Best Practices Identified for Peer Support Programs

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Identification of Best Practices in Peer Support Programs: White Paper

Executive Summary

Background

As part of its ongoing mission, the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) explored how to most effectively apply peer support in the military environment. The military has created a culture in which service members take care of each other. Common experiences, particularly for those who have served in combat, bind individuals together. Shared experiences are the foundation for peer support, as they foster the initial trust and credibility necessary for developing relationships in which individuals are willing to open up and discuss their problems despite concerns about stigma. Peer-to-peer programs facilitate opportunities for individuals to talk with trained peer supporters who can offer educational and social support and provide avenues for additional help if needed.

Methodology

DCoE staff compiled information through a literature review, Internet-based research and peer support stakeholder interviews. Empirical research about peer support for the target populations — active-duty service members and veterans — is limited; therefore DCoE's research focused on programs whose target populations have similar cultural characteristics to these populations, such as law enforcement personnel and first responders. Further, the notion of supporting others is often organically ingrained in an organization's operations and mission. To isolate findings on peer support, DCoE confined its research to formalized programs in which peer supporters receive training and resources specifically for their role of supporting others. Often, these peer support roles are a component of a larger intervention or treatment program. A common limitation in the research is the ability to deduce the effectiveness of specific programmatic elements as distinct from the impacts of other program components or the program in its entirety. However, aligning the literature-based peer support elements with the methods from existing programs that address issues relevant to the military and veteran populations facilitated isolation of the findings on peer support.

Findings

Based on an analysis of the research literature, five elements were found to be essential to a successful peer-to-peer program:

1. **Adequate Planning and Preparation,** including identifying needs of the target population and aligning program goals to meet those needs.
2. **Clearly Articulated Policies to Avoid Confusion,** especially around role boundaries and confidentiality.
3. **Systematic Screening with Defined Selection Criteria for Peer Supporters,** such as communication skills, leadership ability, character, previous experience or training, and individuals who can serve as positive role models.

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4. **Leverage Benefits from "Peer" Status,** such as experiential learning, social support, leadership, and improved self-confidence.
5. **Enable Continued Learning through Structured Training,** by providing an atmosphere for peer supporters to support each other and improve peer support skills.

In addition, the literature review and examination of exemplar programs points to several underlying features or "key ingredients" that appear to account for the special effectiveness of peer support interventions. These are (1) social support, (2) experiential knowledge, (3) trust, (4) confidentiality and (5) easy access.

Actionable Options

Building on the research on essential elements, potential options are outlined for further applying peer support in the military environment.[1] Each of these options is structured around a goal that meets a military need, to provide both the frame of reference and examples of applicability. Combat and operational stress, suicide prevention and recovery-related issues are the three military needs used to illustrate actionable options for how peer support could be applied in the military environment.

1. Peer support to address **combat and operational stress** could include:
   - The establishment of a peer supporter role within a unit to provide a relationship-based support role throughout the deployment life cycle.
   - Regular meetings between a unit's behavioral health assets and trained peer supporters for the purpose of (1) honing peer supporter skills (e.g., active listening, ability to recognize signs for need to refer) and (2) providing additional referral conduits to increase access to behavioral health services.
   - A service member acting as peer supporter who serves as a liaison to chaplains, leadership and the military medical community.
   - Provision of additional resources as needed — for example, hotlines in theater for those who seek peer support beyond their own unit.
2. Peer support to address **suicide prevention** could include:
   - Further integrating and highlighting the benefits of peer support in suicide prevention programs to bolster these efforts throughout the military community, including veterans.
   - Recognizing that peers might be the first point of contact because of their close proximity to the individual. Those with similar experiences may be better able to relate to a service member seeking help, which may compel the individual to listen and trust the peer supporter's guidance at a particularly critical time.
3. Peer support to address **recovery-related issues** could include:
   - The use of trained patient volunteers (or hiring former patients) at military treatment facilities or VA facilities to act as peer supporters.

[1] The military environment extends to veteran status, where the issues of suicide prevention and recovery are also relevant.

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- Peer supporters who serve as examples of how to overcome injuries and offer support as someone who has "been there." For example, the VA uses this model in substance abuse and post-traumatic stress disorder (PTSD) programs.
- Peers playing advocacy roles, for example, assisting with understanding and accessing benefits and services.

Final Thoughts

To verify applicability of the peer support actionable options in the military setting, a working group of experts could explore additional considerations such as how peer-to-peer support would accommodate the diverse nature of the military population, including varied ranks, gender and job requirements. The working group could comprise representatives from across the services and ranks to further refine the peer support options and develop an implementation strategy that is specific, as needed, to each of the services.

Introduction and Background

This *Identification of Best Practices in Peer Support Programs: White Paper* seeks to identify elements associated with success in peer support program models as they might relate to the active-duty military and veteran environments. Peer support is assistance provided by a person who shares commonalities with the target population, for example, direct experience in a particular situation or event, familiarity with a particular stressor, or other shared characteristics.[1] Currently, peer support is widely used in formal and informal programs and has been found to have a positive impact on individuals with shared diseases, conditions or situations.[6] Potential positive outcomes from the use of peer support are listed in Figure 1. For the purposes of this paper, the primary population under consideration is active-duty service members, with the understanding that within that population there are many subset cultures and needs. Veteran populations are another critical group that could benefit from peer support programs, especially when separation from service distances an individual from the natural peer environment.

Due to the stressful nature of the work of service members, particularly those who have seen combat, the military has created a culture in which service members take care of each other. This mentality easily lends itself to an environment where service members rely on the natural support of their colleagues to cope with stress. In a recent behavioral health survey of more than 28,000 active-duty military personnel, talking with friends and family was the second most common coping strategy for dealing with stress, with 73 percent responding to using that strategy frequently or sometimes.[2] Strong social support networks have been linked to resilience, which is a fundamental component of successfully managing stress.[3]

Figure 1. What Peer Support Can Do

- Foster social networking
- Improve quality of life
- Promote wellness
- Improve coping skills
- Support acceptance of illness/situation
- Improve compliance (e.g., medication adherence)
- Reduce concerns
- Increase satisfaction with health status

Sources: Heisler 2006, DHHS 2007, Solomon 2004

Peer-to-peer programs are those that use peer support as a primary intervention for healthy to recently distressed individuals. In a formalized peer-to-peer program, the peer providing the support has received some level of training and has access to more intensive support resources.[4] Although peer support discussions can facilitate the strengthening of an individual, a peer supporter is not a professional counselor, and some individuals may have needs that fall beyond the scope of a peer-to-peer program, requiring professional support. Providing peer support training to service members and veterans, many of whom are already providing informal social support, could increase the effectiveness of the individual providing support as well as increase his or her ability to identify a potential high-risk situation before a crisis event occurs.[5]

Various approaches exist to effectively implement peer support. In examining these approaches, DCoE isolated key elements that could be applied to diverse military situations.

Role and Benefits of Peer Support

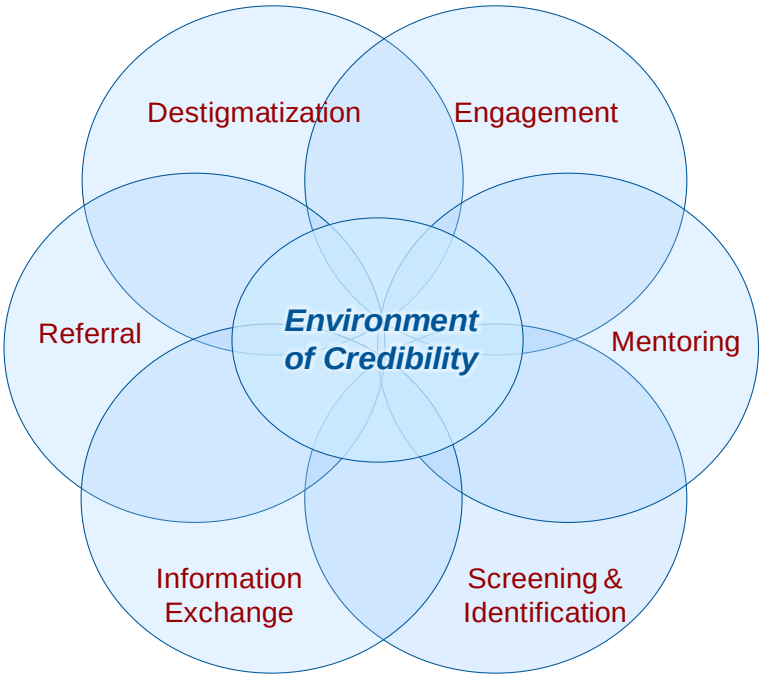
Peer support is an intervention that leverages shared experience to foster trust, decrease stigma and create a sustainable forum for seeking help and sharing information about support resources and

positive coping strategies. Peer-to-peer programs can also promote awareness among the target population(s) and reduce stigma merely by providing a platform for discussion. Peer supporters "speak the same language" as those they are helping as a result of shared experience(s), which fosters an environment of credibility and trust. Importantly, peers tend to interact more frequently with service members than do chaplains or members of the medical community. As a result, peers are most likely to notice changes in behavior and personality of an individual. Peer support is also critical to unit cohesion and confidence in leadership, critical factors in mitigating PTSD.

Service members and veterans are more willing to share their feelings and concerns with someone who has had similar experiences, such as combat, than with someone who has not. Credibility and trust are integral to building beneficial relationships in peer support and in developing positive peer-to-peer interactions. Figure 2 illustrates how peer support provides wide-ranging benefits by connecting individuals within an environment of credibility.

Peer support provides benefits to the individual participant, peer supporter, health care provider community and surrounding community.[2, 6] For the individual, peer support increases the number of social relationships, and provides education to support positive coping behaviors as well as information on resources available beyond the immediate peer supporter. Peer supporters, in turn, can experience a sense of empowerment by helping a peer, while at the same time building their own self-confidence and strength.[7]

Figure 2. Interconnected Benefits Derived From Peer Support



Source: Booz Allen Hamilton

Peer supporters can facilitate referrals of individuals needing professional assistance before or when a crisis event occurs. Through peer support options, the health care provider community can reach individuals who might not be currently using their services.[6] Peer supporters can also serve as a liaison between the individual and a psychological health professional, helping the professional to better understand the experiences (e.g., military environment) and needs of the individual seeking services.[5]

Finally, the community — the military itself or an individual's family or loved ones — benefits from the participation of the individual service member or veteran in peer support. Benefits include healthier relationships and empowered individuals who are better able to cope with their feelings. Peer support can help individuals be more productive absent the distractions caused by stress or coping with depression or substance abuse.[8]

PEER PROGRAM STRUCTURES

Four models demonstrate how peer-to-peer programs can be structured (Table 1): (1) support group, (2) peer mentor, (3) community health worker and (4) peer educator.[9] Peer support can be delivered through multiple modes, including in-person, by phone or over the Internet. A peer-to-peer program can apply and combine these models and modalities in various ways, offering more than one option to participants.

Table 1. Peer-to-Peer Program Models

Model	Description	Strengths	Limitations
Support Group	Multiple individuals meeting to share experiences	Opportunity to learn from others' experiences and more opportunities to strengthen social network	Can be difficult to start, requires administrative support and multiple individuals
Peer Mentor	Mentor meets with an individual one-on-one	Individual attention and advocacy	Dependent on the abilities of the peer mentor
Community Health Worker	Liaison between a population and health care providers; not always a true peer	Ability to build a bridge between health care providers and individuals not already in care	Peers may be absorbed into health care provider system and lose peer qualities
Peer Educator	Educational course with discussion time	Access to information, recognition that there are others in same situation	Short-term intervention; does not provide ongoing support

Support Group

A professional or a peer can lead the support group model. To facilitate and provide a welcoming forum for engaging discussion, groups typically include no more than 10 to 15 individuals and meet on a regular schedule, for example, at least once a month.[9] Depending on the structure of the group, participants may be part of a group that meets together regularly or may be able to participate on a drop-in basis. Some groups offer mutual support to a mixed membership while others are targeted to a specific subpopulation (e.g., based on gender or condition).[8] Participating in a peer support group can offer individuals the opportunity to share coping strategies with others currently managing the same situation. The group meetings can also serve as an entry point for a one-on-one discussion with either the professional or peer leader.

Peer Mentor

In the peer mentor model, the mentor typically meets one-on-one with the individual. For instance, a peer mentor may be assigned to a group of individuals in a clinical treatment setting, or the individual may choose a peer mentor from a group of trained peer supporters. In all models, the peer mentor's role is to provide a positive example of someone who has experienced the same or similar situation/issues. Peer mentors receive training in communication skills, available resources and steps to take if a situation requires expertise beyond their level of training.[10] Of the various programs that use the peer mentor approach, some employ the mentors and some rely on volunteer personnel.

Community Health Worker

The community health worker model involves an individual, typically employed by a health care provider, to act as a liaison between an individual and the health care provider. Although the community health worker may not share a specific condition or situation with the individual, he or she should share some cultural factors with the target population.[11] For example, a community health worker might be someone with a military background but no longer in the service, or someone with minimal combat experience who provides support for those coping with combat-related stress. The community health worker approach can provide a means to overcome barriers to access to care, such as language or distrust of medical professionals.[10] Typically, the focus in this model is less on peer support and more on education, prevention, and awareness.[12]

Peer Educator

The peer educator model uses an educational platform, for example, one in which one to two peers lead a short course on condition or situation management and incorporate an interactive discussion period.[8] Courses tend to be approximately six weeks long and small enough (10 to 15 individuals) so that group dialogue can take place.[10]

Many peer-to-peer programs also use phone and Internet support to supplement face-to-face meetings and enable geographically isolated service members or veterans and families to connect with each other and access services and resources.[10] These approaches have benefits and drawbacks. When individuals do not meet face-to-face, body and facial clues that might otherwise inform the state of psychological distress, provide context, or raise an alert are lost. While anonymity of online interaction may encourage disclosure, it complicates tracking, referrals, and follow-up. Moreover, some communities do not have reliable, or any, Internet access and may be in need of peer support services.

Methodology

This effort focused on peer support programs that could be most effectively applied to active-duty service members, including activated National Guard and Reserve members, and to veterans. Information was compiled through a literature review, as well as Internet-based research and peer support stakeholder interviews conducted between October 2009 and January 2010 (Appendix A). Several programs were identified that consistently showed applicability to the military environment (Figure 3). (For additional information on these programs, please see

Figure 3. Programs Reviewed

- Amputee Coalition of America National Peer Network (ACA-NPN)
- California National Guard Peer-to-Peer Program (CNG)
- Canadian Department of National Defense and Veterans Affairs Operational Stress Injury Social Support Program (OSISS)
- Centers for Disease Control and Prevention Workforce and Responder Resiliency Team Deployment Safety and Resiliency Team (CDC DSRT)
- Department of Veterans Affairs Peer Support Technicians (VA PST)
- Michigan National Guard Buddy-to-Buddy Program (MI NG)
- New Jersey Law Enforcement Cop 2 Cop (Cop 2 Cop)
- NY Police Organization Providing Peer Assistance (POPPA)
- Tragedy Assistance Program for Survivors (TAPS)
- U.K. Royal Navy and Armed Forces Project Trauma Risk Management (TRiM)
- U.S. Navy/ U.S. Marine Corps Operational Stress Control and Readiness Peer Mentors (OSCAR)
- Vet-to-Vet
- Vet Center Readjustment Counseling Services (Vet Center)
- Vets4Vets
- Vet-2-Vet NJ

Appendix B.)

In compiling the research, several limitations should be noted. Research related to the benefits of peer-to-peer programs on the target population — active-duty service members and veterans — is limited. As such, DCoE included programs for participants with cultural characteristics similar to those of current and former service members. The peer support programs on which the findings are based are those that are geared toward law enforcement personnel and first responders, as well as limited research on veterans.

Much of the evidence of proven success of key elements of these programs centers on anecdotal data. Although useful, these data are limited because they cannot provide a verified assessment of an element. The empirical evidence that does exist is limited to randomized control and quasi-experimental trials comparing peer support to non-peer support interventions, which makes it difficult to identify successful specific programmatic elements. Further, peer support is often a component of a larger program; thus, deducing the relative effectiveness of a single component versus the impact of other or all elements of a program cannot be inferred from the literature.

Finally, available research does not reveal or take into account the participating individual's point of view, which could uncover additional benefits of peer support or suggest improvements.

Based on the limited available evidence, DCoE identified:

- Elements repeatedly confirmed to be central to the success of peer support efforts.
- Methods used by peer-to-peer programs to address various concerns in diverse environments.
- Methods effective in populations with needs similar to those of the military community.

By aligning the literature-based peer support elements with the methods from existing programs that address issues and populations similar to the military, findings on peer support were isolated, as discussed in the next section.

Findings

Research indicates that effective peer-to-peer programs share several critical elements that are important throughout the program life cycle, from planning and preparation through implementation, and finally program maintenance and adaptation.

ADEQUATE PLANNING AND PREPARATION

As discussed earlier, the benefits of peer support can be applied to a range of goals across vastly different settings. It is critical for the implementing organization to identify the needs of the target population and set specific program goals to meet those needs.[13] These identified needs can be used to shape the role of the peer supporter. Programs that develop comprehensive processes and policies are able to hold peer supporters and participating individuals accountable and responsible for performance.[13, 14] Even for a volunteer-based program, it is beneficial to prepare clearly articulated policies to avoid confusion. Production of a program manual can enable replication and facilitate model

fidelity monitoring among program sites.[8] In the military environment this would include service-specific doctrine.

A written job description for the peer supporter enables all stakeholders to have a view into what is and what is not within the scope of the peer supporter's responsibilities. Involving non-peer staff (e.g., medical or administrative personnel) in defining the role of the peer supporter can help avoid confusion in the future and establish peer-to-peer program buy-in.[14] A clearly defined peer supporter role can also enhance the development and scope of the peer selection screening criteria and peer supporter training needs. Taking the time to define these elements in advance of a program launch may eliminate difficulties in the future.

CLEARLY ARTICULATED POLICIES

Those involved in peer support may have multiple roles within an organization; for example, they might have shared and non-shared relationships (e.g., a peer leader in one group could be a participant in another group). To assist both the peer leader and the participant(s), two crucial steps have been identified: establishing clear role boundaries and defining the level(s) of confidentiality.[15]

Role Boundaries

Role boundaries define a professional relationship and create clarity, safety and predictability for the individual and the peer supporter.[5] These boundaries set limits on the interactions between the individual and the peer supporter (who is not a therapist) for a beneficial relationship. When a peer supporter is chosen from a group of individuals who know each other, there is the possibility that those who are not chosen may be resentful.[16] When the peer supporter has a connection to the individuals outside of the peer-to-peer interaction, dual roles can be present. The individuals may also feel that confidentiality is at risk.[16] For this reason, some programs (e.g., Police Organization Providing Peer Assistance [POPPA], Cop 2 Cop) provide peer support only between individuals who do not know each other. However, in the military environment, particularly in theatre, it is critical to train peer supporters who will be involved on a daily basis with their unit.

Confidentiality

Regardless of whether the individual is known to the supporter, confidentiality is an essential element to allow the individual to overcome apprehensions about stigma and negative repercussions and to freely discuss his or her concerns. Confidentiality policies should be frequently discussed and detailed in writing for all parties involved in the peer support program. Protection should be in place for the peer supporter as well as the individual participant.[15] Figure 4 provides some examples of measures that programs undertake to provide a confidential environment. If peer supporters share information learned about an individual "outside of service setting," it could diminish trust in the system.[15] The violation of trust by one peer supporter could potentially discredit an entire peer-to-peer program.

Figure 4. Anonymity and Confidentiality Measures

- Additional confidentiality — The Air Force affords those individuals at risk for suicide with increased confidentiality when they are seen by mental health providers.
- No records of contact —The POPPA program does not share records of contact or referrals with the New York Police Department (NYPD), and it is not noted on employment records.
- External volunteers (i.e., vets) — The New Jersey Cop 2 Cop program hotline is staffed by retired police officers and not by individuals still on the force.
- Limited sharing with superiors — The California National Guard peer supporters do not volunteer information to supervisors outside of the confidentiality guidelines established by the unit.
- Separation of data — The OSISS program stores all data on password-protected files on civilian computers and uses commercial e-mail services for communication.

While confidentiality must be respected, it is not limitless. Most programs have conditions under which the individual's right to confidentiality will be broken. In most peer-to-peer programs, these include situations where individuals pose a threat to themselves or a threat to specific people. Other programs, such as the California National Guard Peer Support Program, include additional limits on admitted child, spouse and elder abuse and other violations of criminal laws (e.g., Uniform Code of Military Justice).

SYSTEMATIC SCREENING AND DEFINED SELECTION CRITERIA FOR PEER SUPPORTERS

At the crux of a peer-to-peer program is the interaction between the trained peers offering support (peer supporters) and the service members or veterans receiving peer support (individual participants). Adequate screening for a peer supporter is critical. Effective peer supporters typically possess a range of skills and competencies across key knowledge domains. Commonly desired traits are superb communication and listening skills, demonstrated leadership ability or potential, ability to stay calm under pressure, and previous experience or training. Figure 5 provides the selection criteria of the Centers for Disease Control and Prevention (CDC) Deployment Safety and Resiliency Team (DSRT). Figure 6 provides the selection criteria of the California National Guard Peer-to-Peer Program. The draft list of competencies for VA support technicians is provided in Appendix C.

Figure 5. CDC/DSRT Team Member Selection Criteria

- Able to deal with ambiguous situations
- Possesses and routinely applies analytical skills
- Communicates in concise but caring manner
- Decisive
- Firm but flexible
- Learns quickly and easily
- Reputation as "good listener"
- Observant of behavior and processes
- Persuasive without being overbearing
- Rugged
- Sensitive to nuances of situations and people
- Consistently manages stress effectively
- Able to identify teaching moments
- Experience negotiating successfully
- Able to recover quickly from illness, change or misfortune; "buoyant"

Source: CDC Deployment Safety and Resiliency Team Member Training Presentation

Multiple stakeholders have to be considered in the screening process of a peer support program.[14] In the POPPA program, administrative staff, a psychological health professional, and a current peer supporter screen potential volunteers.

One benefit of peer-to-peer support is the opportunity for the individual participant to be able to look to the peer supporter as a positive role model. Therefore, based on observations from researchers, a peer supporter should be stable and in recovery for any psychological health and substance abuse issues.[6, 14]

Figure 6. California National Guard Peer Support Persons Selection Criteria

- Peer support persons should be chosen from volunteers who are currently in good standing with their unit and who have received recommendations from their superiors and/or peers.
- Considerations for selection of peer support persons include, but are not limited to: previous education and training, resolved traumatic experience, and desirable interpersonal qualities, such as maturity, judgment and personal and professional credibility.

Source: California National Guard Peer Support Guidelines

Recovery programs for individuals with physical injuries (e.g., Amputee Coalition of America National Peer Network [ACA-NPN]) try to match individuals to peer supporters who have sustained similar physical injuries, so they can best provide knowledge-based support to individuals. Similarly, experiential knowledge gained from past experience with the mental health delivery system can provide a peer supporter with additional credibility when engaging an individual who may be struggling, and provide firsthand answers and referral to services.[6] To ensure this credibility, some recovery-based programs (e.g., Operational Stress Injury Social Support Program [OSISS], Veterans Administration Peer Support Team [VA PST]) require past experience with a psychological health issue in their definition of a peer.

LEVERAGING BENEFITS FROM UNIQUENESS OF PEER STATUS

Benefits of peer support identified in the research literature include experiential learning, social support and self-empowerment. For the benefits to be realized, peer supporters must be open and honest about their experiences and journey to recovery. This genuine communication enables the participants to realize maximum benefits. Research and anecdotal evidence validates this approach.

For example, in four randomized studies and three quasi-experimental design studies conducted in the mental health community, essentially the same services were delivered by a peer with an acknowledged psychological health issue and by another non-peer provider. Participants experienced the same or better outcomes from the peer-delivered services.[6] This result is attributed to the ability of a peer to share first-hand knowledge of coping with the problems the participants are facing as discussed above. If peers did not willingly share their own experiences with participants, through individual choice or program design, the peer-to-peer program would lack this experiential learning benefit.[6, 14]

> *"The magic of the group is when the social bonds gel and the guys support each other outside of the program."*
>
> – Peer-to-Peer program director

Social support has been shown to increase resilience by moderating the impact of a potentially stressful event and having someone to talk with in order to prevent maladaptive response.[5] It has also been demonstrated as a mechanism for reinforcing positive behavior change.[3] Individuals under duress from stress or other conditions may begin to withdraw from social situations or may have a limited support network. Participating in a peer-to-peer program broadens an individual's support network.[6] Individuals may develop friendships with other participants that expand beyond the formal program. These relationships provide additional sources of support in times of need for physical assistance (e.g., a ride to work) or emotional assistance (e.g., someone who will listen). Peer-to-peer programs that provide sustained contact will facilitate opportunities for the development of stronger relationships and strengthen a participant's social support network.

> *"One would like [peer support] to be mandatory, but then it becomes a check the box program, and then it loses its luster."*
>
> – Peer-to-Peer program Director

The concept of empowerment is central to the use of peers. By learning from peers who are "like me," participants build their view of what is possible for them. Peer supporters provide education and support that is easier to accept than instructions from a medical professional or supervisor who "tells you what to do." Participation in a peer program also gives individuals the opportunity to take care of each other and empowers them to be a part of the solution by helping others. This desire to help one another is a motivating force in veteran and law enforcement peer-to-peer programs (POPPA, VA PST). The peer supporters gain value from helping others with their problems. In four pre- and post- test studies in the mental health community, hospitalizations for peer case manager aides were reduced.[6] Interestingly, key components for realizing the empowerment benefit are that participants voluntarily choose to attend, and that the program itself is controlled by the peer. Programs that require mandatory participation lose the self-determination and commitment that comes from voluntary participation. Studies in which participants were randomly assigned to participate in peer programs had a low return rate and a lack of commitment.[6] Investigators observe that they also see lower empowerment in individuals when the program is controlled by non-peers.[6]

ENABLING CONTINUED LEARNING

Training

Training is a critical aspect of ensuring consistency and confidence in peer supporters. As mentioned earlier, specific training needs should be developed in association with the defined role of the peer supporter within the peer-to-peer program. Some programs have developed or adapted their own training program while others use external training programs (Appendix D). Two highly regarded training programs are the Georgia Peer Support Certification Project and the Depression and Bipolar Support Alliance on-site training.[14]

Peer support training typically consists of content-based training on relevant topics and procedural training on relevant skills.[16] Topic-based training can include information on stress-related injuries, substance abuse, confidentiality, boundaries, ethics, available referral resources and other subjects. Skills-based training can include topics such as effective listening, crisis procedures and how to facilitate a support group. Several programs (e.g., CNG, VA PST, POPPA, Combat Mindsaver/BATTLEMIND) use role play to allow peer supporters to enact scenarios and practice how to respond in challenging peer interactions. Even less formal volunteer-based programs would benefit from training on leadership, organizational, and listening skills.[15]

In the most robust programs, training is not a one-time occurrence, and additional training (e.g., annual) is provided to refresh peer supporters on their skills and enable sharing of lessons learned. Peer supporters can also learn by "provid[ing] support to one another as peers."[15] Although there is little research evidence, it logically follows that peer supporters would themselves find peer support beneficial. Some peer-to-peer programs have conference calls (Vet-to-Vet), newsletters (Amputee Coalition of America National Peer Network [ACA-NPN]), and Internet groups to facilitate discussion and strength building among peer supporters.

Data Collection and Outcomes

It is critical for programs to collect data on the effectiveness of the program and the peer supporter. If neither is performing effectively, it is necessary to determine if the cause is systemic or related to the individual peer supporter. These data could then be aggregated to determine best practices.[14] (See Appendix E for examples of data). Programs can also informally monitor how individuals are doing. If the monitoring indicates that an individual is not doing well, then someone from the program can check in with that person.[15] By collecting process and impact evaluations, data programs can "address gaps in empirical knowledge … [and] also assist in advancing the potential of this unique peer-based intervention to the next level."[13]

Few peer-to-peer programs have published studies on outcome measures and effectiveness. In general, these studies look to reconcile measures of participant satisfaction, program structure and health outcomes (Appendix E). Figure 7 provides details on the Vet-to-Vet peer support survey.

Figure 7. Vet-to-Vet Peer Support Survey

The Vet-to-Vet program has worked in close partnership with New England Mental Illness Research, Education & Clinical Center (MIRECC) and Yale University to develop a survey-based monitoring system for peer support programs. The survey data are self-reported, anonymous and voluntary in alignment with the peer support culture of Vet-to-Vet. The survey data collects information from veterans who participate in peer support programs including Vet-to-Vet. The survey collects socio-demographic data, involvement in peer support (participation and leadership), and overall satisfaction with peer support. The survey also collects information on recovery-based measures: recovery orientation (derived from Patient Outcomes Research Team client survey); spirituality (derived from Daily Spiritual Experiences Questionnaire); and engagement (in the spirit of positive psychology). Because it is voluntary and anonymous, there is no way to verify representativeness or track individuals over time. A tool is under development to measure Vet-to-Vet model fidelity at the different sites to determine whether sites with lower effectiveness are implementing the model as intended.

Source: Barber JA, Rosenheck RA, Armstrong M, Resnick SG. Monitoring the dissemination of peer Support in the VA Healthcare system. *Community Mental Health Journal*. 2008;44:433-441.

A caution about the limits of research and metrics is that although valuable for assessing the efficacy of a program or intervention, the use of survey instruments and other measures in peer support programs may, in some cases, run the risk of damaging the trust that is essential for success, and could even drive away individuals 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. In such cases, metrics of success should be sought that do not 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 duty to protect individuals from harm also applies to the use of metrics in treatment programs.

KEY INGREDIENTS TO PEER SUPPORT

In addition to the above elements found to be essential to effective peer-to-peer programs, the following five "key ingredients" were found to account for the special effectiveness of peer support interventions: (1) social support, (2) experiential knowledge, (3) trust, (4) confidentiality and (5) easy access.

Social Support

While social support is mentioned at several points in this report, because it is thought to be such a primary feature of peer-based programs, the effective components and benefits of social support are worthy of elucidation. Social support from peers is thought to include *emotional support*, *information and advice*, *practical assistance*, and *help in understanding or interpreting events.*[13, 17] 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.[18, 19] Social support from peers in the period shortly after traumatic stress exposure has also proven to be a protective factor for U.S. soldiers exposed to sexual assaults and other trauma.[20] A meta-analysis of studies conducted with trauma-exposed adults further confirms the value of social support as a protective factor against PTSD.[21] In several studies of Vietnam veterans, Dr. Robert H. Stretch[22, 23] 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. James Griffith[24] 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. Dr. Paul Bartone[25] 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 U.S. 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

Experiential knowledge 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 are soldiers, police officers, firemen or recovering alcoholics, have greater credibility as "experts" in dealing with the problems and challenges faced by the person seeking support.[13, 15] Having similar experiences and backgrounds also contributes to the sense of social cohesion, through a process of social identification in which the individual more readily sees the peer supporter as "like me."[26]

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.[14] What is trust, and how is it established between strangers? A classic and highly influential theory on trust describes it 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."[27] In the peer support arena, peers are more likely to win trust quickly because of 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. It is also important for the peer counselor to be seen as honest, truthful and unselfishly motivated. In this regard, 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

Protecting confidentiality is critical to successful peer support programs. Assurances of confidentiality establish trust in the peer support relationship. If an individual fears that information provided might be disclosed to third parties without his or her permission, he or she is less likely to seek needed support. In his white paper on stigma and mental health in Army veterans of OEF and OIF, Andrew Brandi reflects on the success of the post-Vietnam storefront "walk-in, drop-in" centers for Vietnam veterans.[28] Brandi points out that in that setting, a veteran walking into a center was not asked to complete any paperwork for the first five or six visits. This was believed to be essential for establishing a relationship of trust and confidentiality with the veteran.[28]

Easy Access

Service member peers are the most accessible psychological supports for fellow service members on or off the battle. This is particularly true in theater where they fight , live and work together. As a result, service members who act as direct conduits to medical, spiritual and or psychological health assets are vital for ensuring access to care.

Out of theater, 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.[29] Considering the fears and stigma that service members and veterans often attach to seeking mental health support, access must be as easy and convenient as possible to encourage participation. Easy access is part of the reason for the success of the vet centers, which are community-based, as opposed to being located in VA medical centers. Some of the programs reviewed provide services during limited hours (e.g., California National Guard "buddy to buddy" program operates only Monday through Friday). Regardless of how well other aspects of a peer support program are resourced and managed, if access is difficult for the target population, it will be difficult for the program to succeed. Many available peer support telephone help lines seek to be available 24/7 (e.g., NJ Vet-2-Vet). This certainly makes access easier, but the lack of face-to-face contact in a telephone call may impede the development of trust with the peer counselor.

Discussion of Actionable Options

In both formal and informal programs, the military community already applies peer support in many ways.[30] For example, through the Army Wounded Warriors Program (AW2) and DCoE's Real Warriors Campaign, service members volunteer to share their own stories, which can encourage others to seek help or to understand that they are not alone. The new Master Trainer Resilience (MRT) program, part of the Army Comprehensive Soldier Fitness initiative, is reinforcing the strengthening of individual resilience skills and sharing those coping mechanisms with fellow service members to increase overall strength. A behavior currently used by service members to cope with stress is informal naturally occurring social support. In fact, the majority of active-duty service members state that they talk with family members or friends to cope with stress.

As a result of reviewing existing peer-to-peer support programs inside and outside of the military as well as literature pertaining to peer support methods and practices, and building on the findings previously identified, outlined are some potential options for how the military community could continue to offer peer support. In discussing these options, each approach is framed to address a specific need for the military community: combat and operational stress, suicide prevention and recovery. Because these needs intersect, there is some crossover in the discussion of ideas offered below. Moreover, these ideas are not intended to be mutually exclusive; a comprehensive peer-to-peer program could include several components designed to address different needs, or elements of peer support could be enhanced in existing programs. (Some of the key components for peer support are highlighted in Figure 8.)

Figure 8. Key Components for Peer Support

- Adequate training must be provided to peer supporters so they are able to:
  - Identify and be aware of signs of stress
  - Know when to reach out to others for assistance
  - Facilitate referrals to additional resources
- A program must be able to follow through with individuals to monitor improvement
- Individuals must feel safe to make use of the program
  - Strong confidentiality agreements

Several of the examples of peer-to-peer program models reviewed had multiple program components to address the needs of their target audiences (see Appendix F).

Numerous existing programs and command structures established at different locations within the services already contribute to addressing the identified needs. This discussion acknowledges the existing

programs, but does not address their integration with peer-to-peer support. To do so, a more thorough review at the service level would be required. Peer support is not a therapy or treatment program, and thus requires surrounding resources and programs for those in need of additional care.[9, 10] Some peer-to-peer programs operate independently from health care systems to serve individuals who have a "distrust of the system" or are concerned that a program associated with their employer will negatively affect their career.[31] However, other peer-to-peer programs operate within or in close collaboration with a specific treatment facility or system. Both types of programs can use shared experiences of peers to reduce stigma and encourage individuals to use the existing health resources available to them, and peers can help individuals successfully navigate through the system. Embedded programs can build trust in the system, and peers can serve as liaisons so that the military health system better understands patient needs. These embedded programs alleviate some of the concerns about external peer-to-peer programs that might allow a service member's or veteran's needs to go unheeded if information is not shared for follow-up, or the situation is not adequately addressed. The peer support program options discussed below enable the existence of a peer program within the military or VA structure, which would allow a service member or veteran to seek and receive care.

Combat and Operational Stress

The nature of the work required of service members and the environment in which they operate can lead to increased stress levels. Deployment into theater — away from loved ones and serving in locations where life-threatening situations are likely to occur — can further exacerbate the need to manage high stress levels. Operational stress may result from a particular traumatic incident or can be a gradual response to increased stress. As such, ongoing support and provision of resources following critical incidents are necessary for assisting those who are managing operational stress.[32] Table 2 highlights some of the key components for doing so.

One method for addressing the combat and operational stress needs of active-duty service members via peer support would be to select a peer supporter from within a unit. In this model, the peer supporters could either volunteer or be assigned. In either case, they should be screened and selected for suitability and then must be trained, knowledgeable, and held accountable in their role. The availability and accessibility of a peer supporter throughout the deployment cycle would provide sustained relationship contact and bolster the ability of the peer supporter to relate to the service members, both on and off the battlefield. Identifying those individuals with the interpersonal skills to be a peer supporter — the ability to engage and connect with a service member — is vital to the success of a program addressing operational stress. An individual must be able to relate to and feel comfortable actively reaching out to the peer supporter.

Table 2. Needs and Potential Actionable Options for Peer Support to Address Combat and Operational Stress

Key Components of Need	Potential Actionable Options
Sustained support throughout service	A volunteer or assigned member of the unit is embedded in the unit through the deployment life cycle
Identification of those needing additional support	Embedded member should have an understanding of normal reactions to abnormal circumstances and actively reach out to service members who may not be currently using services
Follow through to additional services if needed	Peer supporter could serve as a liaison with chaplains, leadership and the health care community

Preference for different modes or anonymity	Depending on resources, peer supporters could offer multiple options: e.g., one-on-one, group, hotline

A sustained relationship or contact with a peer supporter over time has significant benefits. Such contact enables a peer supporter to detect changes in an individual who may be having a difficult reaction to a particular stressor. A peer supporter could provide outreach to those who may not realize they could benefit from having someone to talk to. The peer supporter would be trained to identify an extreme reaction to the unusual circumstances service members may face on a day-to-day basis. Through their social relationships, peer supporters may learn of events (e.g., death of a buddy, disciplinary hearing, divorce) that may be difficult for individuals to cope with and know to reach out to them at that time.

In many cases, the individuals who become peer supporters are those who already are unofficially filling this role.[30] They are known as a person who will always listen. A formal peer-to-peer program would provide recognition for the work these individuals are already doing and would train them to enhance their natural ability to provide positive support. As a designated point person, the peer supporter could serve as a liaison with chaplains, unit leadership, and the military health community. As a trusted advisor to their peers, peer supporters can influence individuals to seek additional help. The ongoing relationship between the individual and the peer supporter within the same unit provides several of the benefits mentioned above, but can also lead to confusion in boundaries. The articulation of program policies would help to establish clear boundaries in roles and expectations. Strong and clear confidentiality agreements would also be needed so that the peer supporter is seen as someone trustworthy and as someone a service member can turn to.[30]

Figure 9. Using Peers in Combating Operational Stress

- In the CDC's DSRT program, an individual from each unit is trained in psychological first aid to monitor and assess the state of his or her co-workers during deployment.
- In the CNG Peer Support Program, trained individuals are available to meet with fellow service members at drill and during deployment.
- The U.K. TRiM program uses peers to screen individuals who may need additional testing or services following a traumatic incident.

Because individuals' needs vary, a one-time peer-to-peer interaction might be sufficient for an individual to receive the necessary support and information to cope with his or her situation or to be referred to additional services. In other instances, individuals may benefit from ongoing discussions about changes in their situation. To diminish the burden on peer supporters and not limit their effectiveness, the peer support services would require an administrative structure (e.g., training, oversight) and access to the psychological health team. Figure 9 provides examples of how some programs are currently using peers to address combat and operational stress.

A cadre of trained peer supporters could also be used to provide peer support through additional channels, depending on the operational environment. For example, they could lead a monthly support group, staff a hotline or facilitate an online community. These options could be made available in theater (a hotline could be accessible via a DSN line) or elsewhere and would provide other ways for individuals to connect with a trained peer supporter. Additional modalities would provide access to the peer-to-peer program to those individuals who are uncomfortable talking with someone they know. A list of peer supporters would allow individuals to seek out a supporter who is known or unknown to them depending on their needs, and to access a back-up supporter when theirs is unavailable (e.g.,

reassignment). With multiple peer supporters available, an individual could seek one who is "more like them" if the unit embedded peer supporter is not a good fit (e.g., female service member wanting to speak with another female). This additional level of anonymity or disassociation may be a valuable way to encourage those who may otherwise not take action at all.[33]

Embedded peer supporters are also in a unique position to respond following a traumatic incident. They have a baseline familiarity with the members of their unit. They are seen as trustworthy and credible, which are traits that a trauma stress response team engaging with individuals after an incident has occurred may not have. Some programs use an embedded peer supporter as a touchstone within that unit to coordinate with the trauma stress response team.

Suicide Prevention

Comprehensive suicide prevention programs include ongoing prevention strategies and resources for intervening at time of crisis or suicidal ideation.[34, 35] Addressing the needs of operational stress could indirectly contribute to suicide prevention by providing ongoing support, encouraging assistance seeking, and strengthening resilience. Several of the peer support programs created to address suicide prevention also handle operational stress and vice versa. This allows individuals to reach out to the program for assistance when they are in sub-crisis or crisis mode, thereby increasing the number of people contacting the program and raising awareness of and familiarity with the program. This is critical for suicide prevention, because an individual in crisis should already be aware of the program. Some programs use peers as gatekeepers who can recognize an individual at risk and immediately transfer them to trained counselors. Peer supporter training must include suicide-prevention-specific communication skills so peer supporters are able to change an individual's course of action while they access additional help. Figure 10 provides examples of how programs are currently using peers to aid in suicide prevention. Table 3 highlights some of the key components of the needs and actionable options using peer support to aid in suicide prevention.

Figure 10. Using Peers in Suicide Prevention

- The U.S. Air Force places peers in itst response teams, which are a component of its Suicide Prevention Program.
- The U.S. Army Suicide Prevention Program suggests the possibility of appointing a "life-line" buddy to oversee an individual in crisis until a referral is made or the crisis is over.
- The Massachusetts SAVE program has regional coordinators who travel directly to veterans' homes to provide support or to transport them into a VA medical center.

Table 3. Needs and Potential Actionable Options for Peer Support to Aid in Suicide Prevention

Key Components of Need	Potential Actionable Options
Ability to recognize warning signs and take action	Providing peer supporters with additional suicide prevention training would enable them to act as knowledgeable gatekeepers who can keep an eye on fellow service members
Instant credibility of individual seeking help	Using peers in suicide prevention programs (e.g., staffing a crisis hotline) because they may be able to better relate to individuals in crisis and convince them to seek help

In providing additional suicide prevention training to peer supporters, they will be better positioned to assist chaplains and unit commanders in identifying potential crises and connecting individuals in need to the required resources.[36]

Individuals in crisis may need immediate access to resources, regardless of the time of day or their location (e.g., home, a base or on deployment), and thus many suicide prevention programs employ a hotline model (see Figure 11). The help lines are staffed with volunteer peers (such as law enforcement officers or veterans) to provide instant credibility and to encourage the individual to open up. The individuals seeking assistance know when they log on or pick up the phone that the person with whom they are speaking has been through similar experiences.

Figure 11. Using Peers in Suicide Helplines

- VA's "Veterans Chat" enables veterans to anonymously chat online 24/7 with a trained VA counselor. If the counselor determines there is a crisis, the caller can immediately be transferred to the VA Suicide Prevention Hotline.
- Cop 2 Cop Hotline has a phone bank with retired officers and counselors who are available live on a 24/7 basis.
- POPPA responds within 15 minutes to calls received 24/7 and arranges to meet face-to-face with officers in need.

Recovery

Following a visible or invisible injury, service members may have difficulty during the healing and rehabilitation process, while reintegrating and possibly while carving out a new role for themselves in either military or civilian life.[18] A peer support program to address recovery would focus on injured active-duty service members and/or those having difficulty readjusting. Although it would be based in the military community, it could also have VA and civilian community counterparts because recovery often takes place among family and in civilian life. Those recovering from an injury are part of a subset of service members and veterans who have not only served, but have visible and/or invisible wounds as a reminder of that service. Peers who have gone through and successfully thrived in similar experiences can provide a level of experiential knowledge that family and loved ones cannot provide.

One option for a peer-to-peer program focused on recovery and recovery-related issues would be to develop the program directly within the military treatment facility(ies) where the service members receive care. In this case, the program and peer supporter(s) would coordinate with the medical staff on recovery. As there are military treatment facilities throughout the country, and a service member who participates in this program may return to a more civilian-focused life, the peer supporters and program leaders should be aware of additional available resources, both military and in the civilian community. Table 4 highlights some of the key components of the needs and actionable options using peer support to aid in recovery.

Table 4. Needs and Potential Actionable Options for Peer Support to Aid in Recovery

Key Components of Need	Potential Actionable Options
Coordination with medical team for accessibility and integrated recovery	Use trained patient volunteers (or hire former patients) at military treatment facilities, particularly those with long-term rehabilitation and treatment programs
Benefit from those who have been through the recovery process	Peer supporters would be further along/advanced in their rehabilitation and/or recovery to provide the appropriate mentor level for other patients and experiential knowledge of how to access resources
Follow through is needed to ensure successful road to recovery	Peer mentors could provide a point of contact throughout their next transition back into service, into veteran status, and/or into the civilian community

The peer supporters in military treatment facilities could be volunteers among long-term patients (particularly those in long-term rehabilitation and treatment facilities) or past patients who return as an employed extension of the medical team. If peer supporters are volunteer patients (or former patients), their tenure in the facility is also a benefit, as their institutional knowledge would allow them to provide a more comprehensive resource for individuals currently in the program. In either case, the peer supporters should be at advanced stages in recovery or rehabilitation so that they are able to act as mentors to the individuals, demonstrating an example of success post-injury (e.g., re-learn to drive a car and continue to be independent after multiple limb loss).

This peer relationship also has benefits to the peer supporters, because they are able to reinforce their own progress and recovery through helping someone else.[31] The role of the peer must be clearly defined to not overstep boundaries and to establish that the peer is not a counselor or a member of the treatment team. Without setting boundaries, a peer could potentially become simply another staff member and lose his or her desired peer qualities.

Further, a recovery-based peer-to-peer program could potentially provide stability in a transitional period (e.g., return to active-duty status, or reintegration into civilian community).[3] The social connections of the peer network may be the only contact injured service members have with other military peers once they transition. Figure 12 provides examples of how programs are currently using peers to aid in the recovery of injured service members.

Figure 12. Using Peers in Recovery

- Treatment team — VA hires veterans as peer support technicians to be a part of the case management team for veterans with psychological health issues.
- Education — Vet to Vet is a consumer/provider partnership where trained veterans lead educational group sessions at facilities that offer VA mental health services.
- Social Support through transition — The Canadian OSISS Peer Support Network is a joint program that serves active-duty and veteran service members. The OSISS peer support coordinator is often the only constant for service members who change doctors, counselors and sometimes medications and treatment plans through the recovery process.

Final Thoughts

Several considerations should be taken into account when developing a peer-to-peer support program that would be most applicable to the military environment. A working group of experts could review the peer support actionable options to verify applicability in the military setting and explore areas such as how peer-to-peer support would accommodate the diverse nature of the military, including varied ranks, gender and job requirements. Although all service members are in the military, the cultural distinctions among and within the services are vast. The panel could include representation from the different services and levels of command. This is particularly important as peer support requires active participation and initiative from peers. The panel may need to consider separate working groups for each service that would allow the flexibility to develop individualized peer-to-peer programs following basic guidelines and recommendations of essential elements. Service-specific groups could allow review existing initiatives, programs and training that can be coordinated and integrated with the peer-to-peer program.

As the process evolves, the function and composition of the group should also change. Peer support program and medical directors can offer guidance on the tactical elements of developing policies and procedures, training protocols and performance measures, including integration with existing military health assessments and data collection efforts. Upon the development of any program, the organizers must integrate the flexibility to respond to lessons learned, incorporate participant and peer supporter feedback, and identify changes in need. It is important to remember that peer support can be a valuable tool to reach disenfranchised individuals through common bonds, but it may not be for everyone. Even with a best-in-class program, there may be individuals who choose to not participate in a peer-to-peer program. Finally, certain peer support programs are likely to be more or less effective depending on a variety of factors that should be considered, for example, setting, target population and availability of and access to resources.

Appendix A: Interview List

Organization	Contact	Title
Canadian Department of National Defense and Veterans Affairs Operational Stress Injury Social Support (OSISS) Program	Lt. Col. Stéphane Grenier	Program Manager
California National Guard (CNG) — Peer-to-Peer Support Program	Mr. Jon Wilson	Executive Officer of J1 Manpower and Personnel
CDC Workforce and Responder Resiliency Team, Deployment Safety and Resiliency Team (DSRT)	Dr. Richard Klomp	Behavioral Scientist
Michigan National Guard (MI NG), Buddy to Buddy program	Col. James D. Bartolacci	Executive Director
Police Organization Providing Peer Assistance, Inc. (POPPA)	Mr. Bill Genet	President and Founder
RAND Corporation, Pittsburgh VA VISN-4 Mental Illness, Research and Clinical Center	Dr. Matthew Chinman	Behavioral Scientist, Health Science Specialist
Veterans Health Administration, Mental Health Group	Mr. Dan O'Brien-Mazza	National Director, Peer Support Services
Vet-to-Vet	Mr. Moe Armstrong	Director of Recovery Services

Appendix B: List of Reviewed Peer-to-Peer Programs

	Implementer	Program Name	Primary Model	Program Web Site
1.	Amputee Coalition of America (ACA)	National Peer Network (NPN)	Assigned peer mentors and visitors	www.amputee-coalition.org/npn_about.html
2.	California National Guard (CNG)	Peer-to-Peer Program	Embedded trained team member	www.calguard.ca.gov/j1/Pages/Peer_support.aspx
3.	Canadian Department of National Defense and Veterans Affairs	Operational Stress Injury Social Support (OSISS)	Regional peer coordinators	www.osiss.ca/
4.	CDC Workforce and Responder Resiliency Team	Deployment Safety and Resiliency Team (DSRT)	Embedded trained team member	www.cdc.gov/news/2009/05/dsrt/
5.	Department of Veterans Affairs (VA)	Peer Support Technicians (PST)	Member of treatment team	www.mirecc.va.gov/visn5/docs/phlag5.pdf
6.	Michigan National Guard (MI NG)	Buddy-to-Buddy Program	Hotline assigned veteran buddies	www.buddytobuddy.org/
7.	New Jersey Law Enforcement	Cop 2 Cop	Hotline	www.cop2coponline.com/
8.	Non-profit – law enforcement	Police Organization Providing Peer Assistance (POPPA)	Hotline with in-person meetings	www.poppainc.com/
9.	Non-profit – military families	Tragedy Assistance Program for Survivors (TAPS)	Assigned mentors and semi-annual events	www.taps.org
10.	Non-profit - veterans	Vet-to-Vet	In-person veteran support groups	www.vet2vetusa.org/
11.	U.K. Royal Navy and Armed Forces	Project Trauma Risk Management (TRiM)	Embedded trained crisis team	www.kcl.ac.uk/kcmhr/research/trim/index.html
12.	U.S. Navy/U.S. Marine Corps	Operational Stress Control and Readiness (OSCAR) Peer Mentors	Embedded officer and enlisted peer mentors	www.marines.mil/news/messages/Pages/MARADMIN0667-09.aspx
13.	VA – Vet Center	Readjustment Counseling Services	Provide outreach and counseling at small community based Vet Centers	www.vetcenter.va.gov/

Appendix C: Department of Veterans Affairs (VA) Draft Peer Support Competencies

Proposed/Draft Certification Curriculum for VA Peer Support Staff	
Knowledge Domain	**Skills and Competencies**
Addressing Stigma	Managing internalized stigma Managing environmental stigma
Communications Skills	Effective listening and asking questions Communication styles (passive/aggressive/assertive) and verbal and nonverbal communication Conflict resolution
Cultural Competence	Understand how ethnicity, race, spirituality, gender, sexual orientation, local community and other sub-cultures may influence recovery
Group Facilitation Skills	Understanding group dynamics and interactions Knowing how to use support groups
Managing Crisis and Emergency Situations	Early warning signs of illness' symptoms worsening Crisis prevention, using resources early Crisis interventions An understanding of suicide prevention Ability to work through challenging situations with veterans who are under the influence of substances, angry, in psychosis or a non-verbal state Personal safety issues
Peer Support Principles	Being a role model Instilling hope Being an advocate Knowing principal duties of peer support staff
Professional Development & Workplace Skills	Ethics Boundary issues and dual relationships Ability to work effectively with professionals on an interdisciplinary team
Recovery Tools	Solving problems using solution-focused strategies Telling your personal recovery story, being mindful of who you are addressing Participating in self-help groups Teaching others how to manage self-talk and combat negative self-talk
Recovery Principles	Overview of psycho-social rehabilitation Components of recovery Stages of recovery Peer support role in psycho-social rehabilitation
Understanding Different Illnesses	Major psychiatric conditions in DSM IV Addictive disorders Co-occurring disorders Medications and side effects
TOTAL	33 Critical Competencies

Source: Draft/Proposed Peer Support Competencies Curriculum for VA Peer Support Staff, December 2009.

Appendix D: Peer-to-Peer Program Training Comparison

Program	Initial Training	Curriculum Development	Availability of Materials
CDC DSRT	Employee Volunteer: Four-day training with resiliency component (e.g., Psychological First Aid, Stress Management and Coping, Peer Support, Assessment and Proper Referral Protocols) and a safety component (e.g., customized versions of Disaster Site Worker training)	Center for the Study of Traumatic Stress (CSTS) at the Uniformed Services University of Health Sciences USUHS) – Dr. Dave Benedict adapted materials from military to civil service	Training presentation available online
Combat Mindsaver	Six hour-training, including multiple role play scenarios with structured feedback for trainees regarding their implementation of skills	Two Army psychologists and an Army psychiatrist developed and used with 1st and 2nd Infantry Divisions in Iraq. Some additional development for use in Warrior Transition Battalion at Schofield	Contact Lt. Col. Philip A. Holcombe at 301-295-8418
CNG	Employee Volunteer: Three 8-hour days, including discussion of listening skills, personality types, substance abuse and others and interactive role playing; annual update training	Developed with involvement of a former police chief, influenced by Critical Incident Stress Management (CISM) model	Training presentation available online
MI NG	Employee Volunteer: Two 8-hour training days on communication skills and community resources	Developed by team from MI ARNG and University of Michigan and Michigan State University	Unknown
OSISS	Employee: Required two-week training on critical skills development and knowledge on peer support as well as available resources; Quarterly workshops for ongoing professional development Volunteer: Three-day peer support training program on skills development, less focus on administrative policies and procedures	Developed by multi-disciplinary team at Veterans Affairs Canada and St. Anne's Hospital	Training manual acquired from program director
POPPA	Volunteer: Required Eight-day training on communication skills, available resources for referral. Expected commitment of two years	Unknown	Unknown

TRiM	Employee Volunteer: Two- to Four-day training combines didactic teaching and role play to cover psychological first aid (incident management, psychoeducational briefings) and screening for additional need	Developed by Royal Marines command and assessed by Cranfield University to be of good quality	Unknown
VA PST	Employee: List of qualifying external trainings that develop required competencies	Dependent on training	Dependent on training
Vet-to-Vet	Volunteer/Employee: Four weekly 45-minute classes and ongoing observation and feedback; co-facilitate two meetings. Expected commitment of one year	Developed by team from VHA and Veterans, Errera Community Care Center, and VISN 1 MIRECC. Uses materials from Mental Illness Anonymous	Training manual available online
Vet Center	Employee: Training on assessment and counseling techniques for PTSD, sexual trauma, group and families and training in administrative areas such as clinical record keeping and VA benefits and discharge process	Unknown	Unknown

Note:

Employee: Employed by program and within job description to provide peer support
Employee Volunteer: Employed by program, but not within primary job description to provide peer support
Volunteer: Not employed by program

Appendix E: Peer-to-Peer Program Outcome Evaluations

Program	Data Collected	Evaluation Level	Study Design	Overall Findings
Combat Mind-saver	• Compared soldier satisfaction training for identifying soldiers at risk for suicide and confidence in ability to help fellow soldiers manage stress with same Military Health Advisory Team (MHAT) ratings.	Self-report survey of 60 trained combat mindsavers	Simple comparison between MHAT 2006 and Combat Mindsaver post training survey	Forty-eight percent of MHAT-surveyed soldiers who received typical Army suicide prevention training felt the training they received was inadequate and only a little over half reported confidence in their ability to identify soldiers at risk for suicide. Ninety-four percent of Combat Mindsaver-trained soldiers agreed that training for identifying soldiers at risk for suicide was adequate, and 95 percent agreed that they felt able to identify soldiers at suicide risk. Ninety-two percent of combat mindsavers also reported confidence in their ability to help fellow soldiers manage stress
OSISS	• Effectiveness of department coordination • Peer support network (PSN) sustainability • Program management and governance • PSN support of their peers	Review of program documentation; Focus groups with peer supporters; Interviews with other stakeholders	Program assessment	Chief Review Services 2005: • Program is meeting the needs of service members and veterans with operational stress injuries • Peer coordinators are effective in getting peers to recognize injury, moderate frustration and seek treatment • Program currently key element of social support structure and the only psychological health-consistent support through transition from active-duty to veteran status
TRiM	• Attitude to stress and mental health problems • Occupational health and efficiency • Psychological morbidity	Surveys and sampling of 1:1 informational interviews	2004-07 – cluster randomized parallel group; 12 Royal naval vessels (six trained, six not trained)	Findings not yet published

Program	Data Collected	Evaluation Level	Study Design	Overall Findings
Vet-to-Vet	• Sociodemographic data • Participation and leadership in peer support • Satisfaction • Recovery-based measures include: ▪ Recovery orientation ▪ Spirituality ▪ Engagement	Self-reported survey of 1,847 participants and leaders from 38 programs	No control group or baseline data; Individuals were participating in Vet-to-Vet or other peer support program	Barber, et al., 2008: • Overall satisfaction between "moderately" and "quite" satisfied • Strong correlation between satisfaction of group leader and general satisfaction of group • Moderate correlation between overall satisfaction and frequency of participation and duration of participation
Vet Center	• Operational review of services provided at vet centers	Review of program documentation; Site visits to 14 vet centers	Program assessment	Office of Inspector General, 2008: • Vet centers provide distinctive service and meet responsibilities by making social and psychological services available to veterans

Appendix F: Identified Components of Peer-to-Peer Programs

Program	Individual Mentoring	Support Groups	Trauma Response Teams	Community Education and Outreach	Family Support
ACA NPN	Certified peer visitors	ACA NPN support group leaders; Amputee Communicators Forum	N/A	ACA Volunteer Outreach Team	Certified peer visitors; parent support network
CDC DSRT	DSRT members provide support during deployment	N/A	DSRT members trained in psychological first aid	N/A	N/A
CNG	Peer support persons in National Guard units	N/A	Peer support persons trained in critical incident response	N/A	N/A
Cop 2 Cop	Cop 2 Cop Helpline and Field Support	Cop 2 Cop Wounded Officer Support Group	Cop 2 Cop Critical Incident Stress Management de-briefing teams	N/A	N/A
Combat Mindsaver	Recommended that unit behavioral health assets mentor Combat Mindsavers; combat mindsavers provide assistance to fellow unit members; command selected soldiers throughout the company level rank structure receive the training	Recommend that combat mindsavers meet regularly (based on agreement between unit commander and behavioral health assets) with unit behavioral health assets	Combat mindsavers are embedded unit psychological trauma response assets who become referral conduits to the unit behavioral assets as appropriate	N/A	N/A
MI NG	Buddy-to-Buddy veteran volunteers	N/A	N/A	N/A	N/A
OSCAR	OSCAR extender peer mentors	N/A	N/A	N/A	N/A
OSISS	OSISS peer support network of coordinators and volunteers	OSISS peer support coordinator-facilitated groups	N/A	OSISS speakers bureau and awareness training	OSISS family peer support coordinators

Program	Individual Mentoring	Support Groups	Trauma Response Teams	Community Education and Outreach	Family Support
POPPA	POPPA peer support officers	POPPA officer support groups	POPPA critical incident responders	N/A	POPPA family support groups
TAPS[2]	TAPS 24/7 call center and peer mentors	Support groups at regional and national events	Trained crisis response professionals	N/A	Good Grief Camp for youth
TRiM	N/A	N/A	TRiM Practitioners	N/A	N/A
VA PST	Peer dupport technicians	Peer support technicians-led groups	N/A	Patient outreach	N/A
Vet-to-Vet	N/A	Vet-to-Vet peer group facilitators	N/A	N/A	N/A
Vet Center	Individual readjustment counseling	Group readjustment counseling	Military sexual trauma counseling	Outreach and community education	Marital and family counseling

[2] TAPS programs are primarily designed for families, casualty officers, and caregivers grieving the death of a military service member.

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***ADDITIONAL PROGRAMS IDENTIFIED AFTER THE MAIN REVIEW WAS COMPLETE:**

Vets4Vets
www.vets4vets.us/

Vets4Vets is an independent non-profit organization founded in 2005 with the goal of establishing a nationwide, free, peer support community for Iraq and Afghanistan era veterans. It trains volunteer peer counselors through free weekend workshops. Optionally, this is followed by a weeklong leader training seminar in Tucson, Arizona leading to Certification as a Vets4Vets Peer Support Leader.

Vet-2-Vet NJ
http://nj.gov/military/publications/guardlife/volume34no4/22.html

Vet-2-Vet program New Jersey is primarily a telephone hot line counseling service for veterans staffed by peers. The program has expanded to also provide counseling services within the state of New Jersey, and trains combat veterans to serve as volunteer peer counselors "since they can best understand the strains that veterans feel upon returning home."

The University of Medicine and Dentistry of New Jersey (UMDNJ) first partnered with the State's Department of Military and Veterans Affairs (DMAVA) 5 years ago to create the Vet-2-Vet program and claims to have "managed" 3,200 cases in 2009. They rely on year-to-year state funding.

Never Leave a Marine Behind
www.usmc-mccs.org/suicideprevent/index.cfm

Never Leave a Marine Behind suicide prevention training is "A shift in training delivery - from outsider-led to peer-led, from outsider-developed to audience and expert developed, and from power-point based to evocative video drama and discussion based." In reaction to audience feedback that the usual prevention training was boring, painful and ineffective, the U.S. Marine Corps created the Never Leave a Marine Behind training series. The series is delivered by sergeants who are specially trained to teach Never Leave a Marine Behind to two groups - to their peer non-commissioned officers (NCOs), and to their subordinate junior Marines.

Both training audiences see a dramatic video that focuses on a junior Marine's downward spiral and the actions taken by his peers and supervisor to intervene when the Marine begins experiencing suicidal ideation. The drama is followed by videotaped testimonials by family members, friends and leaders who

lost a Marine to suicide and, in the case of the NCO course, testimonials by Marines who themselves were suicidal. The videos are interspersed with guided discussion and instruction on: U.S. Marine Corps suicide trends; warning signs; resilience training; aiding fellow Marines; and supportive resources. Major themes include the importance of addressing problems before they are overwhelming, reassurance that getting help will not harm a career, that confidential assistance is available, and that treatment works.

Never Leave a Marine Behind received positive feedback from commanders and course participants. Out of thousands of entries, it recently won best-of-show in the 2010 National Healthcare Information Awards, as judged by a panel of health care information specialists. In addition, preliminary program evaluation indicates that following the course, participants with no previous exposure to suicide demonstrate improved confidence in their ability to handle a peer or subordinate who is suicidal.

Never Leave a Marine Behind is one part of a multifaceted suicide prevention program implemented by leaders across the U.S. Marine Corps. The program's website, which includes all training materials and videos, can be accessed at www.usmc-mccs.org/suicideprevent/index.cfm.

BRIEF SUMMARIES OF 15 PEER-TO-PEER PROGRAMS EXAMINED FOR "IDENTIFICATION OF BEST PRACTICES IN PEER SUPPORT WHITE PAPER"

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

ACA's 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.*

http://www.amputee-coalition.org/npn_about.html

ACA currently has volunteer regional representatives who are experienced support group leaders. These volunteers are located throughout the United States and communicate with groups in regions varying in size and usually including 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's location.

The NPN involves support groups and individual peer visitors (more than 1,000 civilian and military visitors have been trained since 2001), providing emotional, educational and advocacy assistance in an effort to empower those who have lost limbs to lead the most fulfilling life they can achieve. ACA has also created the Parent Support Network, with a Parent Peer Visitor Program designed to 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 cannot 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.

ACA conducts a yearly workshop for the support group leaders. The workshop is designed to function as a support group so that the leaders 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, show that he or she has successfully adjusted to the 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. An Internet discussion board is also available to peer visitors. It serves as a place to discuss issues and to find support at any time should the caregivers themselves need some care.

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 February 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 (PSP) is a member of the National Guard who volunteers to serve in that position. PSPs are enlisted men and women, warrant officers or commissioned officers, who are specifically trained to provide emotional and practical support at the first sign of need, before any problems are compounded. They are colleagues, not counselors or therapists. Over the course of three days, 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.

Units are encouraged to train as many PSPs as they feel are qualified for the work. Guard members have the right to refuse the support of the peer; however, the regulations defining the program are readily available to ensure that boundaries are not crossed. Rules of confidentiality are detailed in the manual and specify that anonymity will be preserved as much as possible, except when a member presents a risk to him or herself or others, or has violated the Uniform Code of Military Justice.

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). VAC co-manages the OSISS Program at the national level. OSISS was created in May 2001. The program is an initiative of the chief of military personnel 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 from a number of regional sites across southern and eastern Canada. The peer support coordinators (PSC) and peer support volunteers have experienced and recovered from an OSI and reach out to help others experiencing a similar situation. The PSCs are trained, paid employees of the DND/VAC Centre working throughout Canada. There is 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. Through outreach and education, it connects those who are suffering to the resources that can help them. In addition to the paid coordinators, a group of peer support volunteers, who are trained veterans and usually recovering

from an OSI, work under the direction of the paid coordinators as they continue to heal while reaching out to help empower others.

Using general selection criteria, PSCs are selected by medical and mental health authorities, in particular the Operational Trauma and Stress Support Centre (OTSSC) and the VAC OSI clinics. Rather than simply asking for volunteers, mental health personnel are asked to identify suitable candidates based on 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 client is called a peer and can be anyone who is suffering from or living with someone who is suffering from an OSI. The program provides immediate outreach in person, by phone or e-mail. 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 participants will not be put at risk for additional harm to themselves as a result of their participation. Although numerous measures are taken to ensure a client's privacy and sense of trust, including identification by number, not name and the use of nonmilitary commercial websites for all data and Web interaction, confidentiality cannot be maintained in cases 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/ (This is a link to an article about DSRT research.)

The role of the peer supporter is to apply basic concepts of psychological first aid to build resiliency among colleagues 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 makes physical and psychological safety assessments and calms and stabilizes distressed persons while offering practical assistance such as linking the person in crisis to collaborative services. CDC sent a small number of peer supporters who had received the four-day training session along with the teams going into the field during the H1N1 pandemic. Two of them reported that they had been able to apply the knowledge gained during training.

5. Combat Mindsaver

Materials available through Lt. Col. Philip A. Holcombe at (301) 295-8418

Combat Mindsaver is a battle tested, highly experiential peer-to-peer training program. Two Army psychologists and an Army psychiatrist developed Combat Mindsaver in 2006 while serving as behavioral health officers supporting elements of the 4-25th Airborne, 2nd Infantry Division, 1st Infantry, and 1st Cavalry Division. As a result, 60 soldiers of the 2nd Infantry Division were trained in a peer-to-peer program and soldiers of the 1st Infantry Division continued the training with the assistance of the

forward operating base Army physician assistants. Through utilization of realistic battlefield scenario role plays, combat mindsavers are trained to utilize laymen level active listening skills using the S.A.F.E.R. (Stabilize the environment, Acknowledge the soldiers reactions/ emotional responses, Facilitate understanding of the experience through utilization of active listening techniques, Encourage healthy coping strategies, Reassure/ Refer as appropriate) model to structure their peer-to-peer support interactions. Ninety-four percent of soldiers who completed the training reported that they felt confident in their ability to aid another soldier compared to 64 percent on the Mental Health Advisory Team VI 07-09 survey. The 30 percent difference is likely related to some differences in measurement but may also be related to the highly interactive, experiential Combat Mindsaver training method.

Given the strong interactive component of training, the initial six-hour course is limited to 20 trainees and requires a minimum of three to four trainers. Trainees break into small groups to complete the role play exercises. Trainers facilitate the role play interactions using a structured format that seeks to build the combat mindsaver's self-confidence in using the Combat Mindsaver skills while providing feedback that emphasizes utilization of the active listening skills and the S.A.F.E.R model. Materials for training include a 36-slide power point designed to structure the flow of the class, an instructor's guide and multiple role play scenarios. Other materials include a template for an information paper that can be shared with commanders, a template for a memorandum of instruction that can be used to facilitate the implementation of the program within a unit, and a train the trainer power point presentation.

The intent of Combat Mindsaver is that local unit behavioral health assets participate as trainers and utilize the six-hour course to form a collaborative relationship with the combat mindsavers. Combat mindsavers are viewed both as "first responders" and as direct referral conduits to the unit behavioral health assets. Unit behavioral health assets can leverage their investment in combat mindsavers through continuing to develop the skills through regular meetings in which the combat mindsaver has the opportunity to continue practicing active listening skills and the S.A.F.E.R. model, receive further education about psychological health signs and symptoms, and ask the behavioral health asset about any concerns regarding a fellow service member.

The Combat Mindsaver program is designed to include junior-ranking service members in learning Combat Mindsaver skills with senior-ranking service members. The assumption is that because service members are more likely to spend more time with their peers, they need to learn Combat Mindsaver skills as part of their leadership development, and that service members of lower rank can gain from the "lessons learned" from those of higher rank.

Most recently, the Combat Mindsaver program was used to train the Hawaii Warrior Transition Battalion Cadre.

6. Department of Veterans Affairs (VA) — Peer Support Technician

An employee of the VA, the peer support technician (PST) has been hired because he or she possesses a unique set of skills and life experiences that allows him or her to empathize with and fully support veterans who are dealing with serious mental illness. These individuals serve as models of the recovery process and as counselors and conduits to information and additional community support resources and services. These veteran hires are 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.)

7. 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 health care professionals from the University of Michigan and Michigan State University to train Michigan veterans to help veterans of the war in Afghanistan and war in Iraq adjust to life outside the military community. Anyone can call the Buddy-to-Buddy program to refer a veteran or service member, or service members and veterans themselves can call the program. From family concerns to financial struggles and emotional challenges, trained Buddy-to-Buddy volunteer veterans are available to listen and to help the veterans of the two wars access the community resources and care they need.

This program is not a 24-hour crisis or assistance line, but rather a weekday referral service. Volunteers answer the phones for a few hours a week, and the goal is to provide information on where to seek additional counseling, or to suggest where advice or services can be found to help with financial, educational, legal or employment issues or questions. The advisors strive to respond to all inquiries within 24 hours.

8. New Jersey Law Enforcement — Cop 2 Cop

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

http://www.cop2coponline.com/

The Cop 2 Cop program is a 24-hour confidential crisis intervention hotline service staffed by retired officers who are licensed clinical social workers and specially trained mental health professionals, and volunteer retired officers who are trained as peer supporters. Cop 2 Cop also has volunteer peer supporters who are trained in critical incident stress management (CISM). These teams are trained to

respond to police officers who are having marital problems and difficulty dealing with family; legal, financial or other personal matters; alcohol abuse; and trauma following a shooting or other stressful incident, including shakes, tremors, panic attacks, nightmares, anxiety and depression. Confidentiality is maintained whenever possible unless the officer presents a clear and present danger to himself or herself or others. In the field the program aims to empower officers to watch out for each other and encourage them to question, persuade, refer for assistance and not hesitate to call for help when needed.

9. Non-profit Law Enforcement — Police Organization Providing Peer Assistance (POPPA)

"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/

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. Its mission is to help prevent and reduce incidents of marital problems, substance abuse, suicide and existing psychological disorders among its officers and their families. POPPA tries to maintain a large group of police service organizations 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. Donations are accepted to help keep the program running.

10. Non-profit Military Families — Tragedy Assistance Program for Survivors (TAPS)

"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 was founded in 1994 by Bonnie Carroll after her husband was killed in an Army plane crash. The program's mission is 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. It has established a community chat room on the Internet where people can go to share their feelings anytime. Volunteer peer mentors must complete a training program consisting of an online self-study course followed by a classroom session. The mentors should be beyond the one-year anniversary of their loved one's loss and ready to reach out to others in strength. The program is composed of strong yet informal emotional social support component that consists of someone to listen and empathize as well as a formal advocacy and referral function.

11. 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/

Moe Armstrong, a Vietnam veteran who suffered from mental illness as a result of the war, founded the Vet-to-Vet program. Seeking relief in alcohol and drugs, he eventually became an addict. He understands through first-hand experience 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. Peer supporters are recovering addicts and able to relate to other addicts. The goal is to provide daily classes using accepted mental health resources and materials on how to live with stress, and how to break free from addiction in a safe and supportive environment.

12. 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 nonmedical 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 three days after a particularly difficult event and then again one month later. Should the interview reveal potential problems, the goal is to get immediate additional support for the stressed service member. TRiM aims to remove the stigma attached to post-traumatic stress disorder and have it viewed as a mental injury that can be healed in time if treated appropriately.

13. 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."

http://www.marines.mil/news/messages/Pages/MARADMIN0667-09.aspx (This link leads to a Marine Corps directive laying out the guidelines under which Operational Stress Control Peer Mentors are created and utilized.)

In military terms, the program is developed so that units include embedded mental health professionals, referred to as "OSCAR extenders." They include chaplains, corpsman and religious program specialists who function as technicians and peer mentors and deploy into the theater to boost unit resilience and readiness. They continue to be a part of the unit when they return to garrison. Their goal is to help minimize the impact of stress-related issues for Marines and sailors by catching problems as early as possible and providing the best intervention. It is expected that these changes will be implemented by 2011. Initial training for the OSCAR supporters is supplied by a U.S. Marine Corps headquarters mobile training team working in coordination with mental health providers and leaders. Training for peer personnel participating in this program will range between four and five half-days. The directive is very specific and detailed in laying out the relationships among and between the participants, but does not address how the program has been received to date. To warrant such a wide and deep expansion, it can be concluded that it must have been sufficiently well received.

14. Vets4Vets
http://www.vets4vets.us/

Vets4Vets is an independent non-profit organization founded in 2005 with the goal of establishing a nationwide, free peer support community for Iraq and Afghanistan era veterans. It trains volunteer peer counselors through free weekend workshops. Optionally, this is followed by a (free) weeklong leader training seminar in Tucson, Ariz., leading to certification as a Vets4Vets peer support leader.

From the website:

Mission

Vets4Vets is a non-partisan organization dedicated to helping Iraq- and Afghanistan-era veterans to heal from the psychological injuries of war through the use of peer support.

Vision

Our primary goal is to help Iraq- and Afghanistan-era veterans understand the value of peer support and to regularly use peer support to express their emotions, manage their challenges and ease their reintegration into society. Our vision is that anytime a veteran needs to talk with someone who really understands, a local Vets4Vets peer support group is available at no cost. We envision Vets4Vets being a common name in the minds of all veterans as a place where they, and their comrades, can go to heal.

We Believe

Sharing personal experiences with those who have shared similar experiences is a powerful healing tool. Peer support does not require professionals. Peer support can take place in many formats including weekend workshops, one-on-one and in small or large groups. By taking equal and uninterrupted turns we benefit by both listening and speaking. By expressing the feelings associated with our experiences, we help each other heal. In providing an environment that is confidential, safe, and accepting. Taking part in positive community action, of their choosing, empowers veterans to further promote healing and reach out to other veterans.

15. Vet-2-Vet NJ

http://nj.gov/military/publications/guardlife/volume34no4/22.html

Vet-2-Vet program New Jersey was founded in 2005, primarily as a telephone hotline counseling service for veterans. The hotline (1-866-VETS-NJ-4) is available 24 hours a day, 7 days a week, and the telephone counselors are veterans who have experienced a range of problems and challenges, including combat wounds. The program has expanded to include some counseling services
within the state of New Jersey, and also to train combat veterans to serve as volunteer peer counselors "since they can best understand the strains that veterans feel upon returning home."

From the UMDNJ Website:

The University of Medicine and Dentistry of New Jersey (UMDNJ) has partnered with the State's Department of Military and Veterans Affairs (DMAVA) to create the Vet-2-Vet program, which managed 3,200 cases in 2009. The program is only funded by the programs on a yearly basis.

University Behavioral Health Care at UMDNJ – in partnership with the New Jersey Department of Military and Veterans Affairs – launched Vet-2-Vet, a toll-free confidential helpline designed as an early intervention for veterans suffering from psychological or emotional distress and in need of help assimilating back into civilian life. Today, a veteran in this country is twice as likely to commit suicide as someone who has never served, and on average, one returning veteran commits suicide each day. Since the launch of Vet-2-Vet, no National Guard member from New Jersey is known to have taken this drastic step.

Vet-2-Vet employs combat veterans as peer counselors whose experience uniquely qualifies them to understand the rigors of combat and challenges of returning home. Another distinctive feature of the helpline is that it is also available to family members of military veterans. Last year alone, Vet-2-Vet of the helpline is that it is also available to family members of military veterans. Last year alone, Vet- 2-Vet managed more than 3,200 calls. Most callers served in Iraq or Afghanistan and are troubled by anxiety, depression, aggression, post-traumatic stress disorder, suicidal thoughts or simply the

challenges of reintegrating into civilian life.

http://www.umdnj.edu/cgibin/cgiwrap/hpappweb/newsroom.cgi?headline=UMDNJ+Experts+Available+to+Discuss+Lifesaving+V eterans'+Helpline+

The New Jersey Vet-2-Vet program does not appear to have its own website. It is unclear from available materials how telephone counselors are selected, or what special training they may receive.