Editorial

Peer support to improve recovery after critical care for COVID-19

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This editorial describes the history of peer support in critical care and how this prior research and knowledge can be leveraged to support people who have required critical care to survive Coronavirus disease 2019 (COVID-19). To achieve this, the editorial reviews the potential benefits of recovery programs that involve peer support after critical care, discusses important considerations for the clinical implementation of peer support, and makes recommendations for future research in this field.

Recovery is an ongoing experience, not an end point or cure. It is non-linear and brings achievements and setbacks. It is a journey rarely taken alone. Personal recovery is ultimately about creating and living a meaningful life in a community of choice.[1] There is power in connecting with others who have a shared history or experience – particularly a history borne out of illness or trauma. By connecting with a community of support, burdens are shared, experiences normalised, solutions proposed, and hopes restored; this all makes one feel less alone. This is the essence of peer support, and why peer support can be a powerful mediator and facilitator of recovery.

As with many critical care interventions, peer support is an intervention that pre-dates the COVID-19 pandemic.[2] To improve recovery following a period of critical care, researchers and clinicians have been investigating this intervention for several years. In 2015, there was an international groundswell of interest to set up peer support groups, spearheaded by the Society of Critical Care Medicine's THRIVE Peer Support Collaborative. This work was borne from the need to address the symptoms of post-intensive care syndrome,[3] which had been described by survivors and their caregivers for decades. These symptoms include sustained physical, cognitive and mental health impairments that impact the patients and their caregivers, and limit their ability to return to former roles such as employment. Survivors and caregivers also described that the care they received became fragmented as they transitioned from hospital to home, with many not knowing where to turn for help once they had left hospital.[4]

Similarly, those who survive COVID-19 may develop a myriad of physical, cognitive and mental health impairments, which the World Health Organization has termed post COVID-19 condition[5] and which is commonly referred to as 'long COVID'.[6] As the pandemic stretches ahead, this growing cohort of survivors with long COVID contributes to the immense pressure on healthcare systems. In an effort to manage the rehabilitative needs of patients who have required critical care to survive COVID-19, it is incredibly important that the decades of prior research and knowledge to improve recovery after critical care are leveraged and translated into practice rather than starting from the beginning. Overarchingly, it is important that we treat and manage symptoms and problems rather than being concerned with whether we attribute them to post-intensive care

syndrome or long COVID, given that these will overlap in their clinical presentation and sequelae.

Defining peer support

In the critical care literature, the definition of peer support has been adopted from research in psychiatry:

> Peer support services bring together nonprofessionals with similar stressors or health problems for… mutual support or unidirectional support from an experienced peer to a novice peer. Peer support services can be delivered in groups or pairs, and in person, over the telephone, or through the internet.[7]

Peer support is a complex intervention with various models described in critical care, including a community-based model, an outpatient model, intensive care units (ICU) follow-up clinics, online, group support in the ICU for caregivers, and a peer mentor model.[8] Given this varied range, it can be useful to consider the components of peer support, using a systematic approach such as some items from the TIDieR checklist,[9] to frame the practical considerations for program start-up. For example, it is important to consider the 'who, what, when and where' for development of peer support models (Table 1). Further use of the TIDieR checklist would also improve reporting of peer support research, which would help to propel the field forward.

Using peer support as a potentially powerful mediator of recovery

Based on shared experiential empathy, peer support has long been used in other patient populations such as those with cancer.[10] It has more recently been explored in patients with heart failure,[11] diabetes[12] and traumatic brain injury.[13] By promoting a culture of resilience and enhanced recovery, peer support can also ameliorate post-intensive care syndrome.[2]

Peer support in critical care remains a developing field. In 2018, a systematic review evaluated the impact of peer support interventions on patient and family outcomes following critical illness, and synthesised the key elements of model design and structure.[14] Eight studies were included, comprising 192 family members and 92 patients, including adults (with cardiac surgery, acute myocardial infarction or trauma), children and neonates. The most common peer support model of the included studies was an in-person, facilitated group for families, which occurred during the patients' ICU admission. Peer support appeared to reduce psychological morbidity and increase social support. This systematic review highlighted that the evidence for peer support in critically ill populations is limited. There

Table 1
Models of peer support, adapted from McPeake et al.[3]

Model	Who	What	When	Where
Community-based	Patients and/or caregivers, led by staff or former patients	A range of topics are included: themes recalled from ICU, feelings of…, experience of… strategies and resources	Typically, any time after hospital discharge, as suits the patient	Community centres, churches, coffee shops or within hospital setting (not within ICU)
Outpatient	Facilitators enable more experienced patients and/or caregivers to support new members	Guided by psychological principles with the aim of sharing and normalising experiences	As above	As above
Based within ICU follow-up clinics	Patients and caregivers meet their peers and also receive informal support and advice from volunteers who are further in recovery	Provides intentional, unstructured peer support	After ICU follow-up clinic review	Informal setting (eg, waiting room or café)
Online	Moderated by hospital organisation or patients and caregivers, with the moderator approving comments prior to posting, posting links, and posing questions	On an online bulletin board, participants (anonymously) post and respond to existing questions and/or comments	Interaction is staggered, not in real time	Online forums (eg, Facebook)
Group-based within the ICU	Led by staff within ICU and primarily targeting caregivers	Group discussion with the aim of fostering support, where those who attend a session direct the topics for that session	Typically weekly, with participants able to attend at any time throughout the admission	Within the ICU (eg, meeting or handover room)
Peer mentor	Patients still in hospital are linked with patients further along the recovery trajectory	Aimed to create a formal support mechanism for recovery	During ICU/hospital admission	Within the ICU/hospital

is a need for well-designed and rigorously reported research into this complex intervention.

Peer support for people who have required critical care to survive COVID-19

Research has identified three key mechanisms of peer support that can be leveraged to benefit people who have survived COVID-19 that was severe enough to require critical care: sharing of experiences, care debriefing and altruism.[15] Sharing of experiences may reduce psychological morbidity, improve social support and further enhance motivation for rehabilitation and recovery. Care debriefing is where survivors have the opportunity to discuss what happened to them in the ICU – usually with critical care clinicians who can describe critical illness, the interventions delivered in the ICU setting and the impacts of these. It can help patients and caregivers to better understand what has happened and manage expectations of recovery. Altruism can assist patients and caregivers by offering them a sense of purpose by giving back to the healthcare system that cared for them and by helping other patients.

In 2021, the Critical and Acute Illness Recovery Organization published a report on establishing a peer support program for survivors of COVID-19.[16] This report recognised the need to adapt in-person programs to virtual telehealth platforms; however, there have been very few publications reporting the success of such virtual programs during the pandemic,[17] with research evaluating feasibility and efficacy still in progress[18,19] Key considerations for establishing a

peer support program from this report are presented in Box 1. Similarly, international qualitative research has reported a range of barriers that should be mitigated and enablers that can be leveraged when establishing such programs,[20] as presented in Box 2.

Impacts of the pandemic on health professionals

During the pandemic, healthcare professionals have experienced higher rates of psychological distress,[21] including burnout, anxiety and depression. Frontline healthcare professionals (particularly those working in high-risk areas such as the ICU) have been exposed to moral injury[22] and occupational violence. These challenges have arisen from a culmination of complex socio-political factors such as loss of trust in medicine and science, the anti-vaccination movement, and attitudes of indifference exhibited from politicians to the lay public toward some of society's most disadvantaged. These factors have even intersected at the point of care, such as the patient who attended an anti-vaccination protest, was admitted to the ICU in extremis with respiratory failure due to COVID-19 pneumonia, required intubation, and expressed regret for not getting vaccinated. While the role of any health professional is to be aware of one's own biases and to treat patients without fear or favour, bearing witness to these emotionally charged and complex situations has left its mark, and may have changed the way we care for patients and their families in the future.

One potential benefit of providing post-ICU follow-up services – such as peer support programs or clinics – relates to the potential benefit to the staff delivering these programs. We have previously described this as a

Box 1. Key considerations in establishing a peer support program, adapted from Hope et al.[12]

Preparation	• Consider forming a multidisciplinary team with a diverse skillset • Assess local needs of population • Set goals and objectives for the group • Become familiar with online platforms
Recruitment	• Consider whom you will invite to your group and how • Use a variety of communication strategies and methods to target patients, families and other clinicians to get involved
Facilitation	• Consider who will facilitate your group, who can demonstrate active listening and empathic communication skills, set and negotiate ground rules, and manage group functioning
Trauma-informed approach	• Consider a trauma-informed approach to care by knowing the developmental, behavioural, cognitive, social and physical effects of trauma
Planning logistics	• Consider the size of the group and the duration and frequency of the meeting
Planning for the in-between	• Consider how you will debrief as group leaders and facilitators, including incorporation of regular reflection on group functioning and ways to optimise it

Box 2. Barriers to and enablers of peer support programs, adapted from Hibbert et al.[19]	
Barriers	• Patient and family nonattendance • Access to a skilled facilitator • Bureaucratic limitations of health services • Building therapeutic trust and rapport • Challenges in managing expectations of former patients as volunteers
Enablers	• Building social cohesion: to help the survivors connect with each other • Defining operational processes: captured in a standard operating procedure, given the complexity of the intervention • Accessing skilled group facilitators: such as social workers, psychologists who have requisite expertise • Value of debriefing for the group facilitators: to support the well-being of those running the groups • Membership to learning collaboratives such as the SCCM THRIVE Peer Support Collaborative: provides a forum for sharing ideas and trouble-shooting challenges • Engaging participants into the group: working out who is best to attend and how to get them to attend • Motivated interprofessional clinicians: who persist to overcome barriers as they arise • Patients and family volunteers and advocates: who can support the running of the group • Leveraging ICU follow-up clinics: as a means of cross-referral from clinic to peer support group.

key mechanism where ICU follow-up services can improve the care delivered in the ICU.[23] Before the pandemic, we hypothesised that burnout for ICU clinicians might be reduced through learning more about ICU survivorship directly from patients and their carers.[23]

As healthcare systems continue to battle COVID-19, it is even more important to consider the potential benefit to staff wellbeing from delivering such programs. This could be an important part of finding purpose and joy again at work, mitigating the impact of moral injury for ICU clinicians, and providing some form of closure in a less emotionally charged environment than the ICU.

Thinking ahead – the value of peer support

Looking to the future, one of the great challenges for healthcare is how we will be able to manage and sustain recovery for a potentially growing number of people with long COVID, as another chronic disease.[24] With healthcare systems stretched beyond capacity for extended periods and the people that make up the system tired and weary, peer support may become increasingly important; where rich knowledge and lived experience can be drawn upon and communities of support established – that may benefit not only patients and their carers but also staff. Such communities of support recognise that recovery is 'a human process… a journey rarely taken alone…' and that while there might be an 'urge to break and fall back', by supporting each other together there might also be hope to build and recover.

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References

1. Victorian Government Department of Health, Australia. *Recovery: the concept.* https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-n-recovgde-toc~mental-pubs-n-recovgde-3. Accessed February 7, 2022.
2. Mikkelsen ME, et al. *AACN Adv Crit Care.* 2016;27:221–229.
3. Needham DM, et al. *Crit Care Med.* 2012;40:502–509.
4. Hibbert E, et al. *Crit Care Med.* 2021;49:1923–1931.
5. WHO. (2021). A clinical case definition of post COVID-19 condition by a Delphi consensus. https://www.who.int/publications/i/item/WHO-2019-nCoV-Post_COVID-19_condition-Clinical_case_definition-2021.1. Accessed February 7, 2022.
6. Crook H, et al. *BMJ.* 2021;374:n1648.
7. Pfeiffer PN, et al. *Gen Hosp Psychiatry.* 2011;33:29–36.
8. McPeake J, et al. *Crit Care Med.* 2019;47:e21–e27.
9. Hoffman T, et al. *BMJ.* 2014;348:g1687.
10. Hoey LM, et al. *Patient Educ Couns.* 2008;70:315–337.
11. Heisler M, et al. *Congest Heart Fail.* 2007;13:149–157.
12. Heisler M. *Diabetes Spectr.* 2016;20:214–221.
13. Hibbard MR, et al. *J Head Trauma Rehabil.* 2002;17:112–131.
14. Haines KJ, et al. *Crit Care Med.* 2018;46:1522–1531.
15. McPeake J, et al. *Am J Crit Care.* 2021;30:145–149.
16. Hope AA, et al. *Am J Crit Care.* 2021;30:150–154.
17. Lassen-Greene CL, et al. *Ann Am Thorac Soc.* 2021;18:177–182.
18. Danesh V, et al. *J Adv Nurs.* 2021;77:2092–2101.
19. https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?id=381797&isReview=true. Accessed February 7, 2022.
20. Hibbert E, Devine H, Haines KJ. Peer Support to Improve Recovery—Concepts and Considerations (Ch 11). In: Haines KJ, McPeake J, Sevin CM, eds. *Improving Critical Care Survivorship.* Switzerland: Springer; 2021.
21. Holton S, et al. *Aust Health Rev.* 2020;45:297–305.
22. Kok N, et al. *Intens Care Med.* 2020;46:1653–1654.
23. Haines KJ, et al. *Intensive Care Med.* 2019;45:939–947.
24. Vaes AW, et al. *ERJ Open Res.* 2021;7:2.