Addendum to DCoE report on “Identification of Best Practices in Peer Support: Executive Summary and Background Paper”

The above referenced report provides a representative review of selected peer-support programs, as well recommendations for actionable options for DoD to consider in expanding peer-support programs to benefit U.S. troops.

Several points discussed in the report merit special emphasis as key ingredients that make peer support effective. These are (1) social support; (2) experiential knowledge; (3) trust; (4) confidentiality; and (5) easy access.

**Social support**

Among others, Solomon (2004) points out that an important ingredient in the effectiveness of peer support programs is social support, and in particular social support from peers. Social support from work peers is thought to include emotional support, information and advice, practical assistance, and help in understanding or interpreting events (Grauwiler, Barocas & Mills, 2008; House, 1981). There is ample evidence now that peer social support and cohesion function as protective factors for troops exposed to combat-related stressors, protecting against PTSD and other stress-related mental health problems (eg, King, King & Fairbank, 1998; Solomon & Mikulincer, 1990). Social support from peers in the period shortly after traumatic stress exposure has also proven to be a protective factor for US soldiers exposed to sexual assaults and other trauma (Martin, Rosen, Durand, Knudson & Stretch, 2000). A meta-analysis of studies conducted with trauma-exposed adults further confirms the value of social support as a protective factor against PTSD (Brewin, Andrews & Valentine, 2000). In several studies with Vietnam veterans, Stretch (1985; 1991) found that returning veterans who experienced greater peer social support showed less PTSD than those who for various reasons were more isolated from their fellow soldiers. Griffith (2007) summarizes research from multiple studies indicating that cohesion in military units is associated with continued good performance under stressful conditions, and further points out that cohesion in military units largely reflects social support from peers and leaders. Bartone (2000) also reports that horizontal cohesion (peer support) as well as hardiness functioned as a moderator of the effects of combat exposure on PTSD symptoms for US forces who served in the Gulf War. In this study, PTSD symptoms and unit cohesion
were measured in troops within three months after their return from deployment. Together, these findings suggest that to the extent peer-to-peer support programs actually increase social support from peers, they are likely to benefit troops in coping with operational stress and reducing stress-related mental health symptoms.

**Experiential Knowledge**

This refers to the knowledge base of the peer supporter, which is derived from actual experience. Peer supporters who have similar experiences to those being supported, whether they be soldiers, cops, firemen, or recovering alcoholics, have greater credibility as “experts” in dealing with the problems and challenges faced by the client (Salzer and Associates, 2002; Grauwiler, Barocas & Mills, 2008). Having similar experiences and backgrounds also contributes to the sense of social cohesion, through a process of social identification in which the client more readily sees the peer supporter as “like me” (Hogg, 1992).

**Trust**

Trust is an essential ingredient for the success of any mental health intervention. There is good evidence from a national VA study that military veterans with mental health problems trust peer counselors to help them more than they do traditional hospital staff (Chinman et al., 2008). What is trust, and how is it established between strangers? A classic and highly influential theory on trust (Rotter, 1971) describes trust as generalized expectancies that a person is (1) honest, (2) unselfish, not going to take advantage of me, and (3) reliable, or “knows his stuff.” In the peer support arena, peers are more likely to win trust quickly due to their common experience base (similar experiences suggesting that the counselor “knows what he/she is talking about.” Having a good knowledge base regarding available services and how to get them would also contribute to credibility and trust. And it is also important for the peer counselor to be seen as honest and truthful, and unselfishly motivated. In regard to the latter, volunteer peer counselors may have an advantage over paid employees in rapidly establishing trust, since there is no question of their being motivated by financial gain.

**Confidentiality**

Confidentiality is mentioned at several points in the larger report, but deserves greater emphasis. It appears that several of the peer-to-peer counseling programs reviewed require that legal agreements be signed in the beginning sessions, for example to clarify
the limits of confidentiality. This can be a positive thing in establishing clear expectations, one of the recommendations made in the larger report. However, it should be recognized that this can also work against establishing trust in the peer-to-peer relationship, if the client sees it as an indicator that information provided might be disclosed to third parties without his/her permission. In his White Paper on stigma and mental health in Army veterans of OEF and OIF, Sgt Grandi reflects on the success of the post-Vietnam storefront “walk-in, drop-in” centers for Vietnam veterans (reference). Grandi points out that a veteran could come in to a walk-center anytime, and not be asked to complete any paperwork at all for the first five or six visits. This was believed to be essential for establishing a relationship of trust and confidentiality with the veteran. Only after some basic level of trust was established with the veteran was there any mention of paperwork or forms to fill out.

According to a National Public Radio Report (Shapiro, 2007), the first Vet Centers were started over 30 years ago by Vietnam veterans. The Vet Center web site indicates that the program was established by Congress in 1979 as community based veteran support centers under the VA. There are currently 232 Vet Centers in all 50 states and territories providing a range of counseling services with a staff “many of which are combat veterans themselves.” (www.vetcenter.va.gov) The VA peer-to-peer model used in the Vet Centers was not included in this report. This could be a useful follow up analysis because these peer-to-peer programs include clinical and non-clinical issues.

Easy Access

Ease of access, both in terms of physical location as well as hours of operation, is an important consideration in the success of peer support programs. Considering the fears and stigma that veterans often attaches to seeking mental health support, access needs to be as easy and convenient as possible in order for many veterans to come in. This is part of the reason for the success of the Vet Centers; they are community based, as opposed to being located in the VA hospitals. Some of the programs reviewed in the larger report provide services during limited hours only (for example, California National Guard “buddy to buddy” program operates only Monday through Friday). Regardless of how well other aspects of the peer-support program are resourced and managed, if access is difficult for the target population, it will be difficult for the program to succeed.

A final observation on the limits of research and metrics: However potentially valuable they may be for assessing the efficacy of a program or intervention, the use of survey instruments and other measures in peer support programs runs the risk of damaging the trust that is essential for success, and even possibly driving clients away by adding to
their fears about evaluation and loss of confidentiality. Especially in voluntary programs, such measures may be counter-productive vis-à-vis the primary goals of the program. Other metrics of success should be sought that don’t carry the same risks. For example, programs could track the simple number of initial visits, number of return or follow-up visits, and number of referrals to other programs without ever recording personal or privacy data. The Hippocratic oath also applies to the use of metrics in treatment programs..... first of all, do no harm.

References


Grandi, Sgt. (2010). White paper on PTSD and related issues (DCoE internal unpublished paper)


1. Amputee Coalition of America - National Peer Network (NPN)

Their stated mission is “to reach out to and empower people affected by limb loss to achieve their full potential through education, support and advocacy, and to promote limb loss prevention…. Peer to Peer support is one of the elemental programs within this organization.”

ACA currently has volunteer regional representatives who are also experienced support group leaders. These volunteers are located throughout the U.S. and communicate with groups in regions varying in size, usually between six to nine surrounding states. Regional representatives have knowledge of new groups and special group activities forming in their region (e.g., sports, socials, lectures, educational) and identify special interest support groups on request. Information specialists, the outreach coordinator, and regional representatives offer referrals to amputee support groups located nearest to the inquirer location.

[http://www.amputee-coalition.org/npn_about.html](http://www.amputee-coalition.org/npn_about.html)

The NPN involves both support groups, and individual peer visitors (over a thousand civilian and military visitors have been trained since 2001), providing emotional and educational and advocacy assistance in an effort to empower those who have lost limbs to lead the most fulfilling life they can achieve. They have also created The Parent Support Network, with a Parent Peer Visitor Program designed to also provide education and emotional support to the parents of children with limb loss/difference. In addition to written materials and resources, amputee support groups provide a place for new amputees and their families to connect with others who have overcome similar challenges. There, they can learn healthy coping strategies and practice skills in a supportive environment, among others who have experienced similar challenges and frustrations and found solutions that work for them. For those amputees who can’t make use of the in-person support groups, the Amputee Communicator Forum provides a virtual internet support group discussion board maintained for the sole use of the amputees.

For the Support Group Leaders, the ACA conducts a yearly workshop designed to function as a “support group” for the leaders where they can discuss and learn about the issues they have or may encounter. Training and certification is also an essential element of the Peer visitor program. A certified peer visitor, a person with limb loss or difference or a family member, must pass a Peer Visitor Training Seminar and show that they have successfully
adjusted to their loss and demonstrate a positive attitude. They learn what their role will be, and how they can best fulfill that role for the amputee they will be supporting. In addition, there is also an internet discussion board for the peer visitors to go and discuss issues and find support at anytime as a form of care for the caregivers as well.

2. California National Guard - Peer-to-Peer Support Program

“The goal of peer support is to provide all California National Guard members with the opportunity to receive emotional and tangible peer support through times of personal or professional crises and to help anticipate and address potential difficulties.”

http://www.calguard.ca.gov/j1/Pages/Peer_support.aspx

The Peer to Peer program was established in Feb 2005 in an attempt to ensure that California National Guard members had someone from whom they could get emotional and practical support in the event that mission or daily stressors became too much to handle alone. A Peer Support Person is a member of the National Guard who volunteers to serve as a (PSP). They are enlisted, warrant officer or commissioned officer, specifically trained to provide emotional and practical support at the first sign of need, before troubles compound. They are colleagues, not counselors or therapists. PSPs receive “critical incident” training, as well as training in grief management, substance abuse suicide intervention, communication and listening skills, ethics, and problem assessment and problem solving, including situational scenario training over the course of 3 days.

Units are encouraged to train as many peer support persons as they feel are qualified. While the guard member who is being mentored has the right to refuse the support of the peer who is attempting to help them, the regulations which define the program are kept readily available to all to ensure that boundaries are not crossed. Rules of confidentiality are laid out in the manual and state that while anonymity will be preserved as much as possible, the member must be informed of their limits including which can not be protected if the member presents a risk to him/herself or others, or knowledge that the member has violated the UCMJ.

3. Canadian Department of National Defense and Veterans Affairs “Operational Stress Injury Social Support (OSISS)
“The mission of the Operational Stress Injury Social Support (OSISS) program is to establish, develop and improve social support programs for Canadian Forces members, veterans and their families affected by operational stress; and provide education and training in the Canadian Forces community to create an understanding and acceptance of Operational Stress injuries.”

http://www.osiss.ca/engraph/mission_e.asp?sidecat=3&txt=1

The Operational Stress Injury Social Support (OSISS) Program is a joint Department of National Defence (DND) and Veterans Affairs Canada (VAC) Program designed to address some of the many dimensions of Operational Stress Injuries (OSIs). The OSISS Program is Co-Managed by VAC at the national level. OSISS was created in May 2001. The Program is an initiative of the Chief of Military Personnel (CMP) and is under the direction of the Director of the DND-VAC Centre.

In 2001, a small group of veterans set up a peer support network composed of staff and volunteers. The network grew and now includes a separate network supporting the families of serving Canadian Forces members and Veterans suffering from Operational Stress Injuries. These networks operate out of a number of regional sites spread across southern and eastern Canada. The Peer Support Coordinators (PSC) and Peer Support volunteers have experienced and recovered from an OSI and are reaching out to help others experiencing a similar situation. The PSCs are trained paid employees of the DND/VAC Centre working throughout Canada. There is also a similar family focused program in which a Family PSC is employed to aid the family members of those suffering from OSIs and is often a family member of an OSI sufferer. This program attempts to be both a sympathetic ear and a practical means of support which can connect those who are suffering to resources that can help them through outreach and education. In addition to the paid coordinators there is a group of peer support volunteers who are themselves trained veterans usually recovering from an OSI and work under the direction of the paid coordinators as they continue to heal while reaching out to help empower others.

The selection of PSCs is conducted in partnership with medical and mental health authorities and in particular the Operational Trauma and Stress Support Centre (OTSSC) and the VAC OSI clinics using a general selection criteria they have established. Rather than just volunteering, mental health personnel are asked to identify suitable candidates based on both their medical situation, their knowledge of the impact of OSIs and available resources, and their interpersonal and social skills. The selection of Family PSCs is similar, but does not include the medical evaluation component. The clients are called Peers and can be anyone who is suffering from or living with someone who is suffering as a result of an Operational Stress Injury. The program attempts to provide immediate outreach either in person, by phone or email. Because
the PSCs and volunteers have themselves dealt with an OSI, mental health is a key component on both sides of the peer network. Signed medical approval is required to ensure that the no participants will be put at risk of additional harm to themselves as a result of their participation. While numerous measures are taken to ensure a client’s privacy and sense of trust, to include being identified by a number only and utilizing nonmilitary commercial websites for all data and web interaction, confidentiality cannot be maintained if there is an indication of child abuse or neglect; the threat of harm to oneself, or others; or a court order or subpoena.

4. CDC Workforce and Responder Resiliency Team - Deployment Safety and Resiliency Team (DSRT)

“The concept for DSRT is not to provide mental therapy, but knowledgeable peer support. You don’t have to be a therapist to be a DSRT. “In this approach, we carefully select and train non-mental health professionals to deploy with CDC teams. These individuals have a specific mandate to assess and address the physical and emotional health, safety and resiliency of their team members in the field...” Richard Klomp

http://www.cdc.gov/news/2009/05/dsrt/ - (article about DSRT research)

The role of the peer supporter is to apply basic concepts of psychological first aid to build resiliency among colleagues through peer support while in the field. The peer supporter receives training in psychological first aid, including the concepts of safety, calming, connectedness, self-efficacy, and hope and optimism. The peer supporter is to make physical and psychological safety assessments, calm and stabilize distressed persons while offering practical assistance such as linking the person in crisis with collaborative services. The CDC included a small number of peer supporters who had received the 4 day training session in the teams they sent into the field during the H1N1 pandemic and reported that 2 of them felt they had been able to apply the knowledge they gained.

5. Dept of Veterans Affairs - Peer Support Technician (PST) - Member of treatment team
The Peer Support Technician is an employee of the Department of Veterans Affairs who has been hired because he/she possesses a unique set of skills and life experiences that allows him/her to both empathize with and fully support veterans who are dealing with serious mental illness. They serve both as models of the recovery process and as counselors and conduits to information and additional community support resources and services. These veteran hires serve as professional members of the client veteran’s treatment team working in the Psychosocial Rehabilitation and Recovery Center (PRRC) and the Mental Health Residential Rehabilitation Treatment Program (MH RRTP).

http://www.mirecc.va.gov/visn5/docs/phlag5.pdf (This is a link to a job application form used to apply for the PST position. It is not a link to a peer to peer program per se.)

6. Michigan National Guard - Buddy to Buddy Program

“The Buddy-to-Buddy program is part of the Welcome Back Veterans initiative sponsored by Major League Baseball Charities and the McCormick Foundation to raise public awareness about the issues facing today’s veterans and their families, and to raise funds to support programs and services that these veterans need as they reintegrate back to civilian life. Behind the program is a simple concept: military service is unlike any other human experience. No one knows more about the issues facing a veteran – in combat or on the home front – than another veteran.”

http://www.buddytobuddy.org

The Buddy-to-Buddy program was developed by a team of military service members, veterans, veteran advocates and healthcare professionals from the University of Michigan and Michigan State University to train Michigan vets to help OEF/OIF veterans adjust to life outside the military community. Anyone can call the Buddy-to-Buddy program to refer a vet or service member, or a Michigan OEF/OIF Service members and veterans can call the program themselves. From family concerns to financial struggles to emotional challenges, trained Buddy-to-Buddy volunteer vets are there to listen and to help OEF/OIF veterans access the community resources and care they need.

This is not a 24 hour crisis or assistance line, but a weekday referral service. Volunteers man the phones for a few hours a week, with the goal of providing a call back service with information on where to seek additional counseling, or suggestions on where to find advice or services to
help with financial, educational, legal or employment issues or questions. The advisors attempt to return all inquiries within 24 hours.

7. New Jersey law Enforcement - Cop to Cop

“Cop 2 Cop is a program funded by a grant from the New Jersey State Department of Personnel and presented by UMDNJ/University Behavioral HealthCare. It is run as a partnership between The Department of Human Services and the University of Medicine and Dentistry or New Jersey (UMDNJ) and University Behavioral HealthCare (UBHC).”

“Cop 2 Cop is the first program of its kind in the nation, legislated into law to focus on suicide prevention and mental health support for New Jersey law enforcement officers.”

http://www.cop2coponline.com/

The Cop to Cop program is a 24 hour confidential crisis intervention hotline service manned by retired police officers who have become licensed social workers, mental health professionals, and volunteer retired officers who are trained as peer supporters who are trained in Critical Incident Stress Management (CISM). These teams are trained to respond to cops who are having difficulty dealing with family and marital problems, legal, financial or other personal matters, alcohol abuse, trauma following a shooting or other stressful incident, including shakes, tremors, panic attacks, nightmares and anxiety or depression. Confidentiality is maintained whenever possible unless the cop presents a clear and present danger to him/herself or others. In the field they aim to empower cops to watch out for each other and encourage them to Question, Persuade, Refer (QPR) for Assistance and not to hesitate to call for help when needed.

8. Non-profit law enforcement - POPPA - Police Organization Providing Peer Assistance
“With start-up funding from the City Council in 1996, the PBA, and the NYPD, Bill Genet contracted a counseling and psychotherapy group to train the first class of cops who volunteered to become Peer Support Officers (PSOs) in New York City.”

“As a direct result of the September 11th attack of the World Trade Center, the POPPA Organization deployed its volunteer Critical Incident Stress teams and recruited additional volunteers in the mental health professions. The POPPA Organization also coordinated the deployment of more than 600 volunteer counselors who came to New York from across the United States and abroad. Volunteers urged fellow cops to join small groups of officers in "defusing" sessions. Trained Peer Support Officers and mental health professionals ensured that officers in these groups had a supportive environment simply to describe their activities at Ground Zero. Two or three months later, "debriefing" sessions allowed officers to discuss feelings emerging from their Ground Zero experiences. In late September 2001, the POPPA Organization counseled about 100 officers each day. Calls to its HelpLine increased by 300 percent. By September 11, 2002, the POPPA Organization had "defused" or "debriefed" more than 5,000 officers.”

http://www.poppainc.com/

Today donations are accepted to help keep the program running. The Police Peer Assistance Program runs 24/7 and is confidential and free of charge. POPPA maintains assistance lines for both active duty and retired New York police officers and their families. Their mission is to help prevent and reduce incidents of marital problems, substance abuse, suicide as well as existing psychological disorders among our officers and their families. POPPA tries to maintain a large group of PSOs who are available throughout the New York City boroughs 24 hours a day, every day, to go to and meet with officers who contact the POPPA through its HelpLine.

9. Non-profit military families - TAPS - Tragedy Assistance Program for Survivors

“TAPS consists of a peer network made up of people who have the shared experience of the death of a loved one, and are now at a place where they are willing to reach out to others. They have dedicated their time to provide a personal perspective and heartfelt care for grieving family members regardless of the cause of death. They provide a one-on-one connection in whatever manner is most comfortable to the bereaved. Whether telephone, e-mail, or personal visits. The goal is to provide someone who will spend time and listen, and share their experience and their compassion.”

http://www.taps.org/about.aspx
Taps began in 1994, founded by Bonnie Carroll as a result of the death of her husband who was killed in an Army plane crash. As a result she developed a program with the mission to provide comfort and a sense of community 24 hours a day to anyone who has experienced the loss of a military loved one. TAPS provides peer-based support, crisis care, casualty casework assistance, and grief and trauma resources. They have established a community chat room on the internet where people can go to share their feelings at anytime. Volunteer Peer Mentors, must complete a training program consisting of an online self study course followed by a classroom session. They should be beyond the one-year anniversary of the loss of their loved one and ready to reach out to others in strength. The program is composed of both a strong yet less formal emotional social support component which consists of just providing a sympathetic ear and a shoulder to cry on as well as a more formal advocacy and referral function.

10. Non-profit Veterans - Vet-to-Vet

“Our motto is Gladly Teach Gladly Learn. We Leave No Veteran Behind!”

“Vet to Vet is a consumer/provider partnership program that utilizes veterans in recovery in a peer-counseling capacity to help other veterans. Vet to Vet is administered by veterans who themselves have been consumers of VA mental-health services…. Vet to Vet is a support meeting for Vets - Veterans helping other veterans.”

http://www.vet2vetusa.org/

Vet to Vet is a program begun by Moe Armstrong a Vietnam Veteran who suffered from mental illness as a result of the war and sought relief in alcohol and drugs. He became an addict. He began the VET to VET program because he knows the pain and difficulties of not being able to make others understand. Vet to VET is an addiction recovery program based on peer to peer understanding, counseling and education, and support. The peer supporters are themselves recovering from addiction and understand the road the Vets who come to the center are traveling. The goal is to provide daily classes using accepted mental health resources and materials in how to live with stress, and how to break free from addiction in a safe supportive environment.

11. UK Royal Navy and Armed Forces - Project Trauma Risk Management (TRiM)
“It is culture change at the grass roots level so that people accept that stress is an inevitable part of military service, that it is not anything to be ashamed of, is not per se a professional mental health problem, and that coming forward and seeking the help that is available (from padres, colleagues, medical officers and others) can be done without shame.”

http://www.kcl.ac.uk/kcmhr/research/trim/index.html (This is a link to a research report conducted by the King’s Center for Military Health Research)

http://www.mod.uk/DefenceInternet/DefenceNews/TrainingAndAdventure/CopingWithTraumaFollowingMilitaryOperations.htm

(this link provides more information regarding the TRiM program)

Within the Royal Marines, TRiM practitioners are non-medical military members embedded within all units who are specially trained and educated in methods of assessing the psychological needs of military personnel after exposure to a potentially traumatic event. They are trained to be alert to signs of higher than usual levels of stress, and after traumatic events they ensure that the psychological needs of personnel involved in the event are assessed and managed, including referrals to additional support as soon as possible. Service members thought to be at risk are interviewed informally 3 days after a particularly difficult event and then again 1 month later. If the interview reveals potential problems the goal is to get the stressed service member immediate additional support. Trauma Risk Management aims to remove the stigma attached to PTSD and view it as a mental injury that can be treated and healed in time if treated appropriately.

12. US Navy/US Marine Corps - Operational Stress Control and Readiness (OSCAR) Peer Mentors

“This MARADMIN outlines the planned expansion of OSCAR Program capabilities in the Marine divisions to the company level through implementation of operational stress control and readiness (OSCAR) extenders and OSCAR peer mentors.”

(The above link leads to a Marine Corps directive laying out the guidelines under which Operational Stress Control Peer Mentors will be created and utilized.)

In military terms the program is laid out such that units will include embedded mental health professionals, referred to as “OSCAR extenders” to include chaplains, corpsman and religious program specialists to function as technicians and peer mentors who will deploy into the theater with them to boost unit resilience and readiness and continue to be a part of the unit when they return to garrison. Their goal is to help minimize the impact of stress related issue for Marines and Sailors by catching the problem as early as possible and providing the best intervention. Many of these personnel changes are due to be implemented by 2011. Initial training for the OSCAR supporters is supplied by a HQMC mobile training team working in coordination with mental health providers and leaders. Training for peer personnel participating in this program will span between 4 and 5 half days. The directive is very specific and detailed in laying out the relationships among and between the participants, but does not in any way address how the program has been received to date; but it must have been sufficiently well received to warrant such a wide and deep expansion.