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ORIGINAL PAPER

Monitoring the Dissemination of Peer Support in the VA Healthcare System

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Abstract This study illustrates a monitoring system for peer support programs, focusing on Vet-to-Vet, a program for veterans with chronic psychiatric disorders. The sample consisted of 1,847 anonymous surveys from 38 veteran peer support programs. Program satisfaction and recovery orientation were positively associated with duration and frequency of participation in peer support. Program satisfaction was also associated with the Vet-to-Vet model and location at a VA medical center (vs. other model & location types). Payment for peer facilitators was positively associated with recovery orientation, spirituality, and engagement in meaningful activity. Additional research using experimental design methods is needed to determine the impact of peer support on mental health outcomes.

Keywords Peer support · Recovery · Vet-to-Vet · Program evaluation

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Peer Support

Peer support is a growing component of service delivery for people with serious mental illness. While peer support has evolved in various forms over the past five decades (Kurtz 1997), only recently have peer providers begun to be formally incorporated into treatment programs within mental health service systems. Recent evidence suggests that peer support may improve outcomes for individuals with severe and chronic mental illness and co-occurring disorders (Burti et al. 2005; Min et al. 2007). As these efforts expand, it becomes increasingly important to document the delivery of peer support services as a component of the mental health service system, and to develop methods for monitoring implementation and outcomes under real world circumstances. This study presents an anonymous, voluntary system developed to monitor the implementation and delivery of Vet-to-Vet, a peer support program for veterans with a psychiatric disability (Resnick et al. 2004a) as it has been disseminated by veterans in recent years within the Department of Veterans Affairs.

Vet-to-Vet

Vet-to-Vet is a group-based, peer education and support program for individuals with psychiatric diagnoses, developed by Moe Armstrong, a decorated Vietnam combat veteran. Vet-to-Vet has been implemented at a broad range of VA locations including medical center clinics, VA community clinics, and community-based residential facilities. Staff and veterans at these organizations initiate the program, most often by extending an invitation to Mr. Armstrong who offers both introductory information sessions and more formal in-depth training.

The Vet-to-Vet model was first described in 2004 and includes nine key features (Resnick et al. 2004a); (1) The program was created by a decorated Vietnam Veteran who is also a recipient of VA mental health services with a 100% VA disability rating for schizophrenia; (2) it is based on a consumer–provider partnership model in which the peer facilitators are ultimately independent from the VA mental health service system but in which mental health professionals provide administrative support and regular clinical supervision; (3) groups are held in the same facilities where formal mental health services are offered, maximizing their accessibility; (4) potential peer facilitators are nominated by current peer facilitators based on explicit criteria; (5) groups are peer-led although staff may occasionally be invited to participate as guests; (6) meetings are voluntary and open to any veterans who wish to attend; (7) groups are designed to meet for 45 min and to be held at least once each weekday; (8) each meeting has a designated educational focus and follows a read and discuss format addressing specific topics such as: Disability Awareness, Disability Pride; Wellness; Recovery Workshop; Mental Illness Anonymous; and Writers' Workshop Meetings, and (9) meetings are based on a process of mutual and reciprocal education and support between facilitators and group members.

In addition to these key features, Vet-to-Vet also strives to encompass the spirit of recovery and positive psychology, which emphasize personal fulfillment, hope, empowerment, general well-being, self-acceptance, reduction of stigma related to mental illness, and the ability of persons to live meaningful lives despite chronic and/or severe mental illness (Corrigan et al. 2002; Corrigan et al. 2005; Resnick et al. 2005; Resnick and Rosenheck 2006). These ideals are fostered in Vet-to-Vet in a variety of ways. For example, the peer facilitator role promotes empowerment by providing the opportunity for consumers to function as role models and leaders. By endorsing open disclosure on the part of all who participate, Vet-to-Vet helps to reduce stigma and increase self-acceptance. Finally, Vet-to-Vet attenuates the hierarchical relationship between "professional" and "patient" by allowing consumers and non-consumers to work side-by-side.

Evaluation & Accountability of Peer Support

Accountability and outcome evaluation have become central features in the delivery of health care services in recent decades with a particular emphasis on measurement of the quality and outcomes of care (Campbell et al. 2000). To date no large scale monitoring system for peer support has been presented. The anonymous and voluntary monitoring system and preliminary data reported here illustrate an initial attempt at developing a large-scale, convenient, survey-based monitoring system for peer support programs. This project was developed and implemented through a partnership between Moe Armstrong, the veterans who have implemented peer support groups within the VA, VA professional staff, and researchers at the VA New England Mental Illness Research, Education and Clinical Center (MIRECC), one of 10 centers developed to facilitate the improvement of VA mental health care, especially recovery-oriented care, within the VA.

The development of evaluation approaches for peer support is especially challenging because these programs seek to remain independent of formal health care bureaucracies (Mead et al. 2001; Stewart 1990), and many consider this independence to be central to their contribution. Often this independence precludes the collection of data that are typically included in research within medical settings (e.g., collection of identifiers, psychiatric/non-psychiatric diagnoses, health outcomes). For this reason the current study employed a brief, anonymous, self-administered survey with two main two main foci: satisfaction with peer support and veteran recovery attitudes. In addition to being a fundamental indicator of the role of peer support, satisfaction is easily measured by brief, anonymous instruments and was therefore well-suited to studying peer support in a manner that is consistent with the culture in which it is based. Recovery attitudes were also central to this evaluation effort because peer support is based on recovery concepts and is thought to foster a recovery orientation.

A variety of other factors that are not specific to peer support may affect program implementation and outcomes as well. For example, although originally intended to be embedded in VA medical centers, Vet-to-Vet has been implemented in a variety of settings including traditional VA outpatient clinics located in both VA medical centers and in the community, as well as at non-VA community-based residential programs. Another example of program variability that has been the focus of recent dialogue is whether peer facilitators are paid or work on a volunteer basis (Proceeds of the Mutual Learning: A VA Peer Support & Education Conference 2005). It can reasonably be assumed that site differences such as location and ability to pay facilitators may affect group implementation, which may affect group satisfaction, participation, and other outcomes.

In this paper we: (1) describe a system of data collection utilized to monitor peer support in the VA; (2) examine the psychometric properties of the main data collection tool, the Peer Support Survey; (3) document the characteristics of the population of veterans currently participating in VA peer support groups; (4) examine variability in structural characteristics of the programs with a focus on (a) location

type, (b) model type, and (c) differences in compensation models across sites; and (5) present preliminary data on participation in peer support, veterans' satisfaction with participating in and leading groups, participant recovery attitudes, and the interrelationship between these variables. Finally we examine the impact of site-level structural characteristics on satisfaction with peer support and recovery attitudes.

Methods

Source of Data & Sample

The administrative data for this project come from the national monitoring effort of Vet-to-Vet and related peer support programs. Data collection was initiated in January, 2005 and included an initial group of 12 programs. Although participation in the evaluation is completely voluntary, in the 24 months following the start of data collection, involvement expanded to 38 programs nationwide. Veteran peer facilitators at these sites were offered assistance from the New England MIRECC to implement the survey, which includes four components: (1) distribution of the anonymous questionnaire by peer facilitators to program participants on a quarterly basis, (2) mailing completed surveys to a central data aggregation site (the New England MIRECC), (3) compilation and analysis of data by MIRECC staff followed by (4) semi-annual circulation of program-wide, site-level feedback to the peer support staff (VA staff and peer facilitators) at participating programs. The institutional review board of the VA Connecticut Healthcare System reviewed this study and approved a waiver of informed consent.

The surveys are administered by the peer facilitators who are instructed to ask group members to complete the surveys at the end of a regular peer support meeting and to collect the completed surveys before the members leave. For sites with several meetings each week, the peer facilitators are asked to hand out surveys in each group over a one-week period so that all the veterans have a chance to participate. It should be noted that there is no administrative oversight of the survey administration across sites so it is not possible to confirm that each site follows this procedure nor is it possible to confirm that veterans complete only one survey during an assessment period. However, based on anecdotal information obtained via the on-going communication with the peer support staff at each site, we can report that the individuals responsible for administrating the surveys often took care to obtain a single survey from each group member. Additionally, the MIRECC staff responsible for coordinating and organizing the data screened the surveys and removed all obvious duplicates.

Program-level Measures

Program-level information was gathered through informal questioning of the main peer support staff contact at each site via telephone and e-mail. Simple structural characteristics of sites offering peer support were documented including: (1) the location type (e.g., VA medical center vs. VA community clinic vs. community residential facility); (2) the model of peer support used (e.g., Vet-to-Vet vs. hybrid vs. other); and (3) whether or not the peer facilitators within each site are offered financial compensation for their work. A group was considered to be a Vet-to-Vet "hybrid" as long as it retained the psychoeducational component of Vet-to-Vet (even if it included some elements not outlined in the nine key features described above). "Other" programs consisted of groups that were solely support on activity-based did not include any of the Vet-to-Vet psychoeducational components. Financial compensation is not a mandatory element of Vet-to-Vet however the guidelines encourage financial compensation for peer facilitators. The suggested rate of compensation is $10 per hour with a minimum of 2 h of work per group meeting. Payment is decided on a site-by-site basis. In this study, we used a dichotomous measure of whether or not sites paid facilitators (paid vs. unpaid).

Peer Support Survey

Sociodemographic Data

Sociodemographic items documented age, gender, marital status, race/ethnicity, years of education, and participation in self-help groups (other than the group targeted by the survey).

Peer Support Participation & Leadership

Number of peer support groups attended in the past month was assessed on a 5-point scale (1 = "None" to 5 = "More than 20"). The survey also assessed duration of participation. Veterans were asked to indicate the date of their first peer support meeting and to estimate how long they have participated via a 5-point Likert (1 = "one month" to 5 = "More than 2 years"). Veterans were further asked if they have facilitated any peer support groups in the past month, and if so, how many.

Satisfaction

Satisfaction with peer support was measured by four items that assessed enjoyment of groups, helpfulness of the groups, level of comfort while in the groups, and perception of how helpful the program has been in terms of

accomplishing overall treatment goals. These items were all rated on a 5-point scale (1 = "Not at all," 5 = "Extremely"). The total Peer Support Satisfaction score was obtained by averaging the mean values of these items (alpha = .92, N = 1,583).

Using the same 5-point scale, peer facilitators rated their satisfaction in leading peer support groups. The mean of three items was calculated: enjoyment in leading the groups, helpfulness of leading groups, and level of comfort while leading groups (alpha = .91, N = 341).

Recovery-based Measures

The recovery-based concepts assessed: (1) general Veteran Recovery attitudes (e.g., life satisfaction and hope); (2) Spirituality; and (3) Engagement in meaningful personal activities. The specific survey items comprising each of the recovery-based variables are presented in Table 1.

To assess general Veteran Recovery, items were selected that represent four distinct categories derived from the Patient Outcomes Research Team (PORT) client survey (Resnick et al. 2004b, 2005): (1) general life satisfaction—rated on a 7-point Likert scale (1 = "terrible" to 7 = "delighted"); (2) hope—rated on a 5-point scale (1 = "much better" to 5 = "much worse"; (3) perceived knowledge regarding mental illness—rated on a 4-point Likert scale (1 = "a lot" to 4 = "nothing"); and (4) perception of input into treatment plan—rated on a 4-point scale. The scores from each of these items were normalized to be consistent with a 1–4 scale by reversing the first item and multiplying the first item by 4/7 and the second by 4/5. The reverse of items 2, 3, and 4 was used. The Veteran Recovery score for each individual was calculated by taking the average of the normalized scores (alpha = .59, N = 1,624). Although the alpha for this variable was found to be low, the aggregate variable is made up of items representing disparate but complementary recovery domains and therefore the aggregate variable was retained.

Three items measuring spirituality were derived from the Daily Spiritual Experiences questionnaire (Underwood and Teresi 2002). These items assess the degree to which participants find strength and comfort in spirituality; feel a sense of inner peace and harmony; and feel a spiritual presence in their lives. These items are rated on a 6-point Likert scale (1 = "many times a day" to 6 = "Never or almost never"). The reversed scores were averaged to create a single Spirituality score (alpha = .83, N = 1,771).

Five items were created to measure participants' perception of engagement in meaningful activities in the spirit of positive psychology (Seligman and Csikszentmihalyi 2000; Sheldon and King 2001). These items assess level of involvement in activities; perception of self-learning achieved through activities; sense of accomplishment and pride; perception of purpose and meaning in life as a whole; and perception of self-growth. Items were rated on a 4-point Likert scale (1 = "not at all" to 4 = "definitely,

Table 1 Recovery-based items

Items
Recovery orientation
1. How do you feel about your life as a whole?
2. Thinking ahead to twelve months from today, how do you expect your mental health will be?
3. How much do you feel you know about your mental illness, including symptoms and types of treatment, such as medication, and rehabilitation?
4. How much input do you have into your treatment?
Spirituality
How much do you agree with the following statements?
5. I find strength and comfort in my spirituality ...
6. I feel deep inner peace or harmony ...
7. I feel a spiritual presence ...
Engaged
8. In the last month, how often did you participate in an activity where you felt completely involved in what you were doing, so much so that you lost track of time?
9. In the last month, how often did you participate in an activity where you felt you learned something important about yourself?
10. In the last month, how often did you participate in an activity where you had a sense of a accomplishment or felt proud of what you had done?
11. In the last month, how often did you participate in an activity where you felt that your life has a purpose or a meaning?
12. In the last month, how often did you participate in an activity where you experienced yourself growing as a person?

three times or more") and were averaged to create an overall Engagement score (alpha = .83, $N = 1{,}750$).

Statistical Analysis

Analysis proceeded in several steps. First, we examined intercorrelations of: (1) program participation, peer support satisfaction and leadership satisfaction and (2) the recovery-based variables. We then examined the intercorrelation of participation, satisfaction variables, and recovery-based variables with each other. We next used *t*-tests and analyses of variance (ANOVA) to evaluate the significance of differences across three structural measures (location type, model, and pay vs. no pay) on continuous measures of peer support participation, satisfaction, leadership satisfaction, and recovery. Finally, we used multiple regression analysis to explore the independent impact of the program structural measures on the continuous measures of peer support satisfaction, leadership satisfaction, and recovery.

Table 2 Peer support participation and satisfaction

Vet-to-Vet participation and satisfaction		
	N	%
# of groups attended in past month		
1–2	375	21.4
3–10	823	46.9
10–20	249	14.2
>20	130	7.4
Total	1577	89.9
Length of membership		
1 month	380	23.2
2–6 months	565	34.5
6–12 months	290	17.7
1–2 years	156	9.5
>2 years	163	10
Total	1554	94.9

Characteristic (*n*)	Mean (SD)	C_v
Peer support satisfaction ($n = 1{,}632$)	3.66 (.91)	.25
Leadership satisfaction ($n = 334$)	4.01 (.87)	.22

Results

Sample Characteristics

A total of 1,847 veteran surveys were examined, but because of missing data on individual surveys not all analyses reflect the total survey number. The sample is representative of the national composition of consumers of VA mental health services with most participants being male (90.2%). The racial breakdown was: Caucasian (46.3%), Black (33.4%), Hispanic (8%), and Other (9%). Mean age was 53.2 years (SD = 8.9). Nearly half were separated, widowed, or divorced (46.9%) with an average of 13.2 years of formal schooling.

Program Structure Characteristics

The final sample includes a total of 38 sites located in 18 states. These sites had participated in data collection for an average of 13.7 (SD = 5.50) months. A total of 20 (53%) programs are located in traditional VA medical center outpatient clinics, 6 (16%) programs are located in VA community-based outpatient clinics, and 12 (29%) in community residential settings. A majority of sites ($N = 25$, 66%) implement the Vet-to-Vet model of peer support with the remaining 13 sites (36%) employing either a hybrid model, which utilizes some components of the Vet-to-Vet model and some unique components or some other peer support model. A total of 24 (63%) sites offer some form of financial compensation for their peer facilitators with the rest operating on a voluntary basis. Chi square analyses revealed no significant relationship between location type and pay status or between model and pay status.

Peer Support Participation, Leadership, & Satisfaction

Nearly half of the surveys reported that veterans attended three or more groups in the last month with some reporting as many as 20 groups attended in the last month (Table 2). Duration of participation ranged to up to more than 2 years with 37% of the total surveys reporting participation for 6 months or longer. The mean peer support satisfaction score was 3.7 out of 5.0 (SD = .91) indicating that satisfaction levels fall between "moderately" and "quite" satisfied.

A total of 18.4% ($N = 359$) of surveys reported that the veteran led groups within the past month. These veterans led an average of 5.6 groups (SD = 5.4, range = 1–20) within the month prior to the survey period and were "quite" satisfied on average (mean = 4.0, SD = .87) with the experience of leading groups. General satisfaction with peer support was moderately but significantly correlated with the number of groups ($r = .23$, $P < .01$, $N = 1{,}546$) and duration of participation ($r = .18$, $P < .01$, $N = 1{,}435$), and strongly correlated with leadership satisfaction ($r = .66$, $P < .01$, $N = 259$) (Table 3).

Recovery-based Variables

The mean scores for the recovery-based variables were: Veteran Recovery, 2.9 out of 4.0 (SD = .56); Spirituality,

Table 3 Intercorrelations of peer support participation, satisfaction, and recovery attitudes

		1	2	3	4	5	6	7
Participation	1. No. groups attended	*	.31**	.23**	.25**	.10**	.03	.13**
	2. Duration of membership		*	.18**	.20**	.10**	.03	.04
Satisfaction	3. Peer support satisfaction			*	.66**	.30**	.23**	.31**
	4. Leadership satisfaction				*	.33**	.07	.35**
Recovery	5. Veteran recovery					*	.44**	.49**
	6. Spirituality						*	.49**
	7. Engagement							*

* $P < .05$; ** $P < .01$

3.7 out of 6.0 (SD = 1.4); and Engagement in Meaningful Activity, 2.9 out of 4.0 (SD = .72). Correlational analysis revealed moderate correlations among the recovery-based indicators (r = .44–.49) (Table 3).

Relationships Between Peer Support Participation, Satisfaction, and Recovery Variables

Measures of participation, satisfaction, and recovery were significantly related to one another on 26 of 30 comparisons (Table 3). Spirituality was not significantly related to measures of participation or satisfaction.

Impact of Site-level Characteristics on Satisfaction and Recovery Orientation

Oneway analyses of variance revealed significant differences in several variables across program location (Table 4). Veterans attending programs embedded within a medical center were older than veterans attending groups at community-based outpatient and residential programs. There was no significant difference in levels of peer support satisfaction between medical center-based groups and community-based outpatient centers although satisfaction at each of these was significantly greater than satisfaction at residential programs.

Peer support leadership satisfaction also was highest at programs housed within medical centers although this difference was only significant in comparison to residential programs. Veterans attending peer support at medical centers also had participated for longer periods of time as compared to veterans attending programs in community-based VA outpatient clinics or residential treatment centers. Programs located at community-based outpatient clinics had the most frequent attendance, the highest levels of Engagement, and the strongest Veteran Recovery attitudes.

Satisfaction with peer support and number of groups attended was highest at sites using the Vet-to-Vet model and lowest at sites using a hybrid model of peer support (Table 5).

No differences were found in patterns of attendance, peer support satisfaction, or leadership satisfaction between sites that offer financial compensation to peer facilitators and sites where the facilitators are volunteers (Table 6). However, at sites that compensate facilitators veterans had

Table 4 A comparison of demographic factors, peer support attendance, satisfaction, and recovery attitudes across program location type

Variable	MCO Mean (SD)	CO Mean (SD)	CR Mean (SD)	F (df1, df2)	P value (ANOVA)
Age	54.9 (9.2)	52.5 (7.3)	50.4 (7.7)	F (2, 1789) = 50.63	.000[a,b,c]
Level of education	13.3 (2.1)	13.1 (2.6)	13.0 (2.0)	F (2, 1756) = 2.55	.079
Length of attendance	2.5 (1.4)	2.4 (1.3)	1.9 (.98)	F (2, 1540) = 37.32	.000[a,c]
Number of groups attended in past month	2.9 (1.0)	3.2 (1.1)	2.7 (.94)	F (2, 1657) = 15.75	.000[a,b,c]
Engagement	2.8 (.73)	3.0 (.64)	3.0 (.72)	F (2, 1794) = 12.72	.000[a,b]
Spirituality	3.8 (1.4)	3.5 (1.4)	3.8 (1.3)	F (2, 1792) = 3.35	.035[a,c]
Veteran recovery	2.9 (.56)	3.0 (.52)	3.0 (.56)	F (2, 1791) = 2.78	.062
Vet-to-Vet satisfaction	3.7 (.84)	3.8 (.86)	3.4 (1.0)	F (2, 1596) = 25.14	.000[a,c]
Leadership satisfaction	4.1 (.83)	4.0 (.96)	3.7 (.95)	F (2, 329) = 4.74	.009[b]

Note. MCO = medical center-based outpatient; CO = community outpatient; CR = community residential; ANOVA = analysis of variance
Results of post-hoc tests: [a] MCO significantly different from CO. [b] MCO significantly different from CR. [c] CO significantly different from CR

Table 5 A comparison of peer support attendance, satisfaction, and recovery attitudes across program model

Variable	V2V Mean (SD)	Hybrid Mean (SD)	Other Mean (SD)	*F* (df1, df2)	*P* value (ANOVA)
Length of attendance	2.3 (1.3)	2.1 (.89)	2.3 (1.4)	F (2, 1574) = 1.27	.280
Number of groups attended in past month	2.9 (1.0)	2.6 (.86)	2.9 (1.1)	F (2, 1690) = 5.89	.003[a,b]
Engagement	2.9 (.74)	2.9 (.66)	2.8 (.69)	F (2, 1827) = .826	.438
Spirituality	3.7 (1.4)	4.0 (1.2)	3.8 (1.4)	F (2, 1825) = 2.70	.068
Veteran recovery	2.9 (.56)	3.0 (.52)	2.9 (.58)	F (2, 1825) = .784	.457
Vet-to-Vet satisfaction	3.7 (.91)	3.9 (.76)	3.5 (.93)	F (2, 1629) = 8.12	.000[a,b]
Leadership satisfaction	4.0 (.84)	3.7 (.47)	4.0 (1.1)	F (2, 341) = .667	.514

Note. V2V = Vet-to-Vet; ANOVA = analysis of variance

Results of post-hoc tests: [a] V2V significantly different from Hybrid. [b] Hybrid significantly different from other

Table 6 A comparison of peer support attendance, satisfaction, and recovery attitudes across payment status

Variable	No pay		Pay		*t*	df	*P* value
	n	Mean (SD)	*n*	Mean (SD)			
Length of attendance	268	2.4 (1.4)	819	2.4 (1.4)	.052	1085	.959
Number of groups attended in past month	276	2.8 (1.0)	888	2.9 (1.1)	.820	1162	.413
Engagement	354	2.7 (.73)	929	2.9 (.73)	5.69	1281	.000
Spirituality	253	3.5 (1.4)	929	3.8 (1.3)	3.46	612	.001
Veteran recovery	357	2.7 (.51)	923	3.0 (.58)	6.16	719	.000
Peer support satisfaction	314	3.9 (.84)	804	3.7 (.89)	2.15	1116	.032
Leadership satisfaction	83	4.2 (.82)	179	4.0 (.87)	1.87	260	.062

higher levels of Engagement in meaningful activity and stronger Veteran Recovery attitudes.

To assess the independent influence of these program characteristics (location type, model type, and pay status) on peer support satisfaction and leadership satisfaction, two stepwise linear regression analyses were conducted. Programs using the Vet-to-Vet model of peer support had higher satisfaction than programs using hybrid ($\beta = -.76$, df = 3, 1091, $P = .007$) and "other" models ($\beta = -.31$, df = 3, 1091, $P = .001$). As compared to programs housed within medical centers, programs at residential sites were associated with decreased satisfaction in leading peer support ($\beta = -.60$, df = 1, 255, $P < .001$).

Three additional stepwise linear regression analyses were conducted to explore the influence of multiple program characteristics on the three continuous recovery-based variables. Pay status was a significant predictor in all three analyses with sites that offer financial compensation to peer facilitators demonstrating the highest scores on Veteran Recovery ($\beta = .20$, df = 1, 1255, $P < .001$), Spirituality ($\beta = .26$, df = 1, 1258, $P = .003$), and Engagement ($\beta = .25$, df = 1, 1255, $P < .001$). Additionally, participating in programs located in community outpatient settings was predictive of higher Engagement scores as compared with programs located within medical centers ($\beta = .22$, df = 1, 1255, $P = .008$).

Discussion

In light of recent attention to the importance of monitoring the delivery of mental health services (Campbell et al. 2000; Scheid and Greenley 1997) and the continuing growth of peer support (Chinman 2002; Shepherd et al. 1999), the development of a monitoring system for peer support programs has become increasingly important. To our knowledge, this report is the first to describe a monitoring effort designed to document service delivery in a multisite peer support program. The inherent challenge of national program evaluation is further compounded in the case of peer support by the fact that it is by design independent of the formal mental health care system. In order to address this challenge, the current project relied on a partnership between MIRECC research staff and the staff and peer facilitators at participating sites.

Data on duration and frequency of participation suggest that for many veterans peer support is a valued addition to formal VA mental health services. Satisfaction measures also indicate that veterans typically view their group participation as a positive experience.

We also found that satisfaction with peer support is related to an overall stronger sense of engagement in meaningful activity and stronger veteran recovery attitudes. Individuals who are more satisfied with peer support, and

who participate more frequently, endorsed feeling more completely involved in their daily activities and felt a stronger sense of accomplishment, pride, and growth through their pursuits than those who participate less often. They also had more positive perceptions of life as a whole, more positive expectations for mental health in the future, more knowledge regarding their illness, and felt they had more input into treatment and rehab plans.

Satisfaction was highest at sites using the Vet-to-Vet model of peer support. It is not possible with the current data to determine which model features are most related to satisfaction, but several factors warrant further examination; for example Vet-to-Vet is a well-outlined and systematic model of peer support with guidelines and procedures for all aspects of program implementation including recommended educational materials for each group type and guidelines for the selection and supervision of peer facilitators.

Satisfaction with peer support was also associated with the type of location in which the groups took place. Satisfaction was lowest among veterans in residential programs. One possible reason for this is that most residential programs have continually changing resident populations, which may attenuate bonding among group members. The duration and frequency of attendance of peer support is lowest at these facilities, which may make it more difficult for veterans to develop trust and comfort within the groups. Additionally, the individuals served by residential facilities may have more severe problems than other veterans, which may reduce satisfaction (Rosenheck et al. 1997).

Satisfaction with leading groups was also influenced by location type. Leadership satisfaction was highest at sites located within VA medical centers. This may be due to greater potential for programmatic support for peer facilitators at these sites including: staff supervisory support, meeting space, materials, and office equipment. Duration of membership was also found to be highest at these programs suggesting that the group make-up at these sites may be more consistent over time, perhaps fostering greater leadership satisfaction.

A finding of particular interest is that although payment status did not affect peer support satisfaction or leadership satisfaction, it was associated with more positive general veteran recovery attitudes, spirituality, and engagement in meaningful activities. This finding raises the question as to whether payment confers some positive effect on the way the facilitators perform their job that is then passed on to the general group members. Perhaps sites that offer financial compensation to peer facilitators have a more recovery-oriented atmosphere and espouse more recovery-oriented attitudes, which may be passed on to veterans attending peer support groups held at those sites. Alternatively, sites that offer payment may be able to attract more highly skilled facilitators.

Engagement in meaningful activity was also associated with location type. Veterans in programs located within community-based outpatient programs, as opposed to medical center outpatient programs, reported greater engagement in meaningful activity. These veterans may be further along in recovery and may therefore be involved in a fuller range of community activities in addition to peer support.

Limitations

Several limitations require comment. Vet-to-Vet and groups based on this model are attended by veterans only, thus limiting generalizability outside the VA system. Also of importance, this study was not designed to evaluate whether peer support adds to the efficacy of formal mental health treatment, but rather illustrates a practicable system for monitoring peer support groups despite the challenges associated with the task. The finding that the veterans who participated for larger periods of time and who had more visits have stronger recovery attitudes may suggest program impact, but in the absence of systematic baseline data or a control group that did not receive peer support, causal relationships cannot be inferred.

A central focus in creating the primary data collection tool for this project was that it be easily completed through a self-administered survey at the end of a regular group meeting. For this reason the survey was brief and did not include full psychometrically validated scales. In addition, since the survey was voluntary and completely anonymous, we had no way to track specific individuals' attitudes over time or to determine how representative of the entire population the data were. Less satisfied participants are perhaps less likely to have completed the surveys.

Finally, although different models of peer support are represented by the current data, no method of measuring model fidelity was available. A fidelity tool for Vet-to-Vet is currently being developed and future studies would benefit for the inclusion of such measures for Vet-to-Vet and other models of peer support.

Conclusions

This study presents an easily implemented system for anonymously and voluntarily monitoring the delivery of peer support services using brief, face-valid measures. This approach has less scientific rigor than standard research studies, but despite the flaws in this system it provides administrators and policy makers with potentially useful feedback that can serve as a point of entry for the

documentation of accountability for this important component of service delivery. Mean values of measures of participation, satisfaction, and recovery orientation, and the significant correlation of measures of service delivery with satisfaction and recovery orientation suggest that this system may usefully document the successful implementation and benefits associated with peer support.

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