"Reciprocal Peer Support" (RPS):
A Decade of Not So Random Acts of Kindness

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Abstract: A model entitled "Reciprocal Peer Support" (RPS) is introduced in this article to describe the peer support activity provided at University Behavioral HealthCare – University of Medicine and Dentistry of New Jersey (UMDNJ) in a variety of peer programs. More than 10 years of peer support have been developed, reviewed, and assessed by this writer in an attempt to clarify the "lessons learned" and encourage RPS as an effective approach to peer support service in the future. The Cop 2 Cop , NJ Vet 2 Vet, and several other UBHC peer support programs, which conform to "best practices" criteria, have been sustained and expanded based on the RSP principles discussed in this article. [International Journal of Emergency Mental Health, 2012, 14(2)]

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In January 2011 the Department of Defense Centers of Excellence (DCOE) published a white paper entitled "Best Practices Identified for Peer Support Programs" to explore options for the military to develop peer support programs as a tool to combat the rise in military suicides. To summarize their initial findings, successful peer to peer programs have five elements for success. They include adequate planning and preparation, clearly articulated policies, systematic screening and defined selection criteria for peer supporters, leveraged benefits from "peer" status, and continued learning through structured training. Building on the research options

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for actionable items, peer support can address combat and operational stress, suicide prevention, and recovery-related issues. According to the DCOE, Heisler (2006) and the Department of Health and Human services (DHHS, 2007), peer support can offer the following benefits; foster social networking, improve quality of life, promote wellness, improve coping skills, support acceptance of illness/situation, improve compliance, reduce concerns, and increase satisfaction with health status. In addition, the DCOE paper suggests that confidentiality, easy access, and the capacity to follow the peer to peer support for an extended time period are components of the best practice in peer support.

At University Behavioral HealthCare we have provided more than a decade of peer support through the Cop 2 Cop program, NJEA Aid, WTC-RSVP, 4PA COPS, Fire/Ems Lifeline, FEMA SLEF, NJ First, NJ 9/11, and Mom 2 Mom programs. Our UBHC Access Center has sophisticated automated call distribution capacity and an integrated patient

management system utilized by clinical staff for a variety of 800 numbers as a single point of entry for service to those in need of behavioral healthcare support. The unique depth of the access center, combined with the academic excellence and service provision that is available, have provided a strong foundation on which to build the UBHC Peer Support programs. In addition, UBHC historically has employed mental health peer specialists, the more traditional peers offered through the mental health systems across the country, for consumers of mental health and substance abuse services. Given this "perfect storm" of clinical, technical, and academic support, combined with an historical culture in New Jersey and at UBHC that values peer support, a peer support best practice was inevitable.

The peer support services created through the UBHC programs include all of the elements identified in the DCOE document, including those suggestions for a "model" program for the future. Easy access, confidentiality, structured work practices, training, and selection of peers are the foundations of the success of these peer support programs. In addition, this writer believes that the two most profound components for the success of a peer support program that are absent from the extensive DCOE review are 1) the need to utilize peer support/clinician partnerships in peer programs throughout the process, and 2) the provision of resilience sustainability for peers through events and activities for peer advocacy, including both the peer staff and the peer population being served.

The Reciprocal Peer Support (RPS) model

The decade of service in peer support programs at University Behavioral HealthCare have provided the framework for a concept that is entitled "Reciprocal Peer Support" (RPS). The overarching themes and tasks associated with RPS are simply described in four tasks: Connection and pure presence; Information gathering and risk assessment; Case management and goal setting; and Resilience affirmation and praise.

Task One – Connection

A *pure presence* is at the heart of the engagement and is necessary for successful peer support. In RPS, the peer supporter is trained and prepared to engage the client without judgment, avoiding preaching or directing, to cope with the moments of shared suffering and pain, and to simultaneously

be aware from the initial contact that assessment for suicidal risk is an integral role in this process. The peer supporter must be ready to facilitate access to a higher level of care by having access and liaison connectivity with an appropriately trained behavioral healthcare professional as his or her partner to ensure clarity of the RPS system. This peer/clinician partnership is carried throughout RPS but impacts the initial task of connection by ensuring that all presenting problems can be offered the most appropriate care and support.

RPS requires full confidentiality less the guidelines and laws involving suicidal, homicidal, and physically abusive situations. From the RPS perspective, a peer must be a retiree, a veteran, someone who is not actively within the peer group but in a retired or inactive status to ensure the initial connection is free of concerns regarding repercussions to the person in need. The quality of the connection is largely dependent upon the many skills RPS instructs peer supporters to utilize, such as empathy, active listening skills, direct and indirect communication. When an initial contact is of a crisis nature, the intimacy created by the sense of vulnerability of all involved expedites the connection of both the peer in need and peer supporter in RPS, or if handled poorly impedes the connection, perhaps forever. First responders and military service members describe that when surviving a life threatening experience or critical incident they experience a closeness and bonding that is profound. When the initial task of connection in RPS involves acute situations involving suicidal or homicidal risk, many of the same techniques are utilized but they are amplified. If the outcome is positive, most peer supporters in RPS will describe an intense connection established from "surviving the crisis together" that is maintained over a significant period of time post crisis. When encountering resistance, it is important for the peer supporter to be insightful and "manage" the feelings of frustration so they do not interfere with the helping process. Peer supporters in RPS are directed to recognize a resistant peer at the initial contact, as well as to recognize their own frustrations and need to help in the RPS relationship. We reference a focus in the connection phase on truly "hearing" the voice of the peer in need and maintaining a focus on serving that need as a primary tool to connection. If a peer supporter fails to establish the connection of a pure presence with the peer in need the outcome will often result in premature termination of the contact and therefore the helping relationship. In supervision, RPS peer supporters are challenged to explore why the connection was not made. It often involves a contamination of judgment or personal experiences of the peer supporter

that impeded the process. Part of the need for ongoing self assessment in RPS is to ensure that the peer is aware of his or her vulnerabilities and strengths in the beginning of the RPS process, and at all times to ensure that connections are successful. Not all peer supporters can connect with all peers in need. Acknowledging and accepting the experiences we all bring to peer support work in RPS and being guided to focus on peers' most appropriate for our shared life experience sets the stage for effective intervention. RPS tries to match peers most effectively based upon shared experiences. For example, although a police peer may be helpful to a corrections peer, a corrections officer matched with a corrections officer may be more effective at establishing the initial helping relationship. Or, a marine matched with a marine versus any other military peer expedites the connection. Another aspect of effective matching might be shared life experience, rather than profession. Shared experiences such as trauma, self-medication, aggressiveness, etc. can serve as an effective secondary matching criterion. It is essential, however, that the peer supporter's experience is in the past, treated and resolved. If he or she struggles in relapse or life changes it is an important component of self awareness to notify the RPS team to adjust peer "matches."

Task Two - Information Gathering and Risk Assessment

Specific training with clinical partners and supervisors, as well as technical support, can drive the effectiveness of this task. In RPS the information-gathering consists of inquiring into the presenting problem (the "story" of circumstances and reactions), as well as the history of a peer in need. This history includes behavioral, medical, family, and work history in a non scripted series of questions. Law enforcement officers are the most proficient as a sub-group of peers at this phase, likely due to their interviewing and interrogation skills. Our computer program, which collects peer information, has what we call "mandatory" fields so that a peer supporter must collect certain data to move to the next screen in completing documentation about a peer contact. Our face to face peer services follow a standardized training through the International Critical Incident Stress Foundation (ICISF) and our outreach and access training utilizes materials and forms that direct information which should be collected in every setting for RPS.

Crisis and suicide assessment are infused into every aspect of task two in RPS as part of the recognition of the risk amongst the groups using peer support. Although the information gathering is an in-depth process, the awareness of weapons accessibility and suicide risk are components of information to ensure a safe environment that must be discreetly integrated into all information gathering. The information gathering phase, similar to the connection phase in RPS, is not a singular contact and may require several contacts utilizing the same guidelines and assessment because peers present differently at different times. Therefore information and assessment may often be in flux or have changed.

RPS occurs in a variety of venues. Each venue has adapted a protocol or standardized approach to the assessment component of the assessment piece of this phase. For example, the American Association of Suicidology endorses the "crisis call model and lethality assessment" for their accredited help lines. Therefore we have adapted that model in RPS for peer support work for an assessment tool. In face to face peer support work, assessment is often needed in crisis intervention services. RPS utilizes the SAFER-R model of individual crisis intervention as developed by Everly (Mitchell & Everly, 1994; Everly, 1996) and endorsed by the International Critical Incident Stress Foundation.

It is a legitimate concern, when training peers and mental health professionals to provide RPS, that if a traditional more formal information gathering or assessment process occurs, one can quickly jeopardize the connection in task one and in turn impede the RPS process. A conversational style and more informal questioning for both information and assessment purposes are needed unless a peer is reporting behaviors that would indicate serious risk. RPS encourages peers in those acute moments to build on the connection and peer relationship to extract genuine experience and accurate information to ensure a peer is provided all service necessary to ensure safety.

In RPS we utilize homogenous peer supporter groups because they have appeared to be more effective than heterogeneous groups, based on the effectiveness reports of the peer supporters themselves.

This prompted the guideline for RPS that programs not be integrated with a mix of peer cultures but instead be solely devoted to one peer culture. Cops are peer supporters for cops, vets are peer supporter for vets, fire for fire, etc. This leads us into the next phase.

Task Three - Case Management and Goal Setting

Task Three flows naturally as the relationship between

peer supporter and distressed peer builds. Once a peer supporter has completed the first two tasks, he or she is capable of identifying whether or not he or she is a good "match" for the ongoing peer support and case management for the peer in need. In RPS, peer supervisors and mental health partners review peer cases to ensure that task three is provided in a thoughtful manner, matching the peer supporter to the peer in need, based on variables such as branch of service, behavioral healthcare issue, and engagement from initial contact, as well as other possible factors.

Task three in RPS is often presented as the first item a peer in need requires. However, if information and referral was all he or she needed, a peer would most likely not be reaching out to a peer support service. Today's web based referral options and access to information are so prevalent that, although most peers in high risk populations will present as their primary and only need being of a case management nature, he or she will be receptive to peer support on an ongoing basis based on their level of care, initial contact, and quality of referral provided. In task three, the case management is offered not just through a list of names and numbers but, more importantly, as part of a solution-oriented approach to the peer that he or she is not alone and help is viable. Multiple contacts from the peer supporter throughout the peer support process for regular contact are a key unique variable to the model. In particular, the follow up and efficacy of the case management can be experienced as a peer supporter truly "caring" or just doing his or her job.

As the case management is offered, whether it be behavioral healthcare treatment, housing, financial, or family oriented, the credibility of the peer supporter is once again at risk as the positive or negative experiences with the referrals and services offered through the case management are attributed to the peer supporter despite the fact that the services are all separate entities. A peer in need will rationalize that the peer supporter is genuine if services offered in case management go well or is a phony and not truly interested in helping if the case management referrals go badly. Both experiences in RPS have confirmed an approach in which we prepare before hand with case management referrals and services by "vetting" them ourselves through direct contact with providers, visiting sites, and outcome measures, in an attempt to only provide credible resources. This is, however, often difficult to ensure.

The other approach in RPS' task three is to reiterate and emphasize the capacity for change and continuity in this phase. If a referral or service offered is not ideal, RPS ensures that the peer supporter will try again, with other resources and maintain contact with the peer in need throughout. The sense that the peer supporter and peer are pursuing solutions "together" is a key to the approach in RPS. Provider annual trainings, credentialing processes, customer satisfaction surveys, are all tools that have been utilized in RPS to attempt to maintain credible resources.

Task Four - Resilience Affirmation, Praise and Advocacy

This task is often the most rewarding component for the peer supporter, based on their own accounts of their experience. When self care is emphasized for all peer supporters and behavioral healthcare professionals in the peer support model it fosters an environment of openness needed for genuine peer support work. A consistent encouragement of peer supporters' resilience as a group, working as a team in RPS, allows peers to model the importance of recognizing resilience. From the onset of the RPS programs developed at UBHC, monthly, if not quarterly, some form of recognition, award, or advocacy occurred within the peer support group. For example, Cop 2 Cop advocates have walked for years in the American Foundation for Suicide Prevention suicide survivor walk and other events to memorialize officers lost to suicide as part of the mission and group cohesion. Media have reported the successes of NJ Vet 2 Vet. This prompted an opportunity to advocate for soldiers by volunteering to be present at dozens of "Welcome Home" events. Mom 2 Mom has created a visual arts project to utilize as an advocacy tool, entitled "Breathless: Mothers of Special needs children." The peer supporters attend museums when it is shown across the country, putting a voice to the people served. Many of our RPS programs related to the events of 9/11, including memorial events or ceremonies where strength and resilience were the focus. These activities must be offered regularly to the peer supporters in the RPS model to effectively affirm resilience, translating that experience to the peers in need.

In addition, providing training through RPS within the communities served in a particular peer program is another form of the resilience affirmation. Information is a powerful tool for many treatment resistant populations. Stigma is an impediment to this phase and in the details of the peer support relationship it may be an awkward transition for a peer supporter to affirm a peer in need openly. He or she may be worried they may sound condescending or insensitive by

affirming resilience and offering praise. The reports of the peer supporters is that often there are cues from the peer in need that he or she is ready for phase four. Perhaps a peer may say something such as, "I can't believe how much has happened since I first spoke to you." This can be an opening for resilience affirmation and praise. RPS suggests this phase feels like the summary of a term paper or last paragraph of a chapter. Summarizing in a warm and supportive manner with specific references to the resilience witnessed and positive actions taken and achieved is the beginning of this phase and the end of the RPS experience.

Many peers who have accessed RPS will confidently return for additional support over time. Our returning peer clients have reported a confidence and capacity for the RPS experience when they re enter the service. Some peers' RPS experience will reflect more of a crisis intervention and they will not repeat the process. Whether the RPS experience is part of a continuum or a single episode of support, the RPS tasks do not unfold in numeric order. RPS peer supporters are trained to utilize these tasks in order, even when they repeat the phases. The RPS peers are encouraged to remain "client focused" with the populations they serve. Many variables may impact the integrity of the RPS tasks. The RPS tasks remain essential but can be affected by clients' needs and elements such as life events, time, resistance, and staffing changes, all of which can be factors in peers' vacillation through the tasks of RPS.

Most important is the peer supporter's recognition that the fluctuation and attempt to regain the order of activity to allow for the relationship to flow and service to be as effective as possible. RPS allows for these tasks to be cyclical and part of a continuum that is not encumbered by a proscribed number of sessions or period of time. RPS has been offered in an outreach approach wherein our peer supporters will make three to five contacts for every initial contact they receive. It is our constant outreach and sustained contact that supports the RPS model.

Overall the themes most prevalent in RPS are as follows. Peer/Clinician partnership is essential not only for RPS service but throughout the program structure because both peer support and behavioral healthcare must be valued by all in order to establish one unified approach, modeling the concept in all applications. RPS requires a single point of access/contact to begin and can be offered through peer telephone help lines, face to face individual and group peer support, crisis intervention services, prevention and training,

and advocacy for peer groups targeted for RPS. Self Care is emphasized with opportunities for assistance encouraged within the peer support team and managed through resilience building activity and advocacy. RPS is an open ended process that is a continuum. It is most effective with groups who have been exposed to trauma and are at risk for suicide and are seen as a "vulnerable population."

In RPS the staffing patterns and structure are best developed with a process in which a peer supporter can first be recruited and serve as a volunteer or in some provisional status for a period of six months ideally because RPS requires unique skills. Those peers who are not capable of providing the RPS services directly can remain volunteers and be utilized to support the outreach and advocacy as part of the RPS program. Those that thrive are employed and partnered with clinicians, then trained and monitored as employees. Supervision and leadership must reflect the peer supporter/clinician approach at the core of RPS, to avoid dividing the peer supporter/clinician team and to encourage both components of the RPS model.

The RPS training curriculum is a composite of models from national organizations such as American Association of Suicidology, International Critical Incident Stress Foundation, and mental Health America, and broadly resembles the peer support competencies reflected in the DCOE white paper (2011) with some adaptations. The knowledge domains for the RPS Peer Support Curriculum include seven categories; cultural competence (not just in diversity but of the peer culture i.e.; police, military etc.), communication skills, managing crisis and emergency situations, peer support principals, recovery/resilience tools, understanding different illnesses & stigma, and self care. The RPS Peer Support Curriculum domain supports specific skills within the domain areas that may be adapted based on the peer support population and the service delivery system in which the peer support is offered.

Summary

The most significant lesson learned from RPS Peer Support Training is that all trainers/professionals providing the training ideally should be peers and mental health professionals to ensure the peer/clinician model is emphasized throughout the RPS process. All RPS training activity is provided in a variety of modules, initial and annual training, individual and group training, and peer support service specific training, so that training is an ongoing process at the UBHC Peer programs.

At UBHC, we have established 10 peer support programs utilizing the RPS model and employed more than 50 peer per diem staff members and dozens of peer/clinicians over the last decade. The outcomes of these programs appear to have offered healing, support, and solidarity for high risk groups in need of an additional option to traditional behavioral healthcare services. As the program director of many of these services, I have witnessed life changing moments for both the peer supporters and the peers in need. Reciprocal Peer Support has been developed initially in response to suicides and mass disasters, yet over time it has been based on the data from the peers in need and the peer supporters who have all contributed to the model. Most significantly has been recognizing the moment in time when a peer supporter says to another peer in need "I have been where you are and I am with you now" as a powerful experience and a not so random act of kindness.

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