

Development of guidelines on peer support using the Delphi methodology

Final report

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This report has been prepared by Dr Tracey Varker and Professor Mark Creamer. The Peer Support Project was designed by Mark Creamer, Neil Greenberg, Jonathon Bisson, Don Richardson, Gill Moreton, David Forbes, Meaghan O'Donnell, Patricia Watson, Joe Ruzek, Winnie Lau, Tracey Varker, and Kathy Darte.

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Enquiries

Further information concerning this report is available from:

Dr Tracey Varker
Research Fellow
Phoenix Australia - Centre for Posttraumatic Mental Health
Phone: 03 9936 5123
Fax: 03 9936 5199
Email: tvarker@unimelb.edu.au

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Executive summary

The Peer Support Project aimed to achieve an international consensus of expert opinion on a range of issues in peer support. These peer support guidelines were developed using the Delphi methodology, which recognises the value of experts' opinions, experience and intuition when full scientific knowledge is lacking (Linstone & Turoff, 1975). The participants partook in three rounds of an online survey to explore levels of agreement in regards to statements describing major domains of peer support. The aim was to achieve consensus on basic questions pertaining to peer support upon which future research can be built. This study aims to inform the practice of peer support internationally on the basis of the best available advice from experts and practitioners in the field.

Methodology

Ninety-two participants, who were experts and practitioners, were involved in the study. Their roles included: peer supporter, peer support coordinator, academic/researcher, trainer/educator, manager/administrator, policy maker and clinician.

A literature search was conducted to generate possible statements that the participants could consider, and a survey was developed covering these statements. A Delphi process was then undertaken, in which experts participants attempted to reach consensus about these statements.

The statements were grouped into four categories: (1) the definition, goals and principles of peer support; (2) training, personnel and supervision in peer support; (3) peer support models and the delivery of peer support; and (4) the evaluation and effectiveness of peer support. Participants were presented with the set of statements across three rounds, and they were asked to rate their level of agreement or disagreement with each statement.

Results

Seventy-three statements were generated for Round One, and 41 (56%) of these statements achieved good consensus in Round One. In Round Two, participants rated 32 statements and, of these, 14 (44%) reached good consensus. In Round Three participants rated 16 statements and good consensus was reached for eight (50%) of these. In all 62 statements out of the 77 statements that were considered by the participants were deemed to have reached consensus. The statements that reached consensus, and those that failed to reach consensus, are presented at the end of this executive summary.

Key recommendations

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

1. The Goals of peer support

Peer supporters should: (a) provide an empathetic, listening ear; (b) provide low level psychological intervention; (c) identify colleagues who may be at risk to themselves or others; and (d) facilitate pathways to professional help.

2. Selection of peer supporters

In order to become a peer supporter, the individual should: (a) be a member of the target population; (b) be someone with considerable experience within the field of work of the target population; (c) be respected by his/her peers (colleagues); and (d) undergo an application and selection process prior to appointment which should include interview by a suitably constituted panel.

3. Training and accreditation

Peer supporters should: (a) be trained in basic skills to fulfil their role (such as listening skills, psychological first aid, information about referral options); (b) meet specific standards in that training before commencing their role; and (c) participate in on-going training, supervision, review, and accreditation.

4. Mental health professionals

Mental health professionals should: (a) occupy the position of clinical director; and (b) be involved in supervision and training.

5. Role

Peer supporters should: (a) not limit their activities to high risk incidents but, rather, should also be part of routine employee health and welfare; (b) not generally see “clients” on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases; and (c) maintain confidentiality (except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others).

6. Access to peer supporters

Peer supporters should normally be offered as the initial point of contact after exposure to a

high risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters.

7. Looking after peer supporters

In recognition of the potential demands of the work, peer supporters should: (a) not be available on call 24 hours per day; (b) be easily able to access care for themselves from a mental health practitioner if required; (c) be easily able to access expert advice from a clinician; and (d) engage in regular peer supervision within the program.

8. Program evaluation

Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation.

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

Consensus and non-consensus statements

Statements that reached consensus as guidelines for peer support are listed in Appendix 1.

Background

The Peer Support Project, utilising the Delphi method aimed to achieve an international consensus of expert opinion on a range of issues in peer support. Peer support programs have been emerging as standard practice for supporting staff in high risk agencies such as the emergency services, military, and mental health where exposure to potentially traumatic events is high relative to the general population (Levenson, 2003). Despite their increasing popularity and implementation across a range of high risk services, there is currently no evidence base for the effectiveness of these programs. Moreover, little consensus exists around the most basic concepts and issues surrounding peer support such as how it is defined, its goals, how peer support programs should be implemented, and how effective they are on a range of outcomes.

The published literature mostly comprises descriptive studies, often with small samples and cross-sectional designs, or longitudinal designs without comparison groups (Campbell, 2005; Solomon, 2004). A recent review of police peer support programs concluded that more evidence is needed on the effectiveness of peer support programs that research is needed to specifically examine the effectiveness of programs that utilise trained peers in partnership with professionally mental health practitioners (Grauwiler, Barocas, & Mills, 2008). One reason for the paucity of rigour is that traditional randomised clinical trial (RCT) methodologies, widely considered to be the gold-standard in determining effectiveness, can be difficult to implement in 'real-world' peer-services, which are consumer driven and voluntary (Resnick & Rosenheck, 2008). The use of random assignment to condition limits the availability of an intervention, and for peer services built on a philosophy of inclusion, randomisation may fundamentally alter the peer service under investigation (Resnick & Rosenheck, 2008).

Though past research findings are limited due to the lack of rigour in their methodologies, significant gains have been described by participants of groups offering peer support in areas of: self-esteem, better decision-making skills, improved social functioning, decreased psychiatric symptoms (i.e. decreased rates or lengths of hospitalisation), lower rates of isolation, larger social networks, increased support seeking, and greater pursuit of educational goals and employment (Davidson et al., 1999; Froland, Brodsky, Olson, & Stewart, 2000; Humphreys & Rappaport, 1994).

A recent quasi-experimental study compared the effectiveness of the 'Vet-to-Vet' program, a peer education and support program, and standard care without peer support, on measures of recovery orientation, confidence and empowerment (Resnick & Rosenheck, 2008). It was found that those who received peer-support scored more highly on measures of empowerment and confidence, and overall functioning.

Despite the lack of direct evidence relating to peer support programs, there is an emerging body of evidence which shows that boosting and protecting social support can increase an individual's capacity to deal with a potentially traumatic event (Norris & Stevens, 2007). As such, peer support represents one attempt to operationalise social support within organisational structures.

Using a well-established method of enquiry that canvases opinions of experts in a particular field (the Delphi method; Linstone & Turoff, 1975), this study surveyed an international group of experts and peer support practitioners to ascertain consensus on various aspects of peer support. These people participated in three rounds of an online survey to explore levels of agreement on statements describing major domains of peer support. The aim was to achieve consensus on basic issues pertaining to peer support upon which future research can be built. Until an evidence base is developed, this study aims to inform the practice of peer support internationally on the basis of the best available advice from experts and practitioners in the field.

Method

The Delphi process

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

This project had two phases: (1) a literature search to derive a range of statements that the participants could consider and the subsequent development of a questionnaire covering these statements; and (2) the Delphi process itself in which expert participants attempted to reach consensus about these statements.

Literature search

The aim of the literature search was to generate statements related to peer support for the expert participant group to consider. The focus of the search was to locate statements pertaining to aspects of peer support. Broadly, the statements fell into four domains: (1) the definition, goals and principles of peer support; (2) training, personnel and supervision in peer support; (3) peer support models and the delivery of peer support; and (4) the evaluation and effectiveness of peer support.

PubMed and PsychInfo were used to search the literature. This was not a systematic review, and no judgment was made about the quality of the evidence or the methods. The literature was used solely to identify key questions, common practices and intended outcomes.

The search term 'peer*support' was used, and all records for the 20 years leading to the search date were reviewed. Papers were read if they described models of peer support, effectiveness and evaluations of peer support, or if they defined peer support itself or the goals or principles of peer support. Literature meeting our criteria was used to develop 73 statements.

Statement and questionnaire development

The questionnaire was developed by first grouping statements into four categories: (1) the definition, goals and principles of peer support; (2) training, personnel and supervision in

peer support; (3) peer support models and the delivery of peer support; and (4) the evaluation and effectiveness of peer support. In all, 73 statements were generated for Round One. These statements were developed in consultation with the working group. A full list of statements for each of the three rounds is available from the author on request.

A working group comprising the authors of this paper convened at each stage to discuss each statement in the questionnaire. (A core group of Professors Mark Creamer, David Forbes, Meaghan O'Donnell and Dr Tracey Varker met in person; the remainder through email discussion). The role of the working group was to ensure that the questionnaire did not include statements that contained more than one idea, repetition, ambiguity or other problems that may have impeded comprehension. The working group made no judgements about the value of the statements, since that was the role of the expert participants.

All participants answered the questionnaire via the internet, using the online survey tool Survey Monkey (www.surveymonkey.com/).

Participants were asked to indicate the level to which they agreed or disagreed with each statement using a nine-point scale where five was neutral. Participants were also given the opportunity to provide comments for each statement. An example is shown in Figure 1.

Qu 12. A main goal of peer support is to provide an empathic, listening ear								
<input type="radio"/> 1 Completely disagree	<input type="radio"/> 2	<input checked="" type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5 Neither	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9 Completely agree
Comments:								

Figure 1. Example of a statement in Round One.

Ratings between 1 and 3, 4 and 6, and 7 and 9 were considered as 'disagreement', 'neutrality', and 'agreement' respectively. A statement was considered to have achieved consensus when 70% or more of participants scored the statement in the same direction (i.e., disagree, neutral or agree; (Bisson et al., 2010)

The Round Two survey comprised those statements that failed to reach consensus in Round One. Two Round One statements were deleted for Round Two due to overlap with other statements and two new statements were created based on feedback from Round One.

In all, participants were asked to rate 32 statements in Round Two. For each statement, participants were provided with summary statistics indicating the percentage of participants who had agreed, disagreed or were neutral in relation to that statement in Round One.

Participants were provided with an Excel spreadsheet containing a de-identified list of all participants' responses (with their own responses highlighted to ensure easy reading), as well as the mean score, standard deviation, and mode score for each statement. Participants were also provided with a list of all of the comments made by fellow participants about each of the statements. As such, participants were able to reconsider their responses in light of the comments and ratings provided by the other participants.

The Round Three survey consisted of 16 statements. Four Round Two statements were deleted (due to overlap or redundancy) and two new statements were created. Participants were provided with the same information as in Round Two (i.e., summary statistics, fellow participant comments, and a list of all statements including those that had already reached consensus).

Participant recruitment

The Delphi method of enquiry relies on experts in the field to give their opinions about a certain area of expertise. Potential participants were identified and selected in a number of ways.

First, the international stakeholder/author group provided consultation and advice about experts and peer support practitioners to be invited. Second, experts were identified by their profiles and reputation in the field of trauma and peer support (e.g., through published literature, presentation profiles, etc.). Third, key personnel from peer support programs of high risk organizations were invited to participate. A snowballing approach was employed across all three methods whereby identified participants were also asked to nominate other contacts.

Criteria were applied to determine eligibility for inclusion as a participant rater in this study. These included one or more of: a publication record in the area; a national/international profile in the area of trauma and/or peer support; significant clinical/practical experience in the field of trauma and/or peer support provision. A few nominated invitees excluded themselves from acting as a rater, due to them feeling that they did not have adequate experience or expertise, or due to the fact that they had too many other commitments.

The final group of 92 participant raters included:

- a. Peer supporters
- b. Peer support coordinators
- c. Academics/Researchers
- d. Trainers/Educators
- e. Managers/Administrators
- f. Policy makers
- g. Clinicians

Participants were recruited from a variety of settings, such as: police, fire and ambulance services; military services; the journalism sector; international and humanitarian aid organisations; health and mental health services; state emergency services; and the tertiary education sector (i.e., the academics/researchers).

Analysis

The Survey Monkey software was used to generate basic statistics. SPSS version 17 for Windows was used to determine statements that reached consensus. The comments were summarised to identify any themes that emerged in order to inform the following round and interpretation of the final results.

Results

Round One

One hundred and twenty-three potential participants were invited to take part in the first round and of these, 92 responded (75%). The characteristics associated with this group are shown below in Table 1.

Table 1. Participant characteristics

Characteristic	n	%
Gender (m:f)		
Male	56	61
Female	36	39
Age		
31-40 years	16	17
41-50 years	34	37
51-60 years	31	34
61+ years	11	12
Country/region of work		
Asia	0	0
Australia/New Zealand	33	36
Europe	18	20
UK	15	16
USA	14	15
Canada	9	10
Other (all reported this as 'Middle East')	3	3
Perspective		
A peer support program within an existing organisation	82	90
A peer support program external to a specific organisation for people who have experienced certain types of events	9	10
Profession*		
Mental health professional	61	66
Emergency services worker	21	23
Defence force personnel	7	8
Military veteran	6	7
Other (included researcher, nurse, humanitarian aid worker, social worker, air traffic controller, GP, human resources)	14	15

Roles or activities in peer support*		
Peer supporter	31	34
Peer support coordinator	36	39
Academic/researcher	40	44
Trainer/educator	57	62
Manager / administrator	33	36
Policy maker	27	29
Clinician	44	48
Main role or activity in peer support		
Peer supporter	10	11
Peer support coordinator	16	17
Academic/researcher	19	21
Trainer/educator	21	23
Manager / administrator	9	10
Policy maker	5	5
Clinician	10	11
Years involved in peer support		
< 2 years	5	5
2-5 years	15	16
5-10 years	28	30
10-20 years	24	26
>20 years	17	19
Population that the participant works mostly with*		
Paramedics / ambulance officers	30	33
Trauma clients (e.g., MVA survivors, ex-police officers)	13	14
Military officers	18	20
Veterans	14	15
Police officers	34	37
Fire-fighters	22	24
Health / mental health professionals	30	33
Journalists	4	4
Other (included State Emergency Services, correctional officers, air traffic controllers, council staff, international aid organisations, security officers, welfare and legal services)	20	22

*Participants could select as many categories as applied for this statement

Forty-one (56%) of the original 73 statements achieved good consensus in Round One and two new statements were formulated from respondents suggestions. Twenty-two (30%) statements were amended slightly to clarify their meaning as a result of the comments.

Round Two

The Round Two survey was sent to the 92 Round One respondents and 81 (90%) completed it. Participants were told that if they did not wish to re-rate statements in Round Two, then their Round One scores would be used. Round One responses were used for 11 participants who did not re-rate statements in Round Two.

Participants were asked to rate 32 statements in Round Two and, of these, 14 (44%) statements reached good consensus.

Round Three

The Round Three survey was sent to the 92 initial respondents and 82 (91%) completed it. Once again, Round One scores were imputed for those participants who did not re-rate the statements in Round Three. Participants were asked to rate 16 statements in Round Three, and good consensus was reached for 8 (50%) of these. This meant that 62 of the total 77 statements considered were deemed to have reached consensus.

Consensus statements

In this section, the final versions of those statements that reached consensus are presented, along with the percentage of people that agreed, disagreed, or were neutral with respect to the statement. (The numbers refer to that statement's position in the original survey). In addition, the participant comments pertaining to each statement have been categorised and summarised. At the end of each section, the non-consensus statements are detailed.

Section 1: About the definitions, goals and principles of peer support

Statements in the following section all relate to the definitions, goals and principles of peer support.

Note: The statements that appear in **dark blue** boxes reached consensus in the form of agreement. Statements that appear in **light blue** boxes reached consensus in the form of disagreement.

2) A main goal of peer support is to provide an empathic, listening ear (AGREE)

Statement 2 reached consensus in Round One, with agreement from 83% of participants (4% of participants disagreed and 13% were neutral). Two participants took issue with the use of the word 'main', believing that this is not a main goal, and another two noted that this is but one of many goals.

3) A main goal of peer support is to provide low level psychological intervention (e.g., advice in self-care, where to get further help) (AGREE)

Statement 3 reached consensus in Round One, with agreement from 88% of participants (2% disagreed and 10% were neutral). One participant questioned the use of the term 'low level' and 'advise', one disagreed with the term 'psychological', one noted that this is not the main aim, and two suggested that information should be based on the recipients' experience.

4) A main goal of peer support is to provide ongoing formal interventions (e.g., cognitive behavioural therapy, pharmacotherapy, prolonged exposure) (DISAGREE)

Statement 4 reached consensus in Round One, with disagreement from 88% of participants (1% agreed and 11% were neutral). Seven participants made comments relating to the fact that this type of intervention is inappropriate for peers, for example '*I do not feel that this is the role of a peer supporter. If more formal intervention is required, this needs to be referred onto someone else.*' Two participants noted that psychological first aid was a more appropriate intervention to be used by peers, and four participants stated that peers should provide referrals to mental health professionals.

5) A main goal of peer support is to advocate for peers in disputes with management/colleagues (DISAGREE)

Statement 5 reached consensus in Round Two, with disagreement from 85% of participants (3% disagreed and 12% were neutral). All of the comments associated with this statement reinforced the participants' disagreement.

**6) A main goal of peer support is to identify peers who may be at risk to themselves or others
(AGREE)**

Statement 6 reached consensus in Round One, with agreement from 71% of participants (6% disagreed and 23% were neutral). Four participants stated that this is not a main goal of peer support, one said this is the role of the program manager/ mental health professional, and one said that this is the role of the employer.

**7) A main goal of peer support is to facilitate pathways to professional help
(AGREE)**

Statement 7 reached consensus in Round One, with agreement from 88% of participants (0% disagreed and 12% were neutral). Two participants said that this is only one aspect of peer support and three stated that this should only be done if appropriate.

**11) A main goal of peer support is to treat mild psychiatric conditions
(DISAGREE)**

Statement 11 reached consensus in Round One, with disagreement from 79% of participants (3% agreed and 18% were neutral). Comments related mainly to the meaning of the word "treatment", such as 'One might quibble here as to what is meant by "mild" and "psychiatric"; 'I think best not to describe as "treatment" of "psychiatric conditions"; 'prevent or ameliorate rather than treat; and 'this is beyond the training of peers'.

**12) The goals of peer support do not relate solely to recovery from a traumatic or highly stressful incident, but relate to psychological and physical health and wellbeing more broadly
(AGREE)**

Statement 12 reached consensus in Round One, with agreement from 78% of participants (9% disagreed and 13% were neutral). Eight participants reiterated their agreement with the statement; one participant stated 'programs can embrace broader goals, but some do not and still function well', while another said 'for it to work there has to be a clear scope of practice'.

Consensus was not reached on the following statements in this section

8) A secondary goal of peer support is to encourage treatment adherence (i.e., to continue with mental health treatment where relevant) (NON-CONSENSUS)

Statement 8 failed to reach consensus after Round Three (47% of participants agreed, 33% disagreed and 20% were neutral). Originally, wording of this statement was, 'A main goal of peer support...'. Changing the wording to 'A secondary goal...' improved agreement, but consensus was still not achieved.

The main point of contention seemed to be the role of the Peer Supporter. Those who agreed with this statement made comments such as, '*part of peer support is supporting and encouraging recovery*' and '*If a main goal of peer support is to facilitate pathways to professional help (treatment) then it seems this is the next step to help with 'sticking with' the treatment plan where relevant*'.

Those who disagreed with this statement made comments such as '*I do not believe that peers should champion a treatment...If we accept that one of the primary peer support goals is empathic listening, actively promoting a single point of view is contrary*' and '*Peer support is a proactive and reactive response to PTEs i.e. mitigate the effects psychological trauma, secondary role is to promote psychological wellbeing - adherence to treatment is a clinical issue*'.

9) Peer support is designed to promote job performance and increase organisational efficiency (NON-CONSENSUS)

Statement 9 failed to reach consensus after Round Three, although there was a trend towards disagreement (61% of participants disagreed, 18% agreed and 21% were neutral). Those who disagreed made comments such as '*Peer Support isn't 'designed' to promote job performance and increase organisational efficiency but by assisting our employees to feel supported, educated about stress awareness and appreciated by the organisation this may be a side benefit to a minor degree*' and '*I agree that good peer support will enhance unit cohesion and restore individual and unit performance. I draw the line on increasing organizational efficiency. That is generally beyond the scope of peer support. It may be a by-product of a good peer support program, but increasing organizational efficiency should not be the responsibility of a peer support program. That is a management and leadership issue.*

**10) A main goal of peer support is to reduce the likelihood of psychiatric disorder
(NON-CONSENSUS)**

Statement 10 failed to reach consensus after Round Three (38% disagreed, 25% were neutral and 38% agreed). Some of the comments made in relation to this statement included, *'The intention here is that 'signposting' would facilitate early help seeking and thus minimise the impact of adverse psychological reactions through early intervention, practical and emotional support. So if this was a clear goal rather than the likelihood of a 'psychiatric disorder', that would be a better goal' and 'We hope to identify people that are having issues early and get them linked in with a psychologist earlier rather than later. I therefore believe that preventing psychiatric disorder must be one of our goals'.*

Section 2: About the training, personnel and supervision in peer support

Statements in this section all relate to training, personnel and supervision in peer support.

**14) *The peer supporter must be a member of the target population (e.g., a paramedic for paramedic peer support programs, a veteran for veteran peer support programs)*
(AGREE)**

Statement 14 reached consensus in Round One, with agreement from 78% of participants (11% disagreed and 11% were neutral). Three participants disagreed with the use of the word “must” (preferring a word such as “shall”), four participants stated that the peer must be part of the same organisation, while nine participants said that it is not necessary for the peer to be a member of the target population.

**15) *The peer supporter must be someone with considerable experience within the field of work of the target population*
(AGREE)**

Statement 15 reached consensus in Round Two, with agreement from 79% of participants (9% disagreed and 12% were neutral). In Round One, the number of years of experience required was specified (i.e., three or more years’ experience). Based on the feedback in Round One, however, a more general statement about the amount of experience required was developed. In regards to the Round Two feedback for this statement, one participant said that this ‘*depends on the target population*’, while another said ‘*while I agree with this statement in broad terms, it should not be so restrictive that in the absence of such a person no support should be offered*’.

**16) *The peer supporter must be respected by his/her “peers”*
(AGREE)**

Statement 16 reached consensus in Round One, with agreement from 92% of participants (0% disagreed and 8% were neutral). Three participants said that this is not necessary (e.g. ‘*It would be helpful but I don’t think it is a prerequisite*’), one participant said respect could be developed within the role, and one participant said it should ‘*be aimed for, though in large organisations it’s not likely that everyone will respect all peers*’. In contrast, three participants made the following comments: ‘*If not respected, he or she is not a peer*’; ‘*Trust and respect are essential particularly in the military*’; and ‘*If you don’t have credibility you are behind the eight ball. A stranger is better than someone you know and don’t like*’.

17) *The peer supporter should undergo an application and selection process before being appointed*
(AGREE)

Statement 17 reached consensus in Round One, with agreement from 87% of participants (3% disagreed and 10% were neutral). Five participants expressed their agreement with this statement, two participants said that a nomination or volunteer process should be used in some instances, one person noted that *'those who volunteer do not always represent the best candidates for providing support'*, while another noted [this is] *'very important but still doesn't always filter out inappropriate applicants'*.

18) *Anyone in the target group should be able to apply to be a peer supporter, regardless of rank or position in the organisation*
(AGREE)

Statement 18 reached consensus in Round One, with agreement from 78% of participants (12% disagreed and 10% were neutral). Five participants said that this depends on the organisation/setting, two participants said that those of high rank or with a supervisory role may impact the effectiveness of peer support, while two participants said that peer support should be provided to those of a similar rank, but not to lower rank personnel. Two participants said that ranks or levels are irrelevant, while one participant said that *'roles need to be clearly defined'*.

19) *Where possible, the peer supporter should be approved by members of the target group as part of the selection process*
(AGREE)

Statement 19 reached consensus in Round Three, with agreement from 77% of the participants (5% disagreed and 18% were neutral). The wording of this statement was modified based upon participant feedback. The words 'where possible' were added to acknowledge that this is not always possible. In addition, rather than the statement saying 'peer supporters should be nominated by members of the target group...', the wording was changed to 'the peer supporter should be approved by members of the target group. Two participants noted that supervisors/managers should also be involved in selection, two participants thought that this is unnecessary, and four participants reiterated their agreed with the statement.

**20) The selection process should include an interview by a suitably constituted panel
(AGREE)**

Statement 20 reached consensus in Round One, with agreement from 73% of participants (10% disagreed and 17% were neutral). Two participants said that this depends on the context and nature of the role, one person said *'If part of a formal training and certification process, I believe this would be reasonable; if not, I would be uncomfortable with this process'*. Two participants said the panel should comprise two or three persons who have a knowledge and understanding of the role of the PSO.

**21) There should be no selection process for peer supporters; anyone who wants to train as a peer supporter should be able to do so
(DISAGREE)**

Statement 21 reached consensus in Round One, with disagreement from 77% of participants (7% agreed and 16% were neutral). Three participants expressed disagreement with the statement and two participants said that it depends on the type of program. Four participants said that anyone should be able to “train” or be involved in informal peer support, but that selection is essential to be a formal peer supporter. Two participants stated that this would be a potentially dangerous/harmful situation.

**22) Peer supporters do not require any specific training to fulfil their role
(DISAGREE)**

Statement 22 reached consensus in Round One, with disagreement from 94% of participants (3% agreed and 3% were neutral). One person commented that *'some are good at it naturally'*, while eight participants reiterated the notion that formal training is required.

**23) Peer supporters should be trained in simple psychological techniques such as listening skills
(AGREE)**

Statement 23 reached consensus in Round One, with agreement from 91% of participants (3% disagreed and 6% were neutral). One person said *'In truth, it depends on training needs of peers'*, and another person said *'Do not make them second class counsellors. Use their personal authority primarily'*. Three participants reinforced their agreement with this statement.

24) Peer supporters should be trained in more advanced skills such as psychological first aid, mental health first aid, crisis intervention and general counselling (AGREE)

Statement 24 reached consensus in Round One, with agreement from 71% of participants (9% disagreed and 20% were neutral). Five participants said that this depends on the role of the peer and the nature of the program, nine participants disagreed that peers should be trained in general counselling, four participants said that only basic knowledge in the abovementioned skills is required (i.e. not an “advanced” level), and one participant stated ‘*Frequently crisis intervention is over utilised. Psychological First Aid as typically framed is a misnomer that causes more harm than good*’. Eight participants expanded on their agreement with the statement.

25) Peer supporters should be trained in high level mental health intervention skills such as cognitive therapy and prolonged exposure (DISAGREE)

Statement 25 reached consensus in Round One, with disagreement from 90% of participants (0% disagreed and 10% were neutral). Four participants said that peers should be made aware of these interventions (e.g. ‘*They should know enough about these to educate peers about what to expect in therapy and to be able to support compliance*’), two participants said that it may be acceptable to train peers in these skills, while five participants expressed their disagreement for this statement.

26) Peer supporter training should include information about other support services and psychological treatment so supporters can act as a bridge between the "client" and professional support (AGREE)

Statement 26 reached consensus in Round One, with agreement from 92% of participants (0% disagreed and 8% were neutral). Five participants expressed support for this statement.

27) Peer supporters should meet specific standards following training before they can commence in the role (e.g., assessed through role plays, interviews, written tests) (AGREE)

Statement 27 reached consensus in Round One, with agreement from 81% of participants (4% disagreed and 15% were neutral). One participant did not agree with the use of written tests, one participant said that it depends on the formality of the allocation of peer support, one participant said that this is not always feasible but it is a good idea and one participant said '*I have problems in turning them into second class counsellors*'. Four participants expressed agreement with this statement.

**28) Peer supporters should be expected to attend regular supervision and booster training
(AGREE)**

Statement 28 reached consensus in Round Two, with agreement from 94% of participants (0% disagreed and 6% were neutral). One participant stated that this is not always feasible, but is a good idea, while seven participants expressed agreement with this statement.

**29) Ongoing accreditation/certification is recommended for peer supporters
(AGREE)**

Statement 29 reached consensus in Round Three, with agreement from 85% of participants (4% disagreed and 11% were neutral). Originally this statement was worded in the opposite direction and was less compromising (i.e., 'There should be no ongoing accreditation process/certification required for peer supporters'). The wording was changed based upon participant feedback. In the Round Three feedback, thirteen participants reiterated their agreement with this statement, while two participants questioned '*from whom?*' One participant said '*Unfortunately the certification process can become a business of its own where certification becomes more important than the content of the certification*'.

**30) To maintain accreditation, peer supporters should undergo regular review with either a senior peer supporter or mental health professional
(AGREE)**

Statement 30 reached consensus in Round One, with agreement from 72% of participants (7% disagreed and 21% were neutral). Three participants said that this should occur ideally, where feasible, while one person said '*[the] question assumes accreditation is a good idea; it may not be*'. Nine participants expressed agreement with this statement.

**31) To maintain accreditation, peer supporters should achieve competency in regular assessments such as role plays, interviews, or written tests
(AGREE)**

Statement 31 reached consensus in Round Two, with agreement from 74% of participants (6% disagreed and 20% were neutral). The same statement was presented in both Round One and Round Two. In Round Two, one participant said that this should occur '*whenever possible*', and three people disagreed with the use of '*written tests*'.

**32) Peer supporters should discuss every case with a mental health professional, even if it is only a one-off contact
(DISAGREE)**

Statement 32 reached consensus in Round Two, with disagreement from 76% of participants (11% agreed and 13% were neutral). The wording of this statement was changed considerably following the feedback in Round One to provide greater clarity (the original wording was, 'No mental health professional input is required for implementing peer support with a client'). In Round Two, numerous comments were made in regard to this statement, with each participant describing why they disagreed. Reasons for disagreeing included '*too prescriptive*', '*cumbersome*'/ '*impractical*', '*unnecessary*', '*then it is not peer support*' and '*not every case*'.

**33) All peer support programs should have an appropriately qualified mental health professional as clinical director
(AGREE)**

Statement 33 reached consensus in Round Two, with agreement from 72% of participants (10% disagreed and 18% were neutral). The same statement was presented in both Round One and Round Two. In Round Two five participants expressed their disagreement with this statement, while a number of participants said that an appropriate mental health professional should be accessible, but that they do not necessarily have to be the clinical director.

**34) Training in peer support skills should involve appropriately qualified mental health professionals
(AGREE)**

Statement 34 reached consensus in Round Two, with agreement from 91% of participants (4% disagreed and 5% were neutral). Based on the feedback after Round One, the wording of this statement was changed to be more inclusive (i.e. in Round One the statement said 'training... should be conducted only by appropriately qualified...'). In Round Two a number of participants noted that it is important for senior peers to be included also, and one participant said that the wording should be 'could' rather than 'should'.

**35) Supervision for peer supporters should include access to appropriately qualified mental health professionals
(AGREE)**

Statement 35 reached consensus in Round Two, with agreement from 87% of participants (7% disagreed and 6% were neutral). In Round One this statement said, 'Supervision ... should be given only by appropriately qualified...' The wording of this question was changed, to allow supervision to be performed by non-mental health professionals. In Round Two one participant said that '*access just may not be possible*', and another said that supervision may also be '*delivered by a peer who is trained in supervision*'. Several other participants reiterated their agreement with this statement.

**E1) Apart from ongoing support through protracted difficulties (such as family illness, marital breakup, etc.) peer supporters should not see "clients" on an ongoing basis (e.g., more than 3 or 4 contacts)
(AGREE)**

Statement E1 (i.e., Extra statement 1) reached consensus in Round Three, with agreement from 78% of participants (11% disagreed and 11% were neutral). Statement E1 was added following feedback in Round One, where it became clear that it would be beneficial to try and quantify how many contacts with a given "client", are appropriate for a peer supporter. Three participants reiterated their agreement that peers should not have regular clients; one participant thought that this statement is unnecessarily detailed, and four participants thought that this is context specific. One participant thought that referral should be considered after six to eight contacts.

**36) A peer supporter seeing a "client" on an ongoing basis should regularly consult a qualified mental health practitioner for clinical support and advice
(AGREE)**

Statement 36 reached consensus in Round Two, with agreement from 83% of participants (8% disagreed and 9% were neutral). The wording for this statement in Round One was: 'An appropriately qualified mental health practitioner should be consulted throughout the peer support process with any on-going "client" (e.g., for regular review of mental state)'. The wording was changed in Round Two to clarify the intent of the question. In Round Two one participant said '*it depends on the issues at hand not length of involvement*'; while two participants said that this is case dependant. One participant said '*peers should not have clients that they see on an ongoing basis*', while another said peers '*shouldn't be seeing anyone in the 'therapy' sense though*'.

37) A referral pathway should be in place in every peer support program to allow a direct referral to a mental health professional (AGREE)

Statement 37 reached consensus in Round One, with agreement from 92% of participants (2% disagreed and 6% were neutral). Seven participants expressed agreement with this statement, while two participants noted that peer support issues are not always mental health issues, and one participant noted that *'clients should be able to access the psychologist without having to go via a peer'*.

Note: All statements within this section reached consensus.

Section 3: About the peer support models and the delivery of peer support

All statements in the following section relate to peer support models and the delivery of peer support.

39) *All high risk agencies (e.g., emergency services, military, health service workers etc.) should have a well-planned peer support program for their current employees*
(AGREE)

Statement 39 reached consensus in Round One, with agreement from 89% of participants (6% disagreed and 5% were neutral). Two participants said that it is dependent on the situation and organisation, two people said that there is insufficient evidence to show that peer support works, and two participants said that it should be offered only for ‘at risk’ personnel within the workforce (i.e. those with higher levels of exposure).

40) *All high risk agencies should provide well planned peer support programs for personnel, for a limited time, once employment with the organisation ceases (e.g., for ex-police officers, military veterans)*
(AGREE)

Statement 40 reached consensus in Round Two, with agreement from 78% of participants (4% disagreed and 18% were neutral). In Round One the words ‘for a limited time’ were absent. Based on the feedback from Round One these words were added. In Round Two a variety of comments were made in response to this statement. One participant said ‘*limited time needs to be considered carefully*’, while another said ‘*duty of care ceases in law once they are no longer employers*’, while yet another said ‘*this could depend on industrial issues*’. Two participants said that the applicability would vary with the organisation and the setting, while one said that there is ‘*not enough evidence yet*’, and yet another said ‘*necessary but difficult in practice*’.

41) *Peer support programs should be carefully integrated with other support services to employees such as employee assistance programs*
(AGREE)

Statement 41 reached consensus in Round One, with agreement from 80% of participants (6% disagreed and 14% were neutral). Five participants expressed their agreement with the statement, while two participants said that it depends on what is meant by “carefully integrated”. One participant said that peer support should be kept separate to an EAP program, while one participant noted ‘*Not in the media profession. The EAP is immediately*

associated with HR, where there is significant distrust and even disdain. The peer support program has developed its own referral data base of available local therapists. The peer supporters will see the EAP for supervision, but the WILL NOT refer their peers to them'.

**42) Peer support programs need to be tailored to the needs of the particular high risk target group
(AGREE)**

Statement 42 reached consensus in Round One, with agreement from 92% of participants (1% disagreed and 7% were neutral). All comments for this statement reinforced agreement.

**43) The use of spontaneous or informal peer support during the course of a day's work is an important aspect of peer support programs
(AGREE)**

Statement 43 reached consensus in Round One, with agreement from 80% of participants (7% disagreed and 13% were neutral). Two participants expanded on their disagreement, with one commenting that *'“informal” should be avoided as it blurs boundaries'*, while the other said *'I believe peer programs should be well documented, arranged, coordinated etc, not ad hoc'*. Thirteen participants reinforced their agreement with this statement.

**44) Confidentiality should be maintained at all times through the peer support process, with the exception of clinical supervision within the peer support program or in the case of threat to self or others
(AGREE)**

Statement 44 reached consensus in Round One, with agreement from 96% of participants (1% disagreed and 3% were neutral). One participant noted that police services have other exceptions and requirements for reporting, while another noted that there can be legal requirements to disclose.

**45) Consideration should be given to how a peer support scheme fits with formal investigation processes and/or post-operational reviews conducted by the agency
(AGREE)**

Statement 45 reached consensus in Round One, with agreement from 89% of participants (3% disagreed and 8% were neutral). Six participants said that this should be considered and specified, but should be kept completely separate.

**46) Peer supporters should be offered support for themselves
(AGREE)**

Statement 46 reached consensus in Round One, with agreement from 97% of participants (0% disagreed and 3% were neutral). One participant said '*under some circumstances*', while another said '*not sure what this means- not well described*', the rest of the participant comments reinforced agreement with this statement.

**47) Peer supporters should be able to easily access advice from an appropriately trained mental health professional when required
(AGREE)**

Statement 47 reached consensus in Round One, with agreement from 100% of participants.

**48) Peer supporters should engage in regular peer supervision with colleagues
(AGREE)**

Statement 48 reached consensus in Round One, with agreement from 89% of participants. All comments in relation to this statement were supportive.

**49) Peer supporters should have regular supervision, either by a senior peer supporter or a mental health professional
(AGREE)**

Statement 49 reached consensus in Round One, with agreement from 86% of participants (2% disagreed and 12% were neutral). Two participants said that this should occur only with senior colleagues trained to do so, and two participants said peer supporters should engage in regular group meetings.

**51) Peer supporters should have access to appropriate professional development activities funded by the program
(AGREE)**

Statement 51 reached consensus in Round One, with agreement from 96% of participants (0% disagreed and 4% were neutral). Three participants said that this should happen where possible, while another four participants expressed support for this statement.

**52) Every peer supporter should be available on call 24 hours per day
(DISAGREE)**

Statement 52 reached consensus in Round One, with disagreement from 81% of participants (10% agreed and 9% were neutral). Three participants said that this depends on the organisational need and the context, three participants expressed their agreement, and twelve participants expressed their disagreement for this statement.

**55) Employees requesting peer support should be able to self-select their peer supporter from a pool of peer supporters
(AGREE)**

Statement 55 reached consensus in Round Two, with agreement from 78% of participants (8% disagreed and 14% were neutral). In Round One the wording for this statement was 'Individual members of the target group should be able to self-select...'. The wording was changed for this statement based on Round One feedback. In Round Two five participants said that this should occur wherever feasible, one person said they disagreed with this statement due to the term 'employee' (i.e., *'We have many volunteers and rescue personnel who are members of their organisations but not employees. The word 'employee' makes me vote negative'*), and one participant said *'this risks the 'good' PSOs being overworked. There needs to be some ability to allocate a PSO to staff according to workload'*.

**58) A peer supporter rather than a health professional should be offered as the initial point of contact after exposure to a high risk incident unless the member requests otherwise
(AGREE)**

Statement 58 reached consensus in Round Two, with agreement from 72% of participants (11% disagreed and 17% were neutral). In Round One the wording for this statement was 'In emergency service organisations, a peer supporter rather than a health professional should be offered as the initial point of contact after exposure to a high risk incident unless the member requests otherwise'. The wording was changed based on participant feedback, to be more inclusive. In Round Two, two participants said that access to both should be offered; two participants said that in some cases a mental health professional is the most appropriate first contact, while three participants said it depends on the circumstances.

Consensus was not reached on the following statements in this section

**50) Peer supporters should be paid for being peer supporters
(NON-CONSENSUS)**

Statement 50 failed to reach consensus after Round Two (i.e., 48% disagreed, 34% were neutral and 18% agreed). Originally, the wording of this statement was, 'Peer supporters should be paid or otherwise compensated (e.g., extra leave entitlements) for being peer supporters'. Based on feedback from Round One, the statement was divided into two parts (i.e., Statement 50 and Statement E2) so that fewer ideas were presented in each statement. However, consensus was still not reached for Statement 50. The majority of participant comments related to the fact that it depends on the organisation, and upon feasibility.

**E2) Peer supporters should receive non-financial compensation (e.g., extra leave entitlements) for being peer supporters
(NON-CONSENSUS)**

Statement E2 (see comments above regarding Statement 50) failed to reach consensus after Round Two (6% disagreed, 35% were neutral and 49% agreed).

**53) Peer supporters should be available on a roster system so that peer supporters are not on duty at all times
(NON-CONSENSUS)**

Statement 53 failed to reach consensus after Round Three (i.e., 14% disagreed, 17% were neutral and 69% agreed). Based on the Round Two feedback, the original wording of this statement ('Peer supporters should be available on a roster system 24 hours per day') was changed to clarify the intent of the question. Most comments regarding this statement in Round Three were concerned with the feasibility (e.g., '*where realistic*'; '*Not always possible due to resource and industrial issues but totally agree on concept*') while others were still confused by the statement (e.g., '*question is unclear; someone should be available 24 hours per day – not the same person, though*').

**54) Peer supporters should be available only during working hours
(NON-CONSENSUS)**

Statement 54 failed to reach consensus after Round Three (35% disagreed, 20% were neutral and 45% agreed). Based on the Round Two feedback, the original wording of

this statement ('Peer supporters should be available only during working hours) was changed to clarify the intent of the question. Most comments regarding this statement in Round Three either reinforced participant agreement or disagreement, or expressed confusion over the wording (e.g., '*Not sure about the wording of this question. I agree with the first part (available as needed), however I am not sure if I agree with the second part (only during normal hours). I assume this is normal working hours, Seems to contradict the first part (ie as needed but only during normal hours)*') and '*What does 'working hours' mean in a deployed unit? Or even an operational unit in training preparing to deploy? Isn't that 24/7? This question assumes peacetime or garrison environment.*')

**57) The personal mobile phone number of each peer supporter should be made available to enable employees to contact any peer supporter whenever they wish
(NON-CONSENSUS)**

Statement 57 failed to reach consensus after Round Three, although there was a trend towards disagreement (i.e., 62% disagreed, 17% were neutral and 21% agreed). Based on the Round Two feedback, the original wording of this statement (i.e., 'The mobile phone number of each peer supporter should be made available to the target group') was changed to clarify the intent of the question. A number of comments regarding this statement in Round Three said that it depends on the situation or it depends on the program, while several participants said that this would be acceptable if the peer supporter consented.

Section 4: About the evaluation and effectiveness of peer support

The following section contains statements related to evaluation and the effectiveness of peer support.

61) *No formal evaluation of peer support programs is required (DISAGREE)*

Statement 61 reached consensus in Round One, with disagreement from 82% of participants (10% agreed and 8% were neutral). One participant agreed, 'No formal evaluation should be required, however there should be some accountability methods such as data/statistical information on usage of the program/trends', while six participants reinforced their disagreement.

62) *All peer support programs should establish clear goals that are linked to specific outcomes prior to commencement, in order to provide a basis for evaluation (AGREE)*

Statement 62 reached consensus in Round One, with agreement from 74% of participants (7% disagreed and 19% were neutral). Two participants said that this would be good in an ideal world, and one person said this depends on the resources of the organisation.

63) *Peer support programs should be evaluated by an external, independent evaluator in consultation with the peer support team (AGREE)*

Statement 63 reached consensus in Round Two, with agreement from 76% of participants (4% disagreed and 20% were neutral). Following feedback from Round One, the words 'in consultation with the peer support team' were added to this statement. In Round Two, two participants said that both internal and external evaluation are necessary, one said that independent enquiry leads to better results, and one participant said independent evaluation is unnecessary. One participant said '*external evaluators may not understand the intricacies of specific demographics, cultures etc.*'.

64) *The evaluation of peer support programs should include qualitative and quantitative feedback from users (AGREE)*

Statement 64 reached consensus in Round One, with agreement from 87% of participants (1% disagreed and 12% were neutral). One participant said that there should be *'qualitative feedback only'*, while another said *'qualitative is more likely to give us a clearer picture of what is happening'*. In regards to confidentiality, one participant said, *'as long as it maintained confidentiality'*, while another said *'is this a challenge with regards to confidentiality and privacy?'*

65) The evaluation of peer support programs should include objective indicators such as absenteeism, sick leave, staff turnover (AGREE)

Statement 65 reached consensus in Round Two, with agreement from 75% of participants (5% disagreed and 20% were neutral). The same wording for this statement was presented in both Round One and Round Two. In Round Two six participants said that other variables/factors should also be measured, two participants questioned how those indicators are the result of a peer support program, and one participant said *'there needs to be empirical evidence that the program is working well'*.

66) The evaluation of peer support programs should include feedback from those using the service (AGREE)

Statement 66 reached consensus in Round One, with agreement from 94% of participants (0% disagreed and 6% were neutral). Three participants noted that confidentiality must be maintained.

68) Indicators of a successful peer support program may include an increase in appropriate referrals for professional assistance (AGREE)

Statement 68 reached consensus in Round Three, with agreement from 81% of participants (8% disagreed and 11% were neutral). The original wording for this statement was 'Peer support programs should be considered successful if they increase referrals for professional assistance'. The wording of this statement was changed based on the Round One feedback. In Round Three, three participants said that this depends, four participants said 'as long as they are appropriate referrals', two participants said that this is one indicator, while one participant said *'sometimes the measure of success is declining rates of assistance due to the effectiveness of peer support, while sometimes it is an increase due to peer supporters raising awareness of the availability of these programs'*. Another participant said *'it may show*

that cases are being picked up, but it may be that peer supporters are also doing more harm than good and making people worse, where they may have been ok if left alone’.

**69) Indicators of a successful peer support program may include increased work performance
(AGREE)**

Statement 69 reached consensus in Round Three, with agreement from 77% of participants (7% disagreed and 16% were neutral). Originally the wording for this statement was ‘Peer support programs should be considered successful if they increase work performance and reduce sick leave and staff turnover’. Based on participant feedback in Round Two, this statement was divided into two separate statements to reduce the number of concepts that were asked about in each statement, and to clarify the intent of the question. In Round Three, two participants noted that this is but one of many indicators, two participants said that it would not be possible to link improved work performance with a peer support program, and two participants said that this is a by-product.

**E3) Indicators of a successful peer support program may include reduced sick leave and staff turnover
(AGREE)**

Statement E3 (see comments regarding Statement 69 above) reached consensus in Round Three, with agreement from 70% of participants (19% disagreed and 11% were neutral). In Round Three, two participants noted that sick leave and turnover can be affected by many factors.

**70) One indicator of a successful peer support program is an improvement in overall staff satisfaction within the organisation
(AGREE)**

Statement 70 reached consensus in Round Two, with agreement from 77% of participants (3% disagreed and 20% were neutral). Originally the wording for this statement was ‘Peer support programs should be considered successful if they improve overall staff satisfaction within the organisation’. Following feedback in Round One, the wording of this statement was changed to be more inclusive. In Round Two eight participants noted that other factors are also involved, and two participants said that staff satisfaction is a management issue, not a peer support issue.

71) Peer support programs should be considered successful if they reduce stigma about psychological (ill) health (AGREE)

Statement 71 reached consensus in Round One, with agreement from 85% of participants (1% disagreed and 14% were neutral). Two participants said that this is not the only goal of peer support; one said that this is difficult to prove, and another said that this takes time. Two participants said that this is not the aim of peer support.

E4) Even if only a minority of people who are distressed at work will use a peer support program, it is still a valid program for high-risk organisations to offer (AGREE)

Statement E4 reached consensus in Round Three, with agreement from 93% of participants (0% disagreed and 7% were neutral). Statement E4) was added to the questionnaire in Round Three, and therefore reached consensus the first time that this statement was considered. One participant said '*the usage frequency does not tell anything about validity or effectiveness of a program*', two participants said that usage may improve over time as 'word' gets out, and two participants said '*you only need to stop one stress claim or suicide for the program to be worthwhile*'.

77) Peer support programs must have clear and explicit protocols around confidentiality that are communicated to the target group (AGREE)

Statement 77 reached consensus in Round One, with agreement from 99% of participants (1% disagreed and 0% were neutral). The one participant that disagreed, said 'No, beware of mandatory aspects'.

78) Peer support programs must have full organisational support and acceptance (AGREE)

Statement 62 reached consensus in Round One, with agreement from 98% of participants (1% disagreed and 1% were neutral). One participant commented that '*it depends on if the program is internal or is an external team or service*', and one participant questioned the use of the word 'full'.

Consensus was not reached on the following statements in this section

67) Regular administration of measures such as simple checklists to monitor progress is recommended where possible (NON-CONSENSUS)

Statement 67 failed to reach consensus after Round Three (23% disagreed, 19% were neutral and 58% agreed). Originally, the wording of this statement was 'It is impractical for peer supporters to administer simple, structured pre, post and follow-up test measures such as symptom checklists to every "client" to whom they provide support'. The wording of this statement was changed to increase clarity. Many participants commented, in Round Three, that this depends on the context.

72) There is good research evidence that peer support programs are effective (NON-CONSENSUS)

Statement 72 failed to reach consensus after Round Two (i.e. 34% disagreed, 27% were neutral and 39% agreed). This item was removed due to the fact that it was obvious that there was no likelihood of reaching consensus. Comments for this item were divided, depending upon the participants' profession. Academics/ researchers were more likely to disagree with this item, while peer supporters were more likely to agree with this item.

74) Most employees will use a peer support program if they are distressed at work (NON-CONSENSUS)

Statement 74 failed to reach consensus after Round Three (i.e. 47% disagreed, 34% were neutral and 19% agreed). The original wording for this item was 'Even the best peer support program will not be used by the majority of employees, even if they are feeling emotionally distressed', but this statement was changed based on participant feedback from Round Two. In Round Three, the majority of participant comments said that it depends on the program.

75) Following a high risk event, all those involved should be contacted by a peer supporter to check that they are ok and offer support (NON-CONSENSUS)

Statement 75 failed to reach consensus after Round Three (i.e. 26% disagreed, 34% were neutral and 62% agreed). The original wording for this item was 'Following a high risk event, all those involved should always be contacted by a peer supporter'. The wording was

changed following feedback in Round Two, to clarify the intent of the question. Comments regarding this item ranged from reiteration of agreement or disagreement with the statement, to declarations that it 'depends'.

Key areas of consensus

This section summarises the key points of consensus with the goal of providing a guideline for organisations wishing to establish peer support programs.

The goals of peer support

Consensus was reached that main goals of peer support are to:

- a. provide an empathic, listening ear
- b. provide low level psychological intervention (e.g., advice in self-care, where to get further help)
- c. identify peers (colleagues) who may be at risk to themselves or others
- d. facilitate pathways to professional help.

Consensus was reached that it is **not** a main goal of peer support to:

- a. provide ongoing formal interventions (e.g., cognitive behavioural therapy, pharmacotherapy, prolonged exposure)
- b. advocate for peers (colleagues) in disputes with management/colleagues.

It was agreed that the goals of peer support do not relate solely to recovery from a traumatic or highly stressful incident, but relate to psychological and physical health and wellbeing more broadly. Indeed, the use of spontaneous or informal peer support during the course of a day's work was considered an important aspect of peer support programs.

In terms of the relationship between peer support and mental health care, agreement was not reached on whether the goals of peer support should include encouraging treatment adherence or reducing the likelihood of psychiatric disorder, although comments indicated that these may be desirable components in many cases.

Selection of peer supporters

It was agreed that the peer supporter:

- a. must be a member of the target population (e.g., a paramedic for paramedic peer support programs, a veteran for veteran peer support programs)
- b. must be someone with considerable experience within the field of work of the target population
- c. must be respected by his/her peers (colleagues)
- d. may be anyone in the target group, regardless of rank or position in the organisation.

In terms of the selection process, it was agreed that:

- a. peer supporters should undergo an application and selection process before being appointed (that is, there should be an identifiable selection process; it should not be assumed that anyone who wants to train as a peer supporter should be able to do so)
- b. the selection process should include an interview by a suitably constituted panel.

Training and accreditation

In terms of training, it was agreed that peer supporters require training to fulfil their role, and that such training should include:

- a. simple psychological techniques such as listening skills
- b. more advanced skills such as psychological first aid, mental health first aid, crisis intervention and general counselling
- c. information about other support services and psychological treatment so that supporters can act as a bridge between the 'client' and professional support
- d. peer supporters should not be trained in high level mental health intervention skills such as cognitive therapy and prolonged exposure.

Peer supporters should meet specific standards following training before they can commence in the role (e.g., assessed through role plays, interviews, or written tests).

It was agreed that, following training, on-going accreditation is recommended and that peer supporters should:

- a. be expected to attend regular supervision and booster training
- b. undergo regular review with either a senior peer supporter or mental health professional
- c. achieve competency in regular assessments such as role plays, interviews or written tests.

The role of mental health professionals

There was general agreement that mental health professionals should be involved in peer support programs:

- a. all peer support programs should have an appropriately qualified mental health professional as clinical director
- b. training in peer support skills should involve appropriately qualified mental health professionals
- c. supervision for peer supporters should include access to appropriately qualified mental health professionals.

‘Client’ contacts: Access and role

It was agreed that employees should be able to self-select their peer supporter from a pool of peer supporters.

There was no consensus about whether, following a high risk event, all those involved should be contacted by a peer supporter to check that they are OK and offer support. It was agreed, however, that a peer supporter rather than a health professional should be offered as the initial point of contact after exposure to a high risk incident unless the member requests otherwise.

There was agreement that, apart from ongoing support through protracted difficulties (such as family illness, marital breakup, etc.), peer supporters should not see ‘clients’ on an ongoing basis (e.g., more than 3 or 4 contacts).

Peer supporters do not need to discuss every case with a mental health professional, especially if it is only a one-off contact. However, a peer supporter who is seeing a ‘client’ on an ongoing basis should regularly consult a qualified mental health practitioner for clinical support and advice. Referral pathways should be in place to allow a direct referral to a mental health professional.

Looking after peer supporters

In recognition of the potential demands of the work, participants agreed that peer supporters should:

- a. be offered support for themselves
- b. be able to easily access advice from an appropriately trained mental health professional when required
- c. engage in regular supervision with colleagues and/or a senior peer supporter and/or a mental health professional
- d. have access to appropriate professional development activities funded by the program.

Organisational issues and confidentiality

There was agreement that all high risk agencies (e.g. emergency services, military, health service workers, etc.) should:

- a. have a well planned peer support program for their current employees
- b. have a well planned peer support program for personnel, for a limited time, once employment with the organisation ceases (e.g., for ex-police officers, military veterans).

There was agreement that peer support programs should:

- a. be carefully integrated with other support services to employees such as employee assistance programs
- b. be carefully tailored to the needs of the particular high risk target group.

Consideration should be given as to how the peer support programs fit with formal investigation processes and/or post-operational reviews conducted by the agency, although specific advice on how to manage this relationship was not covered in the consensus process.

It was agreed, however, that confidentiality should be maintained at all times through the peer support process, with the exception of clinical supervision within the peer support program, or in the case of threat to self or others. Participants agreed that peer support programs must have clear and explicit protocols around confidentiality that are communicated to the target group.

Working arrangements for peer support programs

It was hard to gain consensus in this area, perhaps a reflection of the considerable differences across organisations.

In terms of the need for some boundaries to protect the peer supporter, there was consensus that peer supporters should not be available on call 24 hours per day, but no agreement on whether personal mobile phone numbers should be made available to enable employees to contact any peer supporter whenever they wish. There was no agreement on whether peer supporters should be available only during working hours, or whether they should be on a roster system so that individuals are not on duty at all times. There was no agreement on whether peer supporters should be paid or receive non-financial compensation (e.g., extra leave entitlements) for being peer supporters.

These issues will need to be resolved at an individual organisation level.

Program evaluation

There was agreement that peer support programs should be evaluated and should:

- a. establish clear goals that are linked to specific outcomes prior to commencement, in order to provide a basis for evaluation
- b. be evaluated by an external, independent evaluator in consultation with the peer support team.

Participants agreed that the evaluation should include:

- a. qualitative and quantitative feedback from users
- b. objective indicators such as absenteeism, sick leave, staff turnover
- c. feedback from those using the service.

When asked whether regular administration of measures such as simple checklists to monitor progress is recommended, the group was unable to reach consensus. Again, this may be best decided on a case-by-case basis.

Participants agreed that indicators of a successful peer support programs may include:

- a. an increase in appropriate referrals for professional assistance
- b. increased work performance
- c. reduced sick leave
- d. improvement in overall staff satisfaction within the organisation
- e. reduced stigma about psychological (ill) health.

Although consensus was not reached regarding whether most employees will use a peer support program if they are distressed at work, it was agreed that even if only a minority of people who are distressed at work use a peer support program, it is still a valid program for high-risk organisations to offer.

The evidence for peer support

Participants were unable to reach consensus about whether there is good research evidence that peer support programs are effective. Responses for this statement were divided depending upon profession. Academics/researchers tended to disagree with the statement, while peer supporters tended to agree with the statement.

Key recommendations

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

1. The goals of peer support: Peer supporters should: (a) provide an empathetic, listening ear; (b) provide low level psychological intervention; (c) identify colleagues who may be at risk to themselves or others; and (d) facilitate pathways to professional help.

2. Selection of peer supporters: In order to become a peer supporter, the individual should: (a) be a member of the target population; (b) be someone with considerable experience within the field of work of the target population; (c) be respected by his/her peers (colleagues); and (d) undergo an application and selection process prior to appointment which should include interview by a suitably constituted panel.

3. Training and accreditation: Peer supporters should: (a) be trained in basic skills to fulfil their role (such as listening skills, psychological first aid, information about referral options); (b) meet specific standards in that training before commencing their role; and (c) participate in on-going training, supervision, review, and accreditation.

4. Mental health professionals: Mental health professionals should: (a) occupy the position of clinical director; and (b) be involved in supervision and training.

5. Role: Peer supporters should: (a) not limit their activities to high risk incidents but, rather, should also be part of routine employee health and welfare; (b) not generally see 'clients' on an ongoing basis but should seek specialist advice and offer referral pathways for more complex cases; and (c) maintain confidentiality (except when seeking advice from a mental health professional and/or in cases of risk of harm to self or others).

6. Access to peer supporters: Peer supporters should normally be offered as the initial point of contact after exposure to a high risk incident unless the employee requests otherwise. In other situations, employees should be able to self-select their peer supporter from a pool of accredited supporters.

7. Looking after peer supporters: In recognition of the potential demands of the work, peer supporters should: (a) not be available on call 24 hours per day; (b) be easily able to access

care for themselves from a mental health practitioner if required; (c) be easily able to access expert advice from a clinician; and (d) engage in regular peer supervision within the program.

8. Program evaluation: Peer support programs should establish clear goals that are linked to specific outcomes prior to commencement. They should be evaluated by an external, independent evaluator on a regular basis and the evaluation should include qualitative and quantitative feedback from users. Objective indicators such as absenteeism, turnover, work performance, and staff morale, while not primary goals of peer support programs, may be collected as adjunctive data as part of the evaluation.

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

Conclusions

This process has shown that it is possible to develop guidelines on: (1) the definition, goals and principles of peer support; (2) training, personnel and supervision in peer support; (3) peer support models and the delivery of peer support; and (4) the evaluation and effectiveness of peer support; which are acceptable to both experts and practitioners in this field. The guidelines that have been developed can be used as a basis to guide both the development of peer support programs, and future research endeavours. As a result, they can assist in the development of an evidence base for peer support programs and practices.

Appendix 1: Consensus and non-consensus statements

Statements that reached consensus as guidelines for peer support. (Note: The numbers refer to the statement's position in the original survey).

Statement	Round	Consensus Type
2) A main goal of peer support is to provide an empathic, listening ear	1	Agree
3) A main goal of peer support is to provide low level psychological intervention (e.g. advice in self care, where to get further help)	1	Agree
4) A main goal of peer support is to provide ongoing formal interventions (e.g. cognitive behavioural therapy, pharmacotherapy, prolonged exposure)	1	Disagree
5) A main goal of peer support is to advocate for peers in disputes with management/colleagues	2	Disagree
6) A main goal of peer support is to identify peers who may be at risk to themselves or others	1	Agree
7) A main goal of peer support is to facilitate pathways to professional help	1	Agree
11) A main goal of peer support is to treat mild psychiatric conditions	1	Disagree
12) The goals of peer support do not relate solely to recovery from a traumatic or highly stressful incident, but relate to psychological and physical health and wellbeing more broadly	1	Agree
14) The peer supporter must be a member of the target population (e.g. a paramedic for paramedic peer support programs, a veteran for veteran peer support programs)	1	Agree
15) The peer supporter must be someone with considerable experience within the field of work of the target population	2	Agree
16) The peer supporter must be respected by his/her "peers"	1	Agree
17) The peer supporter should undergo an application and selection process before being appointed	1	Agree
18) Anyone in the target group should be able to apply to be a peer supporter, regardless of rank or position in the organisation	1	Agree

19) Where possible, the peer supporter should be approved by members of the target group as part of the selection process	3	Agree
20) The selection process should include an interview by a suitably constituted panel	1	Agree
21) There should be no selection process for peer supporters; anyone who wants to train as a peer supporter should be able to do so	1	Disagree
22) Peer supporters do not require any specific training to fulfil their role	1	Disagree
23) Peer supporters should be trained in simple psychological techniques such as listening skills	1	Agree
24) Peer supporters should be trained in more advanced skills such as psychological first aid, mental health first aid, crisis intervention and general counselling	1	Agree
25) Peer supporters should be trained in high level mental health intervention skills such as cognitive therapy and prolonged exposure	1	Disagree
26) Peer supporter training should include information about other support services and psychological treatment so supporters can act as a bridge between the "client" and professional support	1	Agree
27) Peer supporters should meet specific standards following training before they can commence in the role (e.g., assessed through role plays, interviews, written tests)	1	Agree
28) Peer supporters should be expected to attend regular supervision and booster training	2	Agree
29) On-going accreditation/certification is recommended for peer supporters	3	Agree
30) To maintain accreditation, peer supporters should undergo regular review with either a senior peer supporter or mental health professional	1	Agree
31) To maintain accreditation, peer supporters should achieve competency in regular assessments such as role plays, interviews, or written tests	2	Agree
32) Peer supporters should discuss every case with a mental health professional, even if it is only a one-off contact	2	Disagree
33) All peer support programs should have an appropriately qualified mental health professional as clinical director	2	Agree
34) Training in peer support skills should involve appropriately qualified mental health professionals	2	Agree
35) Supervision for peer supporters should include access to appropriately qualified mental health professionals	2	Agree

E1) Apart from ongoing support through protracted difficulties (such as family illness, marital breakup, etc) peer supporters should not see "clients" on an ongoing basis (e.g. more than 3 or 4 contacts)	3	Agree
36) A peer supporter seeing a "client" on an ongoing basis should regularly consult a qualified mental health practitioner for clinical support and advice (agree)	2	Agree
37) A referral pathway should be in place in every peer support program to allow a direct referral to a mental health professional	1	Agree
39) All high risk agencies (e.g. emergency services, military, health service workers etc) should have a well planned peer support program for their current employees	1	Agree
40) All high risk agencies should provide well planned peer support programs for personnel, for a limited time, once employment with the organisation ceases (e.g., for ex-police officers, military veterans)	2	Agree
41) Peer support programs should be carefully integrated with other support services to employees such as employee assistance programs	1	Agree
42) Peer support programs need to be tailored to the needs of the particular high risk target group	1	Agree
43) The use of spontaneous or informal peer support during the course of a day's work is an important aspect of peer support programs	1	Agree
44) Confidentiality should be maintained at all times through the peer support process, with the exception of clinical supervision within the peer support program or in the case of threat to self or others	1	Agree
45) Consideration should be given to how a peer support scheme fits with formal investigation processes and/or post-operational reviews conducted by the agency	1	Agree
46) Peer supporters should be offered support for themselves	1	Agree
47) Peer supporters should be able to easily access advice from an appropriately trained mental health professional when required	1	Agree
48) Peer supporters should engage in regular peer supervision with colleagues	1	Agree
49) Peer supporters should have regular supervision, either by a senior peer supporter or a mental health professional	1	Agree
51) Peer supporters should have access to appropriate professional development activities funded by the program	1	Agree
52) Every peer supporter should be available on call 24 hours per day	1	Disagree

55) Employees requesting peer support should be able to self select their peer supporter from a pool of peer supporters	2	Agree
58) A peer supporter rather than a health professional should be offered as the initial point of contact after exposure to a high risk incident unless the member requests otherwise	2	Agree
61) No formal evaluation of peer support programs is required	1	Disagree
62) All peer support programs should establish clear goals that are linked to specific outcomes prior to commencement, in order to provide a basis for evaluation	1	Agree
63) Peer support programs should be evaluated by an external, independent evaluator in consultation with the peer support team	2	Agree
64) The evaluation of peer support programs should include qualitative and quantitative feedback from users	1	Agree
65) The evaluation of peer support programs should include objective indicators such as absenteeism, sick leave, staff turnover	2	Agree
66) The evaluation of peer support programs should include feedback from those using the service	1	Agree
68) Indicators of a successful peer support program may include an increase in appropriate referrals for professional assistance	3	Agree
69) Indicators of a successful peer support program may include increased work performance	3	Agree
E3) Indicators of a successful peer support program may include reduced sick leave and staff turnover	3	Agree
70) One indicator of a successful peer support program is an improvement in overall staff satisfaction within the organisation (agree)	2	Agree
71) Peer support programs should be considered successful if they reduce stigma about psychological (ill) health	1	Agree
E4) Even if only a minority of people who are distressed at work will use a peer support program, it is still a valid program for high-risk organisations to offer	3	Agree
77) Peer support programs must have clear and explicit protocols around confidentiality that are communicated to the target group	1	Agree
78) Peer support programs must have full organisational support and acceptance	1	Agree

Statements that failed to reach consensus were as follows. (Note: The numbers refer to the statement's position in the original survey; two questions from the first survey that were deemed to be overlapping with other questions have been omitted).

Statement	Round	Consensus Type
8) A secondary goal of peer support is to encourage treatment adherence (i.e. to continue with mental health treatment where relevant)	3	Non-consensus
9) Peer support is designed to promote job performance and increase organisational efficiency	3	Non-consensus
10) A main goal of peer support is to reduce the likelihood of psychiatric disorder	3	Non-consensus
50) Peer supporters should be paid for being peer supporters	2	Non-consensus
E2) Peer supporters should receive non-financial compensation (e.g. extra leave entitlements) for being peer supporters	2	Non-consensus
53) Peer supporters should be available on a roster system so that peer supporters are not on duty at all times	3	Non-consensus
54) Peer supporters should be available as needed, with the expectancy that it not be used outside of normal hours except in emergency	3	Non-consensus
57) The personal mobile phone number of each peer supporter should be made available to the target group	3	Non-consensus
67) Regular administration of measures such as simple checklists to monitor progress is recommended where possible	3	Non-consensus
74) Most employees will use a peer support program if they are distressed at work	3	Non-consensus
75) Following a high risk event, all those involved should be contacted by a peer supporter to check that they are ok and offer support	3	Non-consensus

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