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National Survey on Implementation of Peer Specialists in the VA: Implications for Training and Facilitation

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Abstract

OBJECTIVES—Peer support is fundamental to the promotion of recovery as indicated in the President's New Freedom Commission Report. Five years into the Department of Veterans Affairs' (VA) initiative to hire Peer Specialists (PSs)—individuals with serious mental illnesses assigned to clinical teams to support others with serious mental illnesses—this study explored challenges, facilitators, and progress of PS implementation from a stakeholder group involved in their management.

METHODS—Ninety-two VA Local Recovery Coordinators (LRCs) from across the nationwide VA mental health system were surveyed about their perceptions about PS hiring, status of implementation, impact, barriers and facilitators to successful employment of PSs, and willingness to support implementation.

RESULTS—The data suggest that PS implementation is going well overall, but challenges remain such as hiring delays, lack of understanding about the PS role, and lack of funding.

CONCLUSIONS AND IMPLICATIONS—Implementation challenges can undermine the employment of PSs. The VA and other organizations using PSs could improve implementation by using existing staff such as the LRCs, who are present at all VAMCs and already play a large role in managing PSs, to more actively monitor the challenges and proactively support the process on an ongoing basis.

Keywords

peer support; needs assessment; qualitative research; quality improvement

Peer Specialists (PSs) work in clinical settings and “draw upon their lived experiences to share ‘been there’ empathy, insights, and skills...serve as role models, inculcate hope, engage patients in treatment, and help patients access supports [in the] community (Chinman et al., 2008, pgs. 1315–1316).” PSs have positively affected, for example, social isolation, hope, service engagement, and even re-hospitalizations across randomized, quasi-experimental, and correlational studies (as reviewed in Doughty & Tse, 2011) and is considered an evidence-based practice by the Center for Medicare and Medicaid Services (<http://www.cms.gov/SMDL/downloads/SMD081507A.pdf>). As a result of this impact, PSs have become a growing workforce, taking on numerous roles in diverse settings and (Salzer, Schwenk, Brusilovskiy, 2010). One estimate using data collected from mental health leaders in 12 states that have Medicaid reimbursable PS services show that more than 2700 individuals are working as PSs (Daniels et al., 2010).

Since 2005, the mental health system within the Department of Veterans Affairs (VA) has become a major leader in the hiring of PSs and is arguably the single largest employer of them in the world. In 2008, VA further codified the use of PSs in its *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics*, which states that “all veterans with serious mental illness must have access to Peer Support (Office of Mental Health, 2008, pg. 28)”. The VA’s Office of Mental Health Services has been supporting the use of PSs in a number of ways including having monthly national calls and e-mail discussion groups for PSs and their supervisors; publishing a training manual and a tool for measuring PS preparedness to ensure PSs’ competencies; providing funding for PS certification training; consulting with local VA facilities to troubleshoot PS implementation; and publishing a policy handbook detailing PS practice expectations.

Despite these supports, like many new service initiatives, research in and outside the VA is showing that the promise of PSs in the workforce may be compromised by serious implementation challenges (Chinman et al., 2008). These include confusion about PSs’ role, inadequate support and pay, and unequal treatment. As such, a new field of Implementation Science has emerged based on the notion that the translation of evidence-based practices into usual care will be maximized when they are based on assessments of the needs, barriers, and incentives of targeted end users and involve local representatives in the planning process (Rubenstein, Mittman, Yano, Mulrow, 2000). Consistent with this approach, a first ever national survey of all VA facilities was conducted to assess the PSs’ impact, implementation challenges, and the perceived need for training and implementation support—key elements to successful dissemination (Stetler et al., 2006)—to help this initiative be carried out successfully.

Methods

An anonymous survey was administered to all 138 VA Local Recovery Coordinators (LRCs) employed in January 2010 (given the anonymity and focus on quality improvement, the study was not submitted to an IRB). The survey was administered by sending an email to the LRCs linking them to an internet survey site. Two follow-up emails were sent to all the LRCs as reminders. Ninety-two LRCs responded representing a response rate of 67%. LRCs are primarily psychologists and social workers who are hired at VA medical centers to assist

in the implementation of policies and procedures facilitating recovery oriented services in the Mental Health Care Line programs. As such, LRCs are the staff persons most often involved in the hiring, training, and supervision of PSs, and therefore were the most appropriate individuals to survey about implementation challenges. However to confirm this, LRCs were first asked whether PSs were hired at their medical center and how familiar they were with PSs (very to not at all). The survey then presented the LRCs at sites with PSs with questions with Likert type response choices, written for this study but informed by previous studies assessing challenges and facilitators of PS employment in other settings (Chinman et al., 2008), about a series of common PS implementation barriers: hiring PSs compared to other VA employees (Much more difficult to much easier), difficulty PSs have in obtaining necessary training (extremely to not at all), status of implementation (very well to very poorly), and impact of PSs (very positive to very negative). For these four questions, fields were also provided to allow for open ended responses. Questions were then asked about whether various issues were a barrier, facilitator, or had no impact on hiring. These included knowledge of PS benefits, PS roles, VA mandate to hire PSs, support of administrative leadership, support of clinical leadership, support of providers, and availability of funding.

LRCs at non-PS sites were asked about potential impact of PSs. All LRCs were asked if they would be willing to train PSs and how much improvement would result from additional assistance in implementing PSs (very significant improvement to very significant harm). Frequencies of various response options were calculated.

Regarding the open-ended responses, the first author read through all the responses under each question and assigned each response to a category code that was not determined *a priori*, but emerged from the responses themselves (Bernard & Ryan, 2010). Then, the responses were reviewed a second time in which similar or overlapping categories were collapsed into higher level, more broad categories. Then, the final categories were reviewed to assess the general frequency with which they were endorsed. The first author prepared text summarizing the response categories in which the other two authors reviewed to reach a consensus.

Results

Seventy percent of the LRC sample stated PSs had been hired at their site and all stated they were familiar with PSs. Data on progress and impact of PS implementation in VA as well as implementation barriers and facilitators is discussed below (see Table 1 for complete results).

Hiring barriers and facilitators

Survey results indicated that many LRCs (62%) have experienced difficulty in hiring PSs compared to other VA employees, although only a minority (38%) reported that training for PSs, which is important for their roles, was moderately or more difficult to get. In terms of particular issues that affect hiring, the most endorsed LRCs survey responses showed that support from clinical (62%) and administrative (55%) leadership and knowledge of the VA mandate to hire PSs (63%) facilitated PS hiring; while the lack of funding was a notable barrier (53%). The most frequent open ended responses about hiring difficulty was the

challenge of being able to hire someone with a mental illness through the VA's Human Resources department, in large part because those LRCs felt that their own HR staff do not understand how to utilize having a mental illness as a hiring criterion. A small number of LRCs stated that the confusion among HR staff sometimes resulted in the hiring of individuals without lived experience of mental illness, which undermines the PS role. A handful of LRCs noted that clinical staff were hesitant to hire PSs in the first place, while a few other LRCs stated that the hiring process proceeded smoothly.

Implementation status and impact

In the 64 sites with PSs, over half (51%) of LRCs reported on the survey that implementation is going well and most (96%) stated that PSs are having a positive impact on veteran care. The most frequent open ended responses about implementation status was that the PSs were "highly regarded" by the veterans, that PSs are working in many areas of the mental health system and that they are of great assistance to other staff. The next most common response was that staff were struggling to define what the PSs were supposed to be doing. There were a few facilities where LRCs felt that PSs were underutilized. The most common open-ended response about impact was that PSs relate very well to veterans (and in some cases better than staff) and that they were role models showing recovery from serious mental illness is possible. PSs were reported to provide hope, and an extra resource for veterans beyond current staffing levels, but in a few cases were described as not preferred by some veterans. LRCs at sites without PSs similarly responded overwhelmingly that PSs had the potential to positively impact Veteran care (85% moderate to very positive impact).

LRCs and training

Regarding the LRCs themselves, about sixty percent of all the LRCs surveyed stated they would be willing train PSs themselves, presumably if no other training resources were made available, and most (62%) stated that additional technical assistance about PS implementation would be very helpful.

Discussion

Hiring those with serious mental illnesses as providers of services is a key component of VA's transformation to a more recovery-oriented system. Not all facilities have yet hired PSs and those that have may not have enough to ensure access to all veterans—as of 2010, 237 PSs had been hired nationally according to the VA Office of Mental Health Services. Nonetheless, the VA has made substantial progress in employing PSs, increasing by more than 2.5 times the number of PSs employed since 2007. Local Recovery Coordinators have stated that implementation is going well in many places and that PSs are having an impact consistent with the role associated with peer support (role modeling, forging strong relationships with veterans, bridging between staff and patients).

However, challenges remain including hiring delays, lack of understanding about the PS role, funding, and to a lesser extent, PSs who are underutilized and do not have the required training. To fully meet the mandate of making peer support available to all veterans with serious mental illness who request it, these challenges must be addressed. The hiring

confusion may be reduced some through the VA's Office of Mental Health's work to comply with Public Law 110-387, Veterans' Mental Health and Other Care Improvements Act, which will create a new job classification for PSs within VA that requires having a mental illness, being a veteran and certified to provide peer support services. However as indicated by the LRCs, greater assistance for VA staff (in particular VA HR staff), could improve PSs hiring and employment. For example, more guidance could be provided to sites on how to assess for the qualification of lived experience with mental illness during interviews without violating labor laws (e.g., American with Disabilities Act), which specifically prohibits asking about such issues. The LRCs, who are present at all VAMCs and already play a large role in managing PSs, could be utilized to a greater extent to enhance implementation by securing the local leadership support needed, educating local staff about PSs, and troubleshooting any implementation difficulties. This type of implementation assistance, often called "facilitation" (Stetler et al., 2006), is becoming widely recognized as a key feature of how new practices are rolled out successfully. Thus, the VA and other organizations using PSs could continue to improve implementation by monitoring the barriers and facilitators and providing facilitation on an ongoing basis.

Currently, peer support in VA requires certification training by one of several non-profit organizations approved by the VA Office of Mental Health Services. This training, ranging 40-80 hours, includes such topics as: using your story as a recovery tool, facilitating mutual support groups, effective listening and asking questions, problem-solving with individuals, planning & accomplishing recovery goals, dealing with ethical and workplace issues, and mental illness basics. This same certification is required for PSs to provide Medicaid reimbursable services in many states. This year, VA will contract with one specific agency to provide this training for PSs. LRCs could provide ongoing, tailored training to reinforce this certification training as continuing education, utilizing recently published VA peer support training manuals or studies and practices being published about peer support in other non-VA employment or academic settings.

Limitations of the study should be noted. The survey was newly created for this study and the sample was small, reflecting about two-thirds of the LRCs working at the time. It is possible that the one third not responding may have had particular difficulty in PS implementation, changing the way the results were interpreted. However, not all respondents were uniformly positive as most LRCs reported experiencing challenges in hiring (part of PS implementation) and 14% of LRCs at PS sites stated that implementation was going poorly or very poorly. Despite these limitations, we believe this information can be helpful to PS initiatives in VA and other mental health systems.

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Table 1

Barriers, Facilitators, and Progress Employing Peer Specialists in VA

Implementation Indicators	Response Choices Endorsed, %						
	Much more 21	Moderately more 31	Slightly more 10	Same 35	Slightly easier 3	Moderately easier 0	Much easier 0
Difficulty in hiring compared to other staff ¹							
Difficulty Peers have getting training ¹	Not difficult 31	Slightly difficult 31	Moderately difficult 18	Very difficult 4	Extremely difficult 16		
Barriers/Facilitators to PS hiring ¹	A great deal of a barrier	Somewhat of a barrier	No affect	Somewhat of a facilitator	A great deal of a facilitator		
Know PS benefits	9	28	24	24	15		
Know about PS mandate	3	14	20	24	39		
Admin. leadership support	9	22	14	24	31		
Clinical leadership support	5	19	14	32	30		
Provider support	5	19	37	25	14		
Availability of Funding	39	14	8	10	29		
Know what PSs can do	14	32	19	25	10		
Implementation status ¹	Very well 27	Well 24	Neither 36	Poorly 11	Very poorly 2		
Impact on veteran care ¹	Very positive 54	Moderately positive 24	Slightly positive 18	No effect 2	Slightly negative 2	Moderately negative 0	Very negative 0
Potential impact veteran care ²	Very positive 62	Moderately positive 23	Slightly positive 15	No effect 0	Slightly negative 0	Moderately negative 0	Very negative 0
LRCs willing to train PSs ³	Yes 60	No 40					
How much improvement from additional assistance ³	Very significant 20	Moderate 32	Slight 10	None 35	Slight harm 3	Moderate harm 0	Very sign. harm 0

¹ n=64 LRCs at PS sites;² n=28 LRCs at non-PS sites;³ n=92 all LRCs