

# Peer Support Maintenance Programs – A Basic Survey

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## INTRODUCTION

Peer Support Programs can be very beneficial to all staff in an organisation. Well planned programs have been found to have positive effects on morale, reducing staff absenteeism and reducing numbers of resignations. But structures also need to be in place to ensure Peers and Mental Health Professionals working on such programs are supported in their roles.

Peers and mental health professionals give a great deal of their own time and energy to the care of others. But they can be at risk of burnout – a state of emotional exhaustion (Fathers, 1995). Furthermore, they can be at risk of “compassion fatigue” or “vicarious trauma” – when the stories you are hearing affects you also (Edwards, 1998. Schauben and Frazier, 1995.).

The message for Peers and Health Professionals is to “practice what we preach” – caring for ourselves is important if we want to be effective in helping others. The message for our organisations is that the maintenance of Peers in their Voluntary role is important to consider in the development of Peer Support Programs. On the basis of peer support program experiences, Robinson and Murdock (1998) suggest peers be provided with on-going training, meetings and clinical support.

Peers would be subject to the same risks for vicarious trauma as counsellors, so in developing maintenance programs it is worthwhile to review procedures successfully used to maintain counsellors and other support workers in their roles.

Debriefing. Pence (1995) found that opportunities to “ventilate” (talking with their peers or counsellors) helped child sexual assault workers cope with their stressful work. Potter and LeBerteaux (1996, 1998) advocate the debriefing of debriefers as a standard procedure following critical incident stress debriefing. They outlined a three-phase “debriefing debriefers” model based on the Mitchell model.

Standing down from voluntary duty when personal stress is high. It has been noted that it is important to deal with your own problems or trauma – any unresolved emotional issues that relate to the incident place you at higher risk for vicarious trauma. (Gross, 1994. Emergency Support Newsletter, 1996). One therapist, Colson (1995) described how his work was affected by his own personal experiences (family death). He found it difficult and advised that counsellors should consider taking a break in times of personal stress.

Clinical supervision / support. Access to clinical support and advice was considered essential for counsellors. (Pearlman and McCann, 1990. Hartman, 1995).

Stress management “practice what you preach”. All researchers noted that effective personal strategies for stress management were vital for counsellor well being. Edwards (1998) wrote that researchers have found boundaries very important. Counsellors should make time for relaxation and family activities. Lowenstein (1991) developed a formal stress management program for teachers in a stressful environment which reduced burnout significantly. It may be useful to consider making stress management issues a regular part of any on-going training program for Peers.

Group meetings / Team building. Many researchers have emphasised the importance of regular meetings and other team building activities. (Pearlman and McCann, 1990. Lowenstein, 1991. Seaburn, 1994.) One important aspect of meetings is to reduce isolation – people suffering burnout tend to cut themselves off from colleagues, which only compounded the problem. Pearlman and McCann (1990) also noted that meetings should be supportive and constructive forums (not used for destructive “griping” or “bitching”).

Training. On-going training has been considered vital for counsellors. Not only for the further development of skills and confidence, but also for opportunities to meet others in similar roles (and reduce isolation). Refer, for example, Gabriel (1994).

These strategies used for the maintenance of counsellors and others were used to develop a survey for Australian Peer Support Programs.

## METHOD

Twenty-two organisations responded to a short questionnaire about peer support program maintenance. Nine of these peer support programs are not longer operational or in the process of major revision.

The 'success' of the program was measured by self-report: Good, Poor or Ceased Operation.

Seven strategies identified from the research were correlated with the success rating of each program. The strategies were:

1. Management support – data obtained from self report:
  - Good Management support
  - Some management support
  - No management support
2. Policy and Procedures (whether the organisation had defined policy for the care of peers)
3. Opportunities for peers to stand down from voluntary duty in times of personal need.
4. Regular Peer Support Team meetings
5. Opportunities to attend further skills training.
6. Debriefs following CISD / incidents
7. Clinical support – data obtained from three levels of support:
  - Mental health professional/s working with the team on a permanent basis (either from within the organisation or external through employee assistance or similar)
  - Access to external employee assistance. That is, Peers could seek advice and support through their organisation's employee assistance program.
  - No clinical support available.

## RESULTS

MAINTENANCE STRATEGY	CORRELATION WITH PROGRAM SUCCESS
Management Support	0.29 (Pearson's r – interval data)
Policy and Procedures	0.8 (Point biserial – nominal / interval)
Stand down from duty	0.78 (Point biserial – nominal / interval)
Regular Team meetings	0.88 (Point biserial – nominal / interval)
Further training / development	0.78 (Point biserial – nominal / interval)
Debriefs	0.69 (Point biserial – nominal / interval)
Clinical Support	0.88 (Pearson's r – interval data)

## DISCUSSION

All suggested maintenance strategies, except management support, correlated significantly with program success. That is, these strategies can assist the stability of peer support programs.

Management Support's surprising low effect was the result of all respondents indicating positive support from their management. It appears that initial training and development of Peer Support

Programs generally receives good management support. Obviously if peer support programs are to survive, guidance for their maintenance is required from the outset.

The clinical support result also has ramifications for peer support program development. Clearly the most desirable level of clinical support was from a mental health professional (or several) working on a permanent basis with the peers. It did not matter whether the mental health professional was employed by the organisation or external to the organisation. Several respondents commented on the necessity for the mental health professional to be familiar with the working environment. Simply providing access to employee assistance for the peers was insufficient clinical support. Structured clinical support appears necessary for programs, and would need to be taken into account when defining the involvement of employee assistance providers.

Several respondents provided additional comments on other successful strategies for maintaining peers in their role. Many felt that team building and social activities were helpful, and could be organised by the Teams themselves. Recognition of the Peers' services could be made in various tangible ways (such as letters of appreciation or certificate of service). Three organisations with peers in isolated areas used newsletters to keep everyone in touch (and promote peer support within the organisation).

In conclusion, this short survey supports the use of maintenance strategies outlined in the literature. Organisations often put a great deal of time, effort and funds into setting up peer support programs. If these programs are not maintained then this is wasted effort – Peer Support programs do not survive without on-going assistance.

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