Narrative 10
Implementing a Peer Support Program for Veterans: Seeking New Models for the Provision of Community-Based Outpatient Services for Posttraumatic Stress Disorder and Substance Use Disorders

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This is the story of physicians and health professionals who came together to establish the Peer Support Program, to develop new models for the provision of community based outpatient services where capacity of the system and providers is challenged to meet a community's needs.

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Defining the Issue

More than 3.4 million rural[1] veterans are enrolled in the VA health care system [1]. Men and women from geographically rural and highly rural areas make up a disproportionate share of service members, comprising about one third (32 %) of the enrolled veterans who served in the recent conflicts in Afghanistan and Iraq, referred to here as Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans. Many of these soldiers are returning to their rural communities [1], and there is a shortage of mental health professionals practicing in rural areas. Hence, rural veterans face significant disparities in accessing care, especially highly specialized services [2].

Rural veterans with depression and anxiety disorders are significantly less likely to receive psychotherapy services, and when they do receive them, the amount provided is limited, relative to rural veterans' urban counterparts [3]. While telehealth and other technological interventions are successful strategies to address some of these issues [4], geographical inequities in the availability and distribution of mental health professionals are unlikely to change in the near future [5].

Effectively treating veterans with posttraumatic stress disorder (PTSD) in a timely manner remains a pressing public health concern. Up to 13 % of OEF/OIF/OND veterans have combat-related PTSD [6, 7]. Despite the availability of evidence-based treatments, which ameliorate core PTSD symptoms and prevent further negative consequences such as substance use disorders (SUDs) and suicide [8, 9], help-seeking veterans often do not follow up with the recommended course of psychological [10] or pharmacological [11] therapies. This may be due, in part, to problems at the interface between the veteran and the health care system. Recent research suggests that veterans with PTSD are less likely to perceive their health care experience as being positive [12] and that negative perceptions of mental health care (e.g., lack of trust in mental health professionals) predicts low service utilization [13].

Further, research has found that veterans' concerns about treatments are larger barriers than stigma, emotional readiness, or logistical issues [14]. These concerns include being misunderstood by clinicians or belief that medications will not relieve their symptoms [14]. For veterans who live in rural communities, studies suggest that the rural culture itself may foster a perceived need for greater self-reliance, independence, and conformity to social norms (whether positive or negative toward mental health treatments) and thereby delay identification of mental health problems and discourage the use of formal mental health services [15, 16]. Finally, OEF/OIF/OND veterans are less likely to present in mental health outpatient treatment than veterans from previous eras [5] and may be prone to prematurely dropping out of PTSD treat-

[1] The US Census defines *rural* as "territory, population, and housing units not classified as Urban" and defines *urban* as "comprising all territory, population, and housing units in urbanized areas and in places of 2,500 or more persons outside urbanized areas."

ment altogether [10, 11]. In light of these challenges, there is a pressing need for innovative interventions that focus on enhancing the reach of PTSD treatment, that is, making treatments more accessible and easier to engage in and adhere to [17].

Toward an Approach/Solution

Involving peer support in the care of rural veterans is an innovative solution [18, 19]. Peer support providers have personal experience with mental illness and have attained significant improvements in their own condition. Peer support programs offer formal services and support to a peer considered to be not as far along in his or her own recovery process. Consistent with this definition, and integral to the peer support process, is that the peer support providers reveal their experiences with mental illness and specifically focus on the skills, strengths, supports, and resources they used in their recovery. Peer support is considered a form of health care, with peer support providers acting as members of the mental health care team [19, 20]. While the use of peer support to provide services to individuals living with serious mental illness, such as bipolar disorder and schizophrenia, has been well investigated, the use of such an intervention for individuals with PTSD is a relatively new concept [21, 22]. We have previously postulated that the principal mechanisms of action of such a peer support intervention are (1) the promotion of social bonds, (2) the promotion of recovery, and (3) the promotion of knowledge about the health care system [23].

With regard to care delivered in rural regions, peers can potentially play a key role in augmenting the PTSD and substance use disorders (SUD) care offered by overburdened mental health professionals. We are not suggesting that peers replace the evidence-based psychotherapies and pharmacotherapies for PTSD and SUDs offered by qualified mental health professionals but, rather, that they provide innovative supplemental services that aim to engage those with PTSD and SUDs in treatment long enough that they might experience benefit from professionally delivered treatment. Also, because these peers come from the same rural community as the patients they are serving, this shared background may be helpful in combating some of the stigma associated with the decision to seek mental health services.

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Introducing the Partners

Mr. Guy Holmes, a Peer Support Program employee since March 2012, is a Vietnam veteran from Sonora, CA, who works 20 hours/week providing peer support services at the VA Sonora clinic. Mr. Erik Ontiveros, a Peer Support Program employee since April 2013, is an Iraq war veteran who provides peer support services at the VA clinics in Stockton and Modesto, CA, 20 hours/week. Kaela Joseph and Hannah Holt have provided administrative and research assistance for the program. William Boddie is a licensed clinical social worker responsible for providing clinical supervision for the certified peer specialists. Dr. Shaili Jain and Dr. Steven Lindley are both psychiatrists and provide administrative leadership and direction for the program. In addition to these partners, the program has the following consultants: Craig Rosen, a health services researcher and deputy director of the National Center for PTSD; Darryl Silva, senior mental health administrator for the Stockton, Modesto, and Sonora Community Based Outpatient Clinics and national director of VA Peer Support Services, located in the VA central office.

A private donation from the Michael Alan Rosen Foundation solely funds the certified peer specialist and program support assistant positions. The funding is primarily used to support the salaries, benefits, and associated costs of the peer specialist and the part-time program support assistant. Additional associated costs include peer specialist training and financial support for outreach efforts and mileage. Along with the Michael Alan Rosen Foundation, Stanford and the VA contribute resources towards the program's support, such as the time of Dr. Lindley and Dr. Jain for project leadership and the computers, servers, telephones, administrative support, office supplies, and workspaces already in place at VA clinics.

Getting Started

In early 2012, we developed the Peer Support Program as a clinical demonstration project at the Sonora Community Based Outpatient Clinic of the VA Palo Alto Healthcare System. During the initial stages we relied on the existing support and infrastructure provided by the national VA Peer Support Services to guide many decisions for implementing the procedures and policies related to this project. Program leadership and direction came from the Menlo Park campus of this health care system, which is located 130 miles from Sonora. The Sonora clinic serves more than 3500 veterans in the Sierra Nevada Foothills, a rural region of Northern California, and its services include mental health, general medicine, social work, substance abuse, and wellness. The majority of veterans seeking services at the clinic are male (93 %) and Caucasian (75 %), and their average age is 61 years. The most common primary diagnosis at the Sonora clinic is PTSD (49 %), and 19 % of veterans have a secondary diagnosis of SUD. Prior to implementing the program, the clinic employed a mental health team that included two full-time general mental

health social workers and one OEF/OIF case manager. All psychiatry appointments are conducted through telemental health, unless the veteran opts to commute to another VA clinic for psychiatric care. In light of the success of this demonstration project, in April 2013 the program was expanded to the Stockton and Modesto Community Based Outpatient Clinics, both in underserved regions of Northern California that serve patients who reside in rural areas.

"The rural clinics are busy," offers William Boddie, the clinical social worker and supervisor for the certified peer specialists. "It feels like we are putting out fires constantly." The biggest challenges he encounters in his daily work for the Peer Support Program are managing referrals to overbooked mental health professionals and engaging veterans in treatment. He continues, "The peer specialists are in a unique position to help with both of these challenges." Boddie helps the peer specialists communicate with other mental health providers and integrates their peer support services with the rest of the veterans' care, thus supporting and augmenting existing mental health services. Boddie says, "I couldn't do my job without the peer specialists. The role of Erik and Guy [certified peer specialists] is crucial in connecting to veterans who have experienced very painful circumstances. I can relate to my patients as a clinician, but the peer can relate on their level. No matter how much training I have as a licensed clinical social worker, I will never be able to share their experience."

An important first step in implementing the Peer Support Program was to recruit the peers who would provide services. We employed rigorous screening and hiring procedures in accordance with previous recommendations [24, 25]. The clinics' senior mental health administrator was actively involved in the recruitment process and remains an important consultant to the program. Ensuring our peers received adequate training for the position and demonstrated certain competencies was the top priority [18, 19, 26]. Essential components of the peer training were (1) understanding and respecting therapeutic boundaries, (2) active listening, and (3) training in psychological crisis management. We aimed to avoid the use of a rigid didactic training, which may have undermined the natural, unique skills that the peers brought to the treatment team [27, 28].

In addition to running peer support groups, the certified peer specialist provides support via telephone and individual "engagement" visits, if requested by veteran patients. Although the peer conducts his groups independently, a licensed mental health professional is required to be available, on site, at all times, while the peer is interfacing with veteran patients. The peer specialist completes chart reviews and documents all his contacts with the veterans.

The peer is required to engage in weekly supervision with a licensed mental health professional. Supervision typically focuses on one or more of the following domains: components of recovery, professional ethics, customer service, outreach efforts, personal self-development, enhancing communication and group facilitation skills, management of stigma, comprehension of mental illness, recovery tools, professional development, and crisis management. Boddie has had extensive experience supervising students in clinical social work and has much of the same discussions during supervision with the peer specialists as with his other supervisees. Discussion and reflection about ethical considerations and boundaries are important

to any mental health provider, but the focus in Boddie's supervision with the peer providers is often how to coach veterans on the basis of the peer specialists' own experience of recovery using available resources and tools. Shaili Jain provides additional supervision through monthly team conference calls and notes that the level of passion and commitment that the peer specialists bring to the team are highly valuable and unique. Dr. Jain admires the peer specialists' commitment to service and their focus on the patient experience. Working in a large health care system with many levels of administrative and regulatory demands can get distracting for clinicians. She reflects, "The peers really want to be of service and are so focused on their patients. It is very refreshing and inspiring."

Another important role for the peer is conducting community outreach, including outreach letters to therapists in the community and personalized letters/flyers to veterans to enhance awareness of the Peer Support Program. Outreach also includes personal appearances at local colleges, job fairs, community events that honor local veterans, and connecting with rural outreach counselors and counselors at the larger hospital system to promote awareness of the program. "The outreach came about organically," states Dr. Jain. "The peer support providers both felt it was an important part of their job and an aspect that most busy mental health professional just do not have time for." One of the advantages of the peer specialists is that they are not burdened by organizational requirements (e.g., billing and charting paperwork) so that they have more time to provide this valuable adjunctive service.

In June 2013, the peer specialists began conducting a focused telephone outreach to Iraq/Afghanistan veterans from the central valley and Sonora area who were not currently engaged in mental health services but had been diagnosed with PTSD and SUD. During these telephone calls, the specialist described the peer support program to his veteran peers and invited them to attend. The specialists both wrote personal letters describing their own journey of recovery and mailed invitations to the peer support program, along with peer support brochures, to this target population.

Erik Ontiveros, one of the certified peer specialists, has cited that dispelling stigma and mistrust is the signature challenge of his work in peer support. As a veteran himself, he recognizes that the culture of the military does not generally lend support to the admission of having a problem or asking for help. Ontiveros overcomes this challenge by using his own experience of difficulty asking for help as an example for the veterans and normalizing their feelings of hesitance about seeking help. He reported that whenever a new group member is present in his support group, he takes the time to share the story of his own treatment and successful recovery after returning home from service. Ontiveros asks the other group members to share their backgrounds and perspectives about how the group has been helpful. He wants the veterans to know that they are not alone and that their hesitation about seeking treatment or help is natural.

Even when veterans have not yet attended one of his peer support groups, Ontiveros still tries to engage veterans over the phone, leaving voicemails and reminding them that help is available when they are ready. Because Ontiveros has been through the process himself, at one point reluctant to accept help after returning home from deployment, he has more empathy for the veterans, which quells any

frustration. He also offers that sometimes he will see a veteran in one of his groups who will tell him, "I got your messages and I'm ready now." Ontiveros has to remind himself that even if he never speaks with a veteran directly while conducting telephone outreach, it does not mean that the veteran is not getting the messages or that they are not having an effect.

Program Outcomes

The program keeps detailed records of the peer specialists' clinical activities. The peer specialists and their clinical supervisor complete tracking sheets, and the program assistant compiles data from these forms into various databases to keep track of program outcomes. Veterans who participate in the program are also asked periodically to fill out satisfaction surveys, which are logged into a database and analyzed for quality assurance. In addition to ongoing direct clinical supervision, the entire Peer Support Program team (which is geographically dispersed) meets monthly via conference calls and annually via an in-person retreat.

As of April 30, 2014, the program served 185 veterans (127 in Sonora and 58 in Modesto and/or Stockton), and the peer specialists provided a total of 258 peer support groups, with an average of 10 patients in each group. The 2013 telephone outreach effort identified 148 veterans who were not engaged in mental health treatment. Of those veterans, 87 were successfully contacted by phone, 58 were sent information in the mail, and 3 were contacted by other means. Forty-seven veterans agreed to engage in the Peer Support Program, and an additional 21 indicated they might be interested. The peer specialists have spent almost 300 hours engaging in telephone outreach.

In addition to these services, the peer specialists have provided 188 individual "engagement" visits and conducted more than 200 hours of active community outreach. Clinical supervision for the peer specialists is conducted weekly and usually lasts 1 hour. Holmes, the original peer support specialist, has documented 53 supervision sessions, and Ontiveros, who joined the team later, has documented 27 supervision sessions.

Preliminary patient feedback shows that 75 % of veterans rated the peer services they received as "always" helpful. Also, 75 % of veterans reported that the peer specialist "frequently" provides high quality emotional support, with 25 % reporting the support as "always" being of high quality. Early ratings of peer support group cohesion are encouraging, with veteran patients consistently highly rating the group cohesion and value of the peer support groups. Below are some comments transcribed from anonymous patient feedback of the group experience:

"*I feel this group meeting is highly beneficial to me*."
"*He* [the certified peer specialist] *respects our statements and leads us in a constructive way*."
"*I wish I didn't have to wait for over 40 years to be in a group like this*."

Several striking stories of success and recovery have come from the Peer Support Program. Ontiveros described a female veteran who made a dramatic transformation over a year of attending peer support groups. The veteran used to sit and listen

very attentively to the other veterans but never offered her own perspective or shared her experience with PTSD and other mental health problems. Whereas she was very uncomfortable when she first starting to attend the peer support groups, Ontiveros states that she now often shares her feelings and offers advice to other veterans about coping skills. He has noticed a dramatic shift in her level of confidence, especially as she is often the only female in a group of service members who are mostly men. Ontiveros noted that she has been able to recognize that her pain and her experiences of the military are just as valid as those of the male veterans.

Dr. Jain recalled an experience several months into the implementation of the peer support program that gave her a perspective on the power of the program. During a team call, one of the peer specialists mentioned that a veteran who had been determined to be at high risk for suicide had not been to the clinic to see his provider or attended the peer support group for quite some time. The peer specialist added that he had been meeting with this veteran at the local coffee shop. Dr. Jain reported that as the project director, her “red flags were going off,” and she became concerned about potential boundary violations and the serious implications of services taking place outside of the clinic. The peer specialist subsequently explained, however, that there is only one coffee shop in this rural town and that he happened to see the veteran there each week when he got his morning coffee. He had not been engaging with the veteran per se, but he could at least offer the veteran a quick “hello” and report back that the veteran was doing well. Dr. Jain realized that overlapping roles would be inevitable in such a rural community. The informal feedback that the peer specialist was able to provide (e.g., that the veteran was fine) was a desirable consequence of him belonging to the same community as the veterans whom he served. The professional boundaries of which Dr. Jain had been trained to be mindful did not entirely map on to the roles that the peer specialists have with veteran patients. The flexibility in the role is part of the unique value that the peers bring to the treatment team.

The Peer Support Program is innovative because, to the best of our knowledge, it is the first program in the US that utilizes peer support specifically to address the needs of individuals living with PTSD. The program is also unique in its deployment of a telephone outreach intervention targeted toward a particular subset of the population identified by the VA databases as being disengaged in treatment. The program also seeks to combine research and practice, keeping detailed records of supervision of the peer specialists’ clinical activities and patient satisfaction surveys.

Lessons Learned

Initially, a low number of OIF/OEF/OND veterans used the Peer Support Program. We noted a significant increase in the percentage of visits by these veterans approximately 10 months after the program started. This increase was likely due to time the peer specialists spent conducting engagement visits with veterans who were initially

ambivalent about attending peer support groups. These individual engagement sessions possibly helped ease sources of the veterans' ambivalence and allowed for their subsequent engagement in mental health services on a longer-term basis. Levels of involvement by OIF/OEF/OND veterans have continued to increase and are likely a result of the peer specialists' targeted outreach efforts and word-of-mouth by veterans who utilize the program. It is important to note that these engagement visits are an example of a service that overburdened mental health providers may not be in a position to provide routinely as they work in rural or other regions vulnerable to becoming understaffed with mental health professionals.

We have learned about the vital importance of frequent, clear communication between team members who are not only geographically dispersed but also have different backgrounds, professional disciplines, and approaches to patients. The team members are in regular contact, on a day-to-day basis, via e-mail, voicemail, and instant messages and through electronic medical records. In addition, we have weekly clinical supervision meetings, monthly team conference calls, and an annual team retreat. We feel this attention to communication and the emphasis on a culture of open and transparent dialogue provide a safeguard against adverse events occurring in the team (e.g., team member attrition or miscommunication) and, most importantly, promote the provision of high quality services to patients.

One of the ongoing challenges for Dr. Jain is educating professional providers about the roles of the certified peer specialists and making it clear that they provide psychoeducation and support but not psychiatric or psychological treatment. Sometimes other providers do not fully understand the role of the peer specialists and assume the peers can take on responsibilities that are actually outside of their scope of practice. Within that vein, Dr. Jain also views it as her duty to protect the peer specialists from burnout and to support their ongoing recovery. She encourages self-care, self-monitoring, and pacing, making it clear that the peer providers' well-being is a team priority.

Implementing a new and innovative program also has organizational challenges. Ontiveros noted some initial resistance from the other mental health care providers and often felt like "the third wheel" in the beginning stages of implementation. As veterans began attending the peer support groups and relaying positive feedback to their other mental health care providers, however, he felt that he began to be taken more seriously. He had to show that the model worked by demonstrating success before the other mental health care providers could validate his role and responsibilities.

Finally, the licensed mental health professionals on the team have learned to encompass ideas or treatment approaches from the peer specialists on the team, which may be quite different to other clinical preferences or rationales. Over the 2 years this program has been operational, the health professionals have come to view the input from their peer specialist colleagues as unique and a reflection of the true value they bring to the treatment team. Valuing this diversity within the team is a key ingredient of the success of the program and has contributed immeasurably to it flourishing despite the considerable challenges of the geographical areas and the populations that the program serves.

Future Directions

Our primary emphasis is on expanding clinical services with an aim to have, at minimum, nine peer support groups running on a weekly basis with an average of 10–12 regular participants. The peer specialists play an invaluable role in engaging veterans, who may by ambivalent to seek care in mental health services. We envision that the Peer Support Program will prove to be an innovative modality, via which Iraq and Afghanistan veterans will be able to engage in mental health services. We hope that data from a formalized program evaluation effort will further serve to promote the Peer Support Program as a model for use in other VA and community settings.

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