Transcript

Video: Global Environmental Scan of Peer to Peer Support Programs

Minutes: 55:42

MR. CHRISTOPHER THRALL: Well, good afternoon to everybody east of Thunder Bay, and good morning to the west. Welcome to the Canadian Patient Safety Institute's Creating a Safe Space Webinar Series, supporting the psychological health and safety of healthcare workers. This, our third episode, focuses on a global environmental scan of peer-to-peer support programs. Our guest speakers will present the results of an environmental scan of published literature that describes interventions used to support second victims, including peer support programs, toolkits, curricula, and other resources.

My name is Christopher Thrall. I'm the communications officer with CPSI. I would like to welcome you on behalf of our partners—The Mental Health Commission of Canada and the IWK Health Centre. Welcome, as well, on behalf of our technical host Gina Peck from CPSI.

Before we begin, I'd like to introduce our speakers today. We will begin with Markirit Armutlu, who joined the Canadian Patient Safety Institute in 2017 as a senior program manager and is the lead for the Psychological Health and Safety of Healthcare Workers Program. Welcome, Markirit, to the webinar.

Next to speak will be Dr. Katrina Hurley. Katrina is the intern chief of the IWK Health Centre Emergency Department in Halifax, Nova Scotia, with an academic affiliation with the Department of Emergency Medicine at Dalhousie University. She is a self-professed data geek with more ideas than time. Her research interests are in examining patient and family experiences in the emergency department and their journey before and after their visit. Thank you so much for being here with us, Katrina.

Katrina will be followed by Diane Aubin, a healthcare culture and patient safety specialist with Diane Aubin Consulting. After working in patient safety for over ten years with the Canadian Medical Protective Association and then the Canadian

Patient Safety Institute, Diane was compelled to study the psychology of errors in healthcare. Her doctoral thesis explored the impact of shame on health professionals after an adverse event. Thank you so much for joining us, Diane.

And, finally, we will introduce Eleanor Fitzpatrick. Eleanor is the coordinator for research programs at the IWK Health Centre Emergency Department. Prior to her role in research, she worked as a pediatric emergency staff nurse for 12 years. Her research interests are in the areas of parental uncertainty and illness, patient safety, and mental healthcare in the ED. She has an academic appointment with the faculty of Medicine at Dalhousie University in the Department of Emergency Medicine. Welcome, Eleanor, to the webinar today.

If you miss part of this webinar or want to share your learnings with others in your team or organization, please know that it is being recorded and will be available on our website within the next week. I will also tell you about the final webinar in this series at the end of our hour together.

Please write your questions in the Q&A box on your screen or chat them directly to me, Chris Thrall. They will be compiled and provided to our speakers at the end of the call. If you run into IT difficulties, please connect with us in the chat box, and we would be happy to assist. And now, with our introductions and orientation out of the way, I would like to invite Markirit to open up the discussion on creating a safe space.

MS. MARKIRIT ARMUTLU: Thank you, Chris. Permit me to spend just a couple of moments to speak to you about CPSI and why this work is of significance to us and to patient safety.

The Canadian Patient Safety Institute works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality. In line with its 2018-2023 strategic direction, CPSI works to contribute evidence to inform policies and standards that best support patient safety at the organizational and health system levels and to embed patient safety requirements in regulations, standards, and accreditation.

In developing the national program for the Psychological Health and Safety of Healthcare Workers, CPSI has partnered with the Mental Health Commission of Canada, and has brought together experts from across Canada to address the needs of

healthcare providers who are traumatized by events during the provision of care, known as the second victim phenomenon.

Now, in an effort to progress this work, CPSI, at the start of 2018, launched document called, “Creating a Safe Space, Addressing Confidentiality for Peer-to-Peer Support Programs for Health Professionals in Healthcare Organizations.” And our first webinar in our series of four webinars really talked about confidentiality and legal privilege, and that information, for those of you who are interested in implementing a peer support program, is available on the CPSI web page.

Our second webinar, which took place about a week ago, was on the results of a survey on the perceptions of healthcare providers. And this really brought to home the need for peer support programs, and it was an excellent presentation by our partners at the University of Ontario Institute of Technology.

Then another component and a very important component that you will hear about today is on the global environmental scan of peer support programs. Now, in an effort to learn from those who have already implemented peer support programs, CPSI determined that it would be valuable to conduct an environmental scan of national and international literature. In the meantime, researchers at IWK Health Centre were conducting a global scoping study to explore how health professionals are supported after a patient safety incident. CPSI, therefore, collaborated with the IWK researchers and, namely, Dr. Katrina Hurley and Eleanor Fitzpatrick, for the report that you’re going to see today towards a study that will be outlined by Katrina, Eleanor, and Diane.

I’m really thrilled to really invite you to the presentation today. We have our webinar, this particular webinar that I’m really excited to have our presenters speak to you. Our presenters will present the results of the environmental scan of published literature that describes intervention used to support healthcare workers who experience emotional distress, including peer support programs, toolkits, curricula, and other resources. In doing so, we hope that you will have a better understanding of the variety of interventions used to support healthcare workers who experience emotional distress.

And, with that, I’m going to ask Katrina to proceed with her presentation.

DR. KATRINA HURLEY: I have unmuted me, and let’s see if I can progress the slide. Gina, I wonder if you could help me with progressing the slide there. There we go. Thank you. It’s a pleasure to be online with you all today.

When we talked about doing this environmental scan or this scoping study and when we were thinking about adverse events and how they affect healthcare providers, what was really on our mind is that it is kind of along and winding road, being a healthcare provider. The work is truly challenging in a number of ways.

Adverse events in healthcare are very common. In adults, they’re estimated to occur in about 7.5 per 100 hospital admissions, and, in kids, 9.2 per 100 hospital admissions. It’s quite a bit. And it’s estimated that at least half of healthcare providers will experience the second victim phenomenon once or more in the career. And I would hazard to say that that’s most likely an underestimate.

Some of the symptoms might include increased anxiety or loss of confidence, sleeping difficulties. And it was an ah-ha moment for me when I was at a CPSI panel out west several years ago, and when I heard the program staff from the Rice [phonetic] program at John Hopkins talking about the impact on work absenteeism and staff turnover. It was something I hadn’t really given a great deal of thought about, because for myself, I assumed whatever happened, I would bounce back and keep going. But it didn’t occur to me that there may be staff who don’t bounce back so well, and there may be people who would rather leave their work environment than risk facing it again.

There was a survey by Scott, et. al., and they found that 30% of clinicians reported concerns about job performance in the preceding 12 months as a result of a safety incident. It makes the fact that we have second victims floating around out there, who are providing healthcare, is also a safety risk, because they are often plagued by self doubt and are concerned about making another mistake. And that, in itself, can cause a concern.

There was a survey of physicians that showed that 90% of organizations that they felt provided inadequate support. It made us question then: What should we be able to find out? We’re thinking about: How could we make something happen at the IWK? And for us, a starting point was to look broadly and see what things were out there.

It’s hard for me to talk about previous events that I have been involved in, but I have talked about it publicly before, and it almost always results in a sense of heightened emotion for me. But, nonetheless, I was involved in the death of a child who had a shunt to treat hydrocephalus. I had received the patient in handover, which we know is an increased time for error. When the patient deteriorated, it became clear that the initial working diagnosis and treatment had not been correct. I honestly think that if, even if I had gone back and done everything all over again, I don’t think I could have really changed what happened. I don’t think that I could have made the patient survive or not die.

But, nonetheless, when I think about all the things that didn’t go perfectly right and I think about the role that I played in that, and that I always feel like if I had done it differently, that it may have improved the family’s experience. And I’ve dissected this a hundred thousand different ways in every sense that you can imagine, but I can’t go back and change it, so all I can do is move forward with it. And I always hope that, in doing so, that I can help other people to move forward, too. Obviously, I haven’t quit my job. I don’t have any staff turnover. But I still can’t talk about that kid, and there’s probably other kids I can’t talk about either. And I know that Eleanor had some similar experiences.

MS. ELEANOR FITZPATRICK: Yeah. When Katrina—and that’s actually the first time I’ve heard Katrina say that. So I’m a little teary here as well.

We have all had horrific experiences in our profession. I haven’t done clinical care for 15 years now; I’ve been doing research. I miss it, but what I don’t miss is the difficulties of these situations and how they have stuck with us through the years.

I have, just thinking of other examples, but just the other day, it was brought to my attention that we had had a death of a baby in the department, and it instantly threw me back to all those babies and all those kids that I took care of. And nothing at the time was dealt with; there was no peer support. Whether it would change how I feel, but it certainly encouraged me to move out of clinical care and into something that was “safer,” safer for me.

I’m going to give one other example. Early in my career, I made a medication error with no bad outcome, thankfully, but it happened during a night shift. And from that day forward,

I was the nurse who hated working nights. And it wasn't because I was lazy, it wasn't because I was a princess. It's because I was terrified of making another med error on a night shift. I've never told anyone that before. Let's move on. It's a time for disclosure.

DR. HURLEY: Part of what inspired me to actually do this review was that after that CPSI panel a few years ago, I had read about a surgeon who had made a technical error that resulted in the death of an otherwise young and healthy patient and how he withdrew from his friends and was not able to continue working as a surgeon in Canada. It made me sad enough to think that we really needed to do something to make a difference.

So Eleanor and I started doing this scoping review, and it has two primary objectives. One is to characterize the range and the context of interventions to support healthcare providers in acute care settings. We chose acute care settings because we needed to make the scope narrow enough to actually be able to accomplish the review. So we chose acute care settings, such as emergency departments, intensive care units, any unit in the hospital that was providing acute care.

And our second objective was to report the intervention outcomes, because whatever we proceeded to advocate for in our institution, we wanted it to be based in evidence. And if there were evidence that supported one type of program or one type of approach over another, that we wanted to make sure that whatever we did was grounded in fact.

One thing that we did was we recruited an information specialist, or a librarian, who helped us to develop our search. We chose the scoping study methodology because it helps us to assess a broad topic. It's different than a systematic review. A systematic review is typically quite restrictive in the types of methodologies that you can include. The scoping study has enabled us to assess a broad topic that could be addressed by a variety of different ways. It would help us map the key ideas, to identify the different kinds of sources it was coming from and the types of evidence, and it would help us to illuminate gaps in the published literature.

The information specialist, together with us, we found some other systematic reviews. We looked at the keywords that they used in their systematic reviews, and we searched PubMed, Embase, CINAHL, EBSCO, PsycInfo, Cochran, Web of

Science, the whole range of different databases. And the concepts were all around second victim in acute care settings. I'm going to keep you in suspense about what we found and let Diane take the talking stick and tell you about the Canadian programs that CPSI gathered data about. And then we'll return to give you the results of our scan.

MS. DIANE AUBIN: Thank you very much, Katrina and Eleanor.

I will be intruding on your presentation to talk a little bit about the Canadian landscape and giving you a brief summary of what we found in Canada.

I just want to make a note that, even though I'm in Alberta, I didn't put a photo of mountains up, because I grew up in Ottawa. And this one reminded me of the Ottawa River. We have such a beautiful country. Hope everyone's enjoying the summer that's finally arrived.

Katrina explained some of the methodology they used, which is very scientific and evidence based. Ours at CPSI was more of an organic research into peer support programs in Canada. It was a more organic or what you might call grassroots approach.

What we did was build on existing CPSI connections—we have extensive connections, obviously, with the patient safety community—and worked from that, and then, of course, made new connections. As we talked more and more about peer support, made new connections at meetings and conferences and when we're talking about peer support or wellness.

And then once the work started, as Markirit had mentioned, we published a document a year ago on confidentiality in peer support programs. People started hearing about the work we're doing, and by word of mouth, reached out to CPSI to let them know that they were interested in peer support or implementing a peer support program. And, obviously, we also did internet search to find healthcare organizations that had peer support programs. And then the important thing Markirit mentioned earlier was that CPSI also partnered with the Mental Health Commission of Canada, and they have a lot of really good resources for building peer support programs, obviously, not just in healthcare, but very relevant to healthcare and the work we're doing.

In the end, we gathered all these organizations together. These were most of the ones were found in Canada who had implemented or who were in the midst of implementing a peer

support program. And representatives from all of these organizations worked together to develop what we're going to be calling a best practices guide, Best Practices for Peer Support Programs in Healthcare Organizations. And that's part of the creating a safe space manuscript. And, as Markirit mentioned, there will be a webinar later in the fall to talk about that.

And just to mention some of the people—maybe you're reading through this as I speak—but some of the organizations that worked on this were the British Columbia Emergency Health Services. They're very far ahead in the work they do with emergency health workers. There's the Health Canada with their Occupational & Critical Incident Stress Management program. Again, they have already done a lot of work. SickKids have been established for a while with their trauma response program. Alberta Health Services, the Quebec Physicians' Health Program actually has been in place for 25 years for physicians and had a lot of resources for us as well. The Michael Garron Hospital, Central Health in Newfoundland and Labrador, St. Michael's Hospital, and Chatham-Kent Health Alliance. Those are some of the ones that we've been working with.

And just to point out, in case some of you who are on the line and say, Well, we have one, too, we don't pretend that we've discovered all of the peer support programs that are out there. And so, we're happy to be in touch with you if you have some resources and want to share some of what you've been doing. We don't pretend we've found them all, but found what we could organically.

We are launching this in the fall, and it's a comprehensive piece of collaborative work, really amazing materials that have been pulled together. And I want to mention also there's a toolkit and resources, a toolkit with a lot of resources and tools for people who are implementing peer support programs. That's going to come out at the same time. However, I'm going to give you a little sneak peek at some of the common themes that emerged, because I think it would be helpful today for you to know what we found.

And some of the common themes were that—and it'll be relevant to our talk today, because, as you've noticed, Katrina and Eleanor are mostly speaking about the distress that happens after a patient safety incident or a medical error. The organizations that we worked in Canada decided that their peer support programs should be available for any type of

emotional distress, not just medical errors or patient safety incidents, which is interesting, because you read bout the ones in the U.S. They're all second victim phenomena. We've tried to stay away from that term. You'll notice in all the documents we have that we try to talk about the emotional distress experienced by health professionals. A lot of reasons why we are staying away from that label of second victim, but more on that later.

Obviously, it's the most, probably the most traumatic experience that a health professional will go through, this distress after an adverse event or patient safety incident. But there are a lot of other emotional experiences for health professionals that all the organizations in Canada, who have a peer support program, decided it was important to support their workers as well through those experiences. That was the first common theme.

The other is that they found that there's more and more recognition of the importance of mental health in healthcare organizations, which made it easier to lobby for peer support programs. So that's really, really good news. And all of you on the phone, on the webinar today, are probably here because it is becoming a much, much more important experience and important initiative in the healthcare organizations to help with wellness.

The other thing is that the common, one of the common themes is that there are very important building blocks that were common to everyone, that you must have that foundational support from the leadership in the organization, and that's really important right from the start. Put together a really strong planning team; bring in your experts from all the different programs that already exist. And the other thing is be very clear about exactly what the peer support program is in your organization: what your goals are, and a really good policy on how your organization will be run and how it will fit within the organization.

The other thing is that as for who they would support. All the organizations found it was better to open the peer support program to all workers, including not just health professionals, but volunteers, students, the non-health professionals. And as one organization put it, anyone wearing a badge, so anyone who worked at the organization. They felt it was better to include everyone than to exclude certain groups.

The group putting together this best practices guide also came to consensus that recruiting, training, and supporting those peer supporters, the ones who are actually doing the peer supporting, was the key to the success of the program. And the organization needs to invest time and resources to this.

They deemed it important to make sure managers and supervisors were also in on this, because they're the ones that have the staff who come to them in distress. And the organizations said you have to make sure that they understand how to connect their staff to the peer support program.

And then, of course, confidentiality is a very important component of the peer support program. We already had a webinar on this, and CPSI has already published the guidelines on confidentiality, but it's worth mentioning again. It's key not only to try to be confidential, but to help the workers understand what is confidential and what you're doing to try to keep that confidential.

Lastly, the one common theme was that all organizations admitted that it was a lot of work to implement a peer support program. And a lot of them said, We never knew, we didn't anticipate how much work. But they all felt that it was definitely worthwhile.

That's a glimpse at what you can look forward to in the best practices document to be published soon with the webinar in September. Thank you very much.

DR. HURLEY: Okay. The suspense about the program, I can list that for you shortly. One of the limitations of our study is that our methodology favored identifying programs that were published in peer-reviewed journals. We were searching in scientific databases for publications, essentially, in peer-reviewed journals. So we expect, just as Diane had mentioned, that there are other programs that are in various stages of development or maybe they're only accessible on protected domains within an institution, so they may not have been findable by our methodology. So, by no means, is the whole thing inclusive of everything.

That being said, we did find a lot of stuff. We used RefWorks to help us manage citations and a program called Covidence [phonetic] to help us to facilitate the screening process. We screened over 4,000 abstracts, and they were each screened by two individuals independently of each other. And together, selected 173 papers to look at in closer

detail. After we applied our inclusion and exclusion criteria, then we were left with 18 studies. Further internet searching and searching of reference lists and talking to authors of those papers helped us to find some more. In total, we had found 28 sources that represent 22 programs.

MS. FITZGERALD: And so I will talk about how we categorized the programs into two groupings: Peer support programs and then pro-education programs. Do note that some of those programs actually do both.

I'm going to touch on the programs that were either a tool kit, a curriculum, or a resource. We found four tool kits which have been developed for educators or managers, two of which were Canadian. One was from PEI, and the other was from the First Nations and Inuit Branch, the other two were American.

The kits consisted of policies, reading materials, videos, talking points, and other resources. Three of the kits were developed to assist in proactive education, and the other one was developed to assist managers in responding post-event as a supplement to their organization's EAP and system [phonetic] programs.

There were three curricula developed to proactively educate. These structured programs were targeting specific healthcare provider groups, so very exclusive as opposed to inclusive. One group was nurse anesthetists, another was staff MDs and residents. And within that program, there were separate tracks for those two groups. And then one was exclusively for medical residents.

As a resource, MISE, or Mitigating Impact in Second Victim, that was a resource developed following a clinical error that was made in a Spanish hospital. And it provides resources that are situated on a publicly available website. The website is structured itself into two packages—informative and demonstrative. Informative one offers information on basic patient safety concepts, for example, near misses or other adverse events. And the demonstrative package includes descriptions of the emotional consequences of adverse events. Katrina.

DR. HURLEY: This overlaps somewhat with what Diane had said. We had found a number of programs that were exclusive in their focus in that they were specifically focused on efforts to assist people who had faced some sort of medical error or

adverse event. But then there were other programs that extended the scope. There were programs that specifically mentioned extending the scope to cover violence against staff or “difficult” encounters. And I put difficult kind of in quotation marks, because it’s an open interpretation as to what that might mean—difficult life events, illness of staff or their family. There were a number of mentions in the American literature about people experiencing trauma and difficulty when they are targets of litigation or complaint. So looking at it not just from a risk management perspective, but from how stressful that type of event is for a clinician.

There were some programs that it was specific to a staff group or to employees. There were others that included physicians as well as staff or employees. Code Lavender extended their support to nonclinical staff as well. So those were getting into almost like what SickKids had mentioned—anyone who has a badge is welcome in some of these programs. But there was a broad range. It certainly didn’t focus on—I can’t say it came together to say… I can’t say one thing as a result of it. It was quite broad.

The same when I get into the details of what the programs really were. I’m going to speak of it in general terms; the details will be in the paper. But there were eight programs that exclusively provided peer support, and there were another eight that provided some combination of peer support and proactive education. And so, when we talk about the proactive education, just like what Eleanor was mentioning a little while ago, is that that’s efforts to help staff to identify second victims in their workplace. It’s to help them educate what the symptoms are and what that looks like. It’s taking a proactive approach so that staff have an increased awareness of the issue, as well as normalizing it.

And then the peer support is the use of peers to provide support to their colleagues. But even that wasn’t universal. There were some programs that called it peer support, but the peers that were providing support, some of them were paid staff, as in they weren’t volunteers to a specific program. There was a program in a Spanish hospital—that is a hospital in Spain—that used, they had a lawyer, and an ethicist, and a psychologist. They called it peer support, but it felt almost a little bit different in that, in the way that we read it. There was some programs that were volunteer peers and some that were really paid professional staff for a dedicated program.

Some of these programs were under the umbrella of patient safety, some were under the umbrella of occupational health and safety, some came under risk management, another under quality improvement. There really wasn't, again, just like I can't narrow it down and say there was universal agreement or consensus about who qualified for these programs, there also wasn't a very sense, a universal sense of where these programs need to live.

And what I gathered in some of the reading is that, I got the sense that, in some institutions, occupational health was appropriate, it was a trusted resource. And in other institutions, there was some distrust about occupational health and concern that the staff were making themselves vulnerable by going to occupational health. It might end up in their file or that it might harm their employment in some way.

The ones that couched in patient safety did so it seemed in an attempt to protect the confidentiality around it. And with confidentiality, as you would have seen in the previous CPSI paper, is a really big deal around this issue. A number of these programs, I would go further and say they weren't just protecting confidentiality, some of them were practically operating in secret, in that they really weren't recording any information at all and were really, there was a lot of fear around protecting the information for fear of litigation or that it might target or make the person, the healthcare provider vulnerable in some way. It almost moved from confidentiality into secrecy.

Now, interestingly, eight of those programs also had a basis in critical incident of stress management. And that is an area in itself which is a little bit controversial. Overall, it's a relatively new area of study. When it comes to the critical incident of stress, which is an area of controversy, it's important, I think, that we make outcome data available and that some of these programs need to actually report outcomes. Otherwise, it's hard for us to know whether these truly have evidence to support them or not.

Even though it's a relatively new area of study, it seems to be a small community of experts that have really informed almost all of these programs. They all reference each other. So that small community of experts which has fanned out and has a growing base, which makes it really interesting, it also means that if there's something that's not effective, for example, in the first part, it means that we would fan

that out and were amplifying it if everybody continues to reference onto the same information.

I think it would be a gap that we notice, as we think that this community of experts needs to come together to provide some kind of consensus about: What are the outcome measures that we think are important? What are the outcome measures that we need to study and we need to focus on?

The confidentiality makes studying this a very big challenge, because there's so much effort and focus on the confidentiality. It makes it hard to actually study what the effect is for the peers that are being supported. Some of the outcome measures that were reported were those of what the supporters' experience were. And that's an important part of the program, of course, but the target of the program is the peers that are receiving the support, and there's very little evidence published on that. We found that to be an area of limitation.

Overall, we were not able to find clear evidence of either benefit or harm for these peer support programs. That is not to say that the programs are not effective, but so far, they have not generated a strong body of evidence to support it. It's intuitive, there's certainly quite a lot of writing on why people think it's important. And, intuitively, it seems like it should be effective. And I guess some people would say, You don't need to study that parachutes work to jump out of airplanes. So do we need to study everything that is intuitive? I think when it comes to getting the buy-in of senior leadership, as was mentioned as a really important factor by Diane, I think having clear benefit or evidence of benefit that you can use when you're talking to executive leadership or senior leadership in your institution can be very helpful. Again, I feel like this area—people need to come together and actually make some consensus, expert guidelines on what evidence they think is important to generate.

That's the end of our part. And we'll pass the talking stick back.

MR. THRALL: Fantastic. Thank you so much for that, Katrina. And I will wield the talking stick with responsibility and decorum, I promise. I thank you very much, Katrina, Diane, and Eleanor, for those important presentations. And thank you, Katrina and Eleanor, for sharing those difficult experiences at the top of the call. And thank you, Markirit,

for inviting these wonderful spokespeople to lend their insights.

We have received a few questions from the chat box. I'm just going to remind you that if you do have any questions for our presenters today, please enter them in the chat box either directly personally to me, Chris Thrall, or to all participants, as well as in the Q&A box. And we would love to entertain your questions.

The first one, actually, came out from Juanita. She just wanted to know for this talk: What is the scope of health workers in this discussion or support study research? Did you look exclusively at primary care or does it include mental health and addictions workers?

MS. FITZPATRICK: The scope of our review was acute care settings. We didn't restrict it to the type of healthcare worker. We were open to anything that we found. Most things that we found focused on employees, so some of them specifically excluded physicians or considered them separate. But when it came to the support of employees, it didn't necessarily specify nurse versus social work versus other types of specialists.

There was that Code Lavender that did actually extend it beyond the clinical staff. It would support any kind of staff at their institution. So we did find a tool kit that was specific to nurse anesthetists.

DR. HURLEY: A curriculum.

MS. FITZPATRICK: A curriculum. Overall, it was, we were open to anything that we found in the published literature. It just seemed like it was mostly focused in a general way on employees.

DR. HURLEY: And I'll add to that. Sometimes it was also just specific to the unit. One was a pharmaceutical error made in the neonatal unit, and that was the unit, so all staff within the unit, so not specific to a type of healthcare provider.

MS. FITZPATRICK: It's interesting. A number of these programs were inspired by specific events. And I think that very much influenced the design of those specific programs.

DR. HURLEY: Yeah, absolutely.

MR. THRALL: Okay. Yeah, that makes sense for sure.

I do have a question for Katrina from Sherry [phonetic]. Is there evidence to support—I realized you kind of addressed this during the end of the talk there. But is there evidence to support peer support programs as best practices for this, or are there other effective programs or options that we could consider to support care providers?

MS. FITZGERALD: We weren't able to pool any of the data, because the things that they measured were each very different. And we didn't find very much that reported from the perspective of the healthcare provider who was receiving the support. As I said, the absence of evidence doesn't mean that the programs are not effective; it means that it hasn't been adequately studied and published and reported. That's why I think that scoping reviews are helpful, because it can help to make a research agenda. And I think that what's clear to me is that we need to not just focus on getting these things up and running, but we do need to also focus on whether or not we can actually report evidence of effectiveness.

The kind of stuff we found is along the lines of satisfaction, which I kind of jokingly refer to as Mikey likes it. That doesn't mean it's effective just because somebody is satisfied with their experience or they think it's good. It doesn't necessarily mean that it's having an effect. So that's one kind of measurement. I think we need to come together for better kinds of measurements so that we can see whether or not the healthcare providers are actually benefitting from it, not just that they like it.

MR. THRALL: Great. Thank you very much for that.

I have another one for Katrina and Eleanor. We'll get to you, Diane, I promise. For Katrina and Eleanor from Ray: Did you consider that data from the thousands of peer support programs in schools across Canada could contribute to your understanding of peer support?

MS. FITZGERALD: We did not consider that. That's an excellent point. Sometimes you have to go outside of your domain in order to find things that you can translate over. So we focused on a specific setting, as in acute care settings. But I have considered that there's a lot we could learn from first responders, which act outside of our hospital organizations and institutions. And I hadn't thought about schools, but I think that also brings up another body of literature that might be able to report some things that are interesting. You'd have to look in different databases to find those, I think.

MR. THRALL: For sure, for sure. Well, thank you very much, Ray. That's a terrific suggestion. And then a question for Diane that came from Christina: Can you speak about the training required or recommended for the peer supporters that you've looked at?

MS. AUBIN: Thank you. And I just want to add to the last question. We did work a lot with the BC Emergency Health Services, and that is beyond the acute care setting. They work with first responders, obviously, police and ambulance workers, so there is some of that in the Canadian scope of work.

Back to the training. The training required—Katrina mentioned earlier the CISM, the Critical Incident Stress Management. Some of the organizations relied on that program to train their peer supporters, and that's about a three-day program. It was all more than just a little workshop in the afternoon. They certainly did some training for at least two or three days beforehand.

And then they didn't just let them go and go on and do their work. A lot of the organizations gave peer supporters opportunities to meet up and debrief every month or two to talk about who they'd met—and confidentially, of course—but experiences and to learn from each other. And then that support also, they recognized, the organizations recognized how difficult and how it can be even a traumatic experience for peer supporters to try to support their peers. There's that ongoing emotional support for peer supporters. More than just training, but support for them.

MR. THRALL: And on an ongoing basis for sure. Terrific. Thank you so much, Diane.

I got a question from Marilyn and I'll throw it out to the open panel here. After an assault on a healthcare worker, is it up to the worker to file charges or should that be done by the employer who is responsible for the safety of their staff? I'm not sure that it fits within the scope of this discussion, but I invite comment from all the panelists on that.

MS. AUBIN: It's quiet because, for me, that is beyond the scope of my knowledge. And that would be more for a legal representative to be able to give input on that. Sorry that I don't have that knowledge, but it certainly… Assault is one of the emotionally distressing things that can happen.

And it would be up to the organization to have a protocol process for dealing with that.

MR. THRALL: For sure, for sure. Thank you. Any other comments? I invite whatever you have to share there, but we can definitely move on.

MS. FITZGERALD: I would say that I think that organizations have an obligation to support the people who work for them, and I think that it would be safe to go to your organization to seek counsel, because there's no doubt that they have expertise to offer, because it's very unlikely that it's the first time it's happened in their institution.

MR. THRALL: Excellent. Well, thank you very much for that.

I do have one more question that came in through the question box. I invite anybody else to please submit their questions into the chat box directly to me, Chris Thrall, or in the Q&A box. And we'd love to entertain them.

But, at this point, I have one question left for Diane. It's a little thorny one, so walk with me through this one. How are these peer support programs different than the support offered by provincial support programs? Off the top of my head, Alberta's Physician and Family Support Program. Can you give us maybe a transnational observation, or how do these peer support programs you're studying differ from provincial support programs?

MS. AUBIN: That's an excellent question. Just to start off, we don't mean to… I don't think any organization means to replace peer support program. The provincial ones that I am aware of are the ones for physicians. There are some for nurses as well through different organizations. They're specific usually to certain health professions. They do support the health professionals. There's the, like you mentioned in Alberta, there's the Physician and Family Support Program through the Alberta Medical Association. I have spoken to them, and they do say they do some great work and they support even physicians who go through medical errors. So they are out there.

Different in that it is right within the organization. The organization, the peers at the organization understand the context, understand who's who, understand what the different departments are, and the "politics" of what goes on, and some of the people involved.

MR. THRALL: Functional expertise, yeah.

MS. AUBIN: So much more, yeah. Much more clear and personal in that sense. That would be the advantage of having a peer support program right in your organization. And it's open to everyone, and it's specific to that organization.

Let me know if that's what you were looking for.

MR. THRALL: Yeah, I think so. I think so. It's not intended to replace; it's just intended to support. And that's all we're really looking for here is other ways to be able to support the people who are going through this kind of trauma.

MS. FITZGERALD: Chris, I think it's also important that we differentiate peer support programs from EAPs and things of that nature. EAPs provide support on a more clinical level versus peer support. It's not meant to replace those other forms of support. It's literally colleague to colleague, I know what you're going through. It's an opportunity to be on the same page as somebody and to just share. If you need a different level of support, peer support doesn't replace that kind of thing.

MR. THRALL: No, no. That's interesting. And did the study extend into those EAPs, the workplace benefits programs, or anything like that, or it was really looking exclusively at those acute care peer support programs?

MS. FITZGERALD: We were looking not just for peer support programs. We were looking for organizational strategies to support. What we found was predominantly peer support programs, but that's not what we were looking for. That's why we found some curricula, some tool kits, some peer support programs, and EAPs were generally mentioned. And when you talk to healthcare organizations, they feel like they're covering this because they have an EAP. But part of my point is that an EAP is not the same. An EAP also excludes physicians who are not employees at the hospital in most settings.

MR. THRALL: Yes, of course.

MS. FITZGERALD: And an EAP is really providing it on a clinical level, which is different than having the support of your colleagues.

MR. THRALL: Yeah. All right. Well, thank you. Another question that came in from the floor. I think this one's going to go out to Markirit, actually. From Christina: Will the tool kit that comes out at the end of this peer-to-peer support program include suggested metrics for evaluating the

effectiveness of peer support programs? The tool kit from CPSI.

MS. ARMUTLU: Sure, Chris. Thank you. Thank you for that question, Christina.

The evaluation of peer support programs is very challenging, particularly due to the fact that when - - program, we pay great attention to protecting the confidentiality of the care providers and healthcare workers who engage and who seek support. In doing so, evaluation is a challenge. There are basic matrix, and you'll see in the tool kit that there is some, the tool kit that we will be launching in September, there will be some resources around that.

However, I want to just bring forward to you the fact that following our launch of the best practices guidelines in September along with the tool kit, we will be engaging in a concerted effort with our working group members and others across the country to really develop a robust matrix and indicators and look at evaluation program for peer support, because, certainly, there are questions being asked of folks who put resources, both human resources and financial, to develop peer support programs, where they're being asked: What's the outcome? What are the effectiveness? You're coming to us with more funds, for more funds, but show us that what you have is effective.

To be able to address that question, absolutely, there needs to be a means to evaluate without breaking confidentiality. And that work will commence in September. There are individuals out there and individuals on this call who have looked at that challenge and have started addressing it. I welcome you to be in touch with me so that we can actually pull that work group together. And we will be identifying the participants of that working group over the course of the summer and initiating that work in September.

So, great question, Christina. And just look out for our tool kit, but also, in September, we will be initiating this work more robustly.

MR. THRALL: Wow. Terrific. Very exciting, Markirit. Thank you very much for that.

Given that we have no more calls from the floor, I will just call time, and we can all get back to our tasks a little bit earlier.

We do want to respectfully thank Dr. Katrina Hurley, Diane Aubin, and Eleanor Fitzpatrick for sharing their time and their expertise. Thanks, of course, to all of you for taking the time to attend. On behalf of me, Christopher Thrall, Program Lead Markirit Armutlu, and Technical Host Gina Peck, and the rest of the team of the Canadian Patient Safety Institute, thanks again to our partners, the Mental Health Commission of Canada and the IWK Health Centre.

If you want to continue the conversation started in this discussion, please feel free to send us an email. We will forward your comments and any questions you may have had that weren't addressed on to our speakers. You should all receive Gina Peck's follow-up thank-you email in your inbox shortly, and you can respond to that. We will also post a recorded copy of this webinar on the CPSI website in the next week or so.

We invite you to join us for the final webinar of this series on September 20th, with Canadian Best Practices for Peer-to-Peer Support Programs and the launch of that peer-to-peer support kit that Markirit mentioned. You'll find registration information on our website.

So have a wonderful day, everyone, and we will hope to see you again soon. Take care.

[END OF TRANSCRIPT]