/ps.62.5.pss6205_0541