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Session: VA Peer Specialists: Who uses them and what benefit do they convey?

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Heidi: Thank you for joining us for today’s Spotlight on Mental Health Centers of Excellence Cyberseminar. Today’s session is VA Peer Specialists: Who uses them and what benefit do they convey? Our presenter today is Dr. Matthew Chinman. He’s a Research Health Scientist with the VISN 4 MIRECC and the Director of the Implementation Core with the Center for Health Equity Research and Promotion. Dr. Chinman, can I turn things over to you?

Dr. Matthew Chinman: Please do. All right. Well thank you so much for having me. It’s a real honor to be here and talking to all of you today. So I’ve been in the VA since 2001, almost 20 years and spent pretty much all that time doing research on VA peer specialists, back when there were really no peer specialists hired in VA. And sort of ridden the wave of the ramp-up of how VA has stood up a new job classification really and just been very fortunate to be able to conduct health services research on this great group of folks. And so today I’m going to be talking kind of in two parts. One is in general, sort of a general overview of VA peer specialists, peer specialists in general, and then talk about some recent peer specialists research that we have just completed and published on, which I think would be of interest. So let’s get going. And I should also say that I represent here in the VISN 4 MIRECC the Peer Resource Center. We’re a center that does obviously research on peer specialists but also are available for consultations and guidance for others who are interested in implementing and evaluating peers at their place.

All right. So as was mentioned this is a spotlight, part of the Spotlight Series on VA Mental Health Centers of Excellence. I’m connected to a MIRECC and a Center of Innovation. There are MIRECCs all over and they specialize in different topic areas. The VISN 4 MIRECC is measurement-based care and sort of personalized medicine which peers do make care more personalized so it definitely fits within that mission.

So I’m going to talk a little bit about the background for peer specialists.

But first we’re going to take a poll and see how much experience the audience out there has with VA peer specialists. So I’ve never done this before but I’m just going to read it and see what works. All right so the question is what has been your experience with VA peer specialists? The answers are and you check one of the, the one that best meets your certain circumstance; I have worked with peer specialists in a clinical setting, I have met peer specialists but have not worked with them, I’ve heard about peer specialists but have not met any, and this is the first time I’m learning about peer specialists.

Heidi: And responses are coming in. I’m going to give everyone just a couple more moments to respond and then I’m going to close the poll and we’ll go through the results here. It actually looks like it’s slowed down so I’m going to close that. And what we’re seeing is 56% of the audience saying they have worked with peer specialists in a clinical setting, 19% have met peer specialists but have not worked with them, 21% have heard about peer specialists but have not met any, and 5% this is the first time they are learning about peer specialists.

Dr. Matthew Chinman: Okay.

Heidi: Thank you everyone.

Dr. Matthew Chinman: So, that’s a nice broad cross-section of responses but it looks like we have some people that, in the audience who definitely you know have some knowledge about peer specialists and work with them so, so that’s great. Let’s keep going.

All right so as part of the overview, peer specialists they’re a key part of recovery for serious mental illness in the VA, peers as we often call them are individuals in recovery from serious mental illness who are trained to work in traditional clinical settings. And they’re a proactive form of peer support. So these peer specialists draw upon a, sort of a tradition of mutual support and the classic mutual support kind of group is like an AA situation where everyone’s sitting around the table, everyone’s equal there’s no real leader in a sense. And there are kind of parallel groups you know just for mental illness as well like Schizophrenia Anonymous and the like. So there’s been data to show that a lot of times people show up to these meetings and then they don’t continue over the long-term. There’s a high dropout. Sometimes it can be intimidating to go to one of these groups. So peer specialists is in a sense of variant of peer support in which we bring the peer support to you. So they go out and they proactively engage people in peer support rather than waiting for people out there to kind of go and join a group. So it’s just another kind of peer support that could have a benefit and potentially reach a lot more people given its proactive nature. And it’s a key component in VA’s move to more recovery-oriented care. And for those who don’t know peer specialists in VA are full-fledged VHA employees. They do everything that other employees do like chart in the medical record, and those kinds of things. They have all the rights and responsibilities of full VHA employees in the clinical system.

So we did a literature review and an expert panel and then conducted some factor analyses, some statistical analyses looking at what are the kind of activities that peers do. And so the literature review was broad. It included some VA but also non-VA papers and then the expert panel was also broad. It included VA and non-VA folks. And the idea was that we’d start it off as really trying to come up with a fidelity measure for peer specialists. And so by doing that we needed to boil down all the different things that they do into some key concrete activities so then we could generate items that could be used in a fidelity measure. And so we, and then we used factor analysis which is a statistical technique which kind of groups items together and we came up with these five clusters of activities which both the literature and experts feel like are key activities for peer specialists. So it starts with core activities. This is a little bit of a cross-section in different kinds of activities but they’re sort of seen as the real critical activities regardless of setting in which the peers work in. So sharing their recovery story, encouraging hope, being a role model, encouraging Veterans to seek more treatment, learning about strengths, showing empathy, building skills, working on a trusting relationship, that kind of thing. So those are core activities. The other four categories are a little bit more narrow. So one is working on symptoms and medications. Sort of using their own knowledge to help their clients navigate those issues. Then there’s resources trying to connect Veterans to community resources and provide them, the Veterans information about those resources. Then there’s a whole bit about goal making and sort of goal following. Trying to get like Veterans and their, other people they work with to set goals and follow them. And then the final one is being a liaison. We see this a lot where a peer could be a liaison between a Veteran and then the wider treatment team. They sort of operate in both worlds and can speak both languages. And they can be really helpful in sort of bridging that gap. So those are some concrete activities that we have then baked into our peer fidelity measure.

So who can be a peer specialist? It’s, there’s guidance around, official guidance around it. It has to be a Veteran it can’t, for the VA. So that’s job one. They have to be in a personal recovery for at least a year and this is you know somewhat subjective but they should not have been hospitalized or had major legal or health issues in the past year. They need to be able to talk candidly about their condition and be facile with providing resources and strategies and tools. They can still be having symptoms and that’s definitely fine. They just need to be not interfering with their ability to work. They may definitely be taking medication but that’s also fine. So that’s sort of some basic outline of who can be a peer specialist.

So the history of peer specialists in the VA goes back to about 2005, 2006. Where there were some pilot programs of hiring peer support technicians, they were called then in the VA about 125. A few years later we had our first Director, National Director of Peer Support was hired. That was most recently Dan O’Brien-Mazza who just retired and they’re looking to fill that position. And then more and more they kept on getting hired. A big boost happened in 2012 when the Obama Administration released an executive order saying that they had, the VA had to hire 800 peer specialists by the end of that year. And they were able to do that. They kept on adding some more. And then by 2014 there was another sort of, this time an executive action issued by the Obama White House to place peers in primary care teams, PACT teams in 25 VA sites. And so that was accomplished and then, and right now, in about 2015 and we’re sort of at this number, we have around 1,100 peer specialists hired, working in VA. There are some requirements that VA should be meeting around peer specialists. They have to have, each medical center and very large CBOCs must have at least two per site. And then also the newest thing is the MISSION Act, 2019 there’s a section of that act, that act does a lot of things but there’s a certain section that says that two peer specialists have to be hired to work in primary care at 30 VA Medical Centers. The earlier Obama executive action didn’t have any money attached to it. The MISSION Act does actually have money to hire the peers. So that’s going on basically right now. And that’s a brief history.

In the early days or for most of the days we actually didn’t have any kind of stop codes or anything for peers. So all their work kind of went, I mean they were in the medical record as notes but they were not recorded as services delivered. So that has changed and so the CEIR or the Center for Evaluation and Implementation Resources and Nick Bowersox and his group have now been looking at data pulled for specifically for peer specialists. And in Fiscal Year 2018 just to give you a sense well, you know all the peer specialists across the whole VA delivered about 350,000 visits across the whole VA, 80,000 Vets. So I think that’s pretty impressive. They work all across in different settings you can see here. Mostly running groups but also doing a fair amount of individual work and in the bottom right here these are the percentages of those 80,000 Vets who have different characteristics. So about a quarter have serious mental illness, almost half have PTSD, half have substance abuse problems and depression, over half are white, a third black. But interestingly 7% of those 80,000 Vets have a suicide flag in their record. And some other analyses that Nick and his group have done have showed that actually compared to other Veterans people that peers work with tend to be sicker and have more problems. So they’re definitely working with Veterans who have a lot of issues and challenges.

So what’s the underlying psychosocial processes behind peer specialists? What are the kind of the theories that undergird their work? Rarely talked about and this was first brought up by Solomon in 2004 four kind of key theoretical models that support peer specialists work. So that’s social support, experiential knowledge, social learning theory, and social comparison theory. And I’ll go through those briefly.

The first one is social support. At some level peers are either another set of hands and they’re here to help offer support and assistance. And that can be really helpful for Veterans in terms of their, increasing their sense of belonging and getting some positive feedback. We know that people with mental illnesses and substance abuse disorder have smaller social networks than others and peers offer just another person in their lives who can help them with a variety of tasks.

Also peers bring a heavy load of experiential knowledge or what we often call street smarts. You know they’ve been through the system or a variety of systems. And so they can really use their own knowledge to help the Veterans that they’re working with kind of on a variety of issues. Like what’s the best way to maybe set up your meds or talk to a psychiatrist or get into supportive employment or think about housing or reconnect with family. You know the peers have done a lot of those activities and they can use their own knowledge to kind of help the people that they’re working within those endeavors. And so, and then that really enables peer, the Veterans to have more choices about what they’re going to do. If they have the knowledge on how to do it.

So social comparison theory and this goes way back to Festinger in the 50s. This is the idea that you know people are attracted to others who are like them. But in this case they’re interacting with someone who appears to “be doing better” and that gives them something to strive for and a sense of optimism. And this is what we talk about peers promoting hope and being a role model; this is social comparison theory is what underlies that process.

And then social learning theory. You know peers are very credible role models. And so because of that a lot of times Veterans are more likely to listen to them and so we hear all the time about from non-peer providers you know peers are so good they connect with people so well. And you know they’re more likely to sometimes listen to the peer than they are us. And this is because they are that credible role model and so sometimes this can lead to, more likely to lead to positive behavior change.

All right so that’s some background. Some literature on peer specialists.

So there’s been a fair amount of research done on the impact of peer specialists, a lot of it’s been done outside the VA. Although the model is very much similar. So first there’s been a lot of outcome that’s shown sort of medically, sort of fewer inpatient days, improved symptoms, better engagement with care. In terms of quality of life greater satisfaction with life, greater hopefulness. And socially, better social functioning, fewer problems and needs. The research that’s been done varies widely in terms of some, the setup of the research. Sometimes it’s a pure, like a treatment as usual control group. Sometimes it’s a control group that has sort of accounts running out of time but doesn’t have any sort of active ingredients. Not all the research that has been done is sort of perfect. And there are some flaws in it but by in large the research does show that when you involve peers there are improved outcomes across a range of different kinds of outcomes.

But there have been a lot of implementation challenges that peer specialists face when they startup. You can kind of boil them down into three main buckets. So that’s role confusion, sort of not knowing what the peers are supposed to do when they first start. Staff resistance, many times staff are, can be leery about bringing someone who has a mental illness into the fold in terms of being on the staff. And so they can sometimes treat peers less than equally. And so because of that they can sometimes get relegated to grunt work or not have access to the tools they need to do their job like having access to the medical record. So we kind of now know about these and this is sort of abated over time. And at least in specialty mental health.

And that’s, so a colleague of mine Amy Cohen and Rebecca Shoai in Greater Los Angeles and I kind of worked on a process by which we used to kind of get peers up and running at a new place, if they haven’t been there before and people don’t know about them. And it sort of starts with sort of heavy planning, involving staff who are going to work alongside the peers in the planning. Like what they want the peers to do, how it’s going to work. Determine the specific needs and try to address those. Training, figure out like who’s going to be trained in what. And then set up a supervision process like who’s going to provide the supervision and when and making sure that is ongoing. And usually if you follow these kinds of activities the implementation goes a lot smoother.

We have actually a toolkit that can answer some of these questions about implementation and it’s available, I believe at that link there. If you just Google peer specialist toolkit you’ll probably be brought to the link. We are going to be updating it some. And so look for that coming out soon.

So that’s some literature on peer specialists.

And now I’m going to talk about a study, a recent study that we did of peer specialists in specifically in HUD-VASH.

And this is called the Administering MISSION Peer Support or AMPS. And so let me just say a little bit about what MISSION is. I forgot the acronym but MISSION is a treatment protocol developed by David Smelson out of Bedford, the Bedford VA and it’s designed to help individuals who have a mental illness and a co-occurring substance abuse disorder who are homeless and need housing. And he’s done a bunch of trials on it that shows that it works. And that essentially it takes peer specialists and pairs them up with case managers to work with these individuals over time. So that was successful and we got the idea well what if we just, mostly just focused on the peer support component of that use some of the MISSION materials but just really focus on the peer support angle of the overall MISSION. And so we then decided to locate this study in what’s called HUD-VASH, people may or may not know that but HUD-VASH is a program that’s co-sponsored by HUD, Housing and Urban Development. So they offer rental assistance to homeless Vets in the form of vouchers. And then the VA provides case management services to help them as they get into housing with these vouchers and then try to kind of stick in that housing. So we decided we were going to do this at two sites. The Bedford VA and then the Pittsburgh VA and we randomized the pool of people that we were recruiting were HUD-VASH Veterans at those two sites. There’s actually HUD-VASH teams and Veterans all across the VA in almost every VA Medical Center. So the randomization was in each site. You could either be randomized to just continue with HUD-VASH as normal or continue with HUD-VASH and get a peer specialist assigned to you for, working with you for a year delivering a series of sessions for a year. And those sessions are divided into two types. There’s structured sessions and unstructured sessions. The structured sessions are basically there’s a MISSION workbook and that has discussion topics and some exercises. And they’re basically sort of psychosocial rehabilitation one-on-one or greatest hits if you will. And they are basically just a series of prompts to get the peer and the Veteran talking about a variety of different kinds of topics from developing a personal recovery plan and looking over their life and seeing where their problems are. And a variety of topics that were used in MISSION. And then there was a series of unstructured sessions which are literally just that. They are open-ended sessions that we use to help engage the Veterans and try to facilitate treatment and do community engagement. Take to, sometimes the peers would take them to appointments and AA meetings, it could really be anything. And there were equal numbers of structured and unstructured sessions. And so that’s the intervention that we were testing.

The inclusion criteria and measures were very broad. Basically to get into the study you just had to be in HUD-VASH and have some sort of mental illness and some sort of substance abuse in your history. And then the measures we, it kind of was a wide gamut of measures. The BASIS of 24 is a broad-brush symptom measure. The Addiction Severity Index is all about substance abuse use. Then something about housing, life skills. We measured the amount of hope that they indicated they had. How much community participation they were engaged in. And then we collected the amount of services that they used from the VA as well. And we had 81 controls and 85 intervention participants.

So cut to the, when we compared the groups over time, what’s called the intent to treat analysis meaning like no matter how much they showed up to the intervention everyone who was assigned to the intervention, compared to everyone who was assigned to the control there was really no difference between the two groups over time. So what that, the intent to treat analysis does not take into account is how much people actually show up to these sessions. And when we started to look at that it seemed that there was a wide variety of attendance and participation in the intervention. So that got us thinking we needed to do some further digging to kind of see what the impact of this intervention was.

So that prompted us to think about is there a subgroup of Veterans assigned to receive these peer specialist services who improved? And so why do we ask this question? Well peer specialists and the services they deliver are clearly an adjunct service throughout the VA. They’re really not designed to be the primary service deliverer but they sort of add a very important service on. And so it’s voluntary so Veterans can kind of show up or not. And that’s clearly what happened. They, not all of them did show up. And so we wanted to understand it’s possible that peer specialists can have you know a positive impact for some people but not all people. And we wanted to understand like well maybe is there a subgroup that they are having more impact with.

So we then used something called the Reliable Change Index or the RCI to identify what we call positive changers on two measures. The hope index and also the BASIS which is that symptom measure. And the Reliable Change Index is a, kind of a method that’s been used a lot in health services research and also in sort of quality improvement. It’s a formula that subtracts the post-test score on an outcome measure from the baseline score and then divides by the standard error of differences. It adjusts for pre-post differences for regression to the mean. And it’s heavily influenced by measure reliability. So we couldn’t use all the measures in the study because its, the Reliable Change Index is very sensitive to reliability. So you can rate reliability on the scale of sort of zero to one and so high reliability is a point nine and above and only the hope index and the BASIS had that kind of high reliability. So those were the two measures that we focused on. And it’s used to determine the amount of change down to even the single individual person in either direction, what we can consider statistically reliable. So we wanted to kind of look at each individual’s level of change and then see what we could learn about that group.

So we used logistic regression to predict being in this positive change group on these two measures. And the key predictor that we used was how much contact that they had with peers. So we split that group by, right in the middle so we had a high participation group and a low participation group. That split was right at 12 contacts. We also had other measures in their receipt of homelessness services and mental health services and substance abuse services. And then their baseline assessment of their drug histories, alcohol use, homelessness, mental health problems, preference for help, and site.

So what we found and this is, I know a big complicated chart but the key thing is that we compared the Veterans in the control group to those who were in, whoop, the high engagement group and found that, that was significant. So compared to controls, Veterans who had higher engagement with peer specialists were more likely to change positively on the BASIS measure. Not the, we didn’t find that on the hope measure but we did on the BASIS. And that’s about symptoms so people who were using more peer services were improving in their symptoms. And we published on that in that paper listed at the bottom of the chart here. So I think, we thought that was pretty important.

So then we got to thinking so if greater use of peer services predicts positive symptom change what predicts greater use of peer services. So we also did another regression to try to predict engagement or number of peer specialist contacts. We used similar variables that we used in the previous analysis. So receipt of services, baseline assessments of drug use, homelessness. We added also community participation and baseline mental health symptoms and hope.

And so what we found was that there were three factors that predicted more peer specialist engagement. So Veterans who were showing more hope at baseline, more mental health symptoms at baseline were more likely to use services during the study. So it’s interesting that you know people who were a little bit sicker but still had some hope that things could get better and were also, tended to be service users in general. Those were the folks, you know all those factors were important in using more peer services.

So then we did, and this was led by Sharon McCarthy here in Pittsburgh and a whole host of others but we did some qualitative research focusing on the degree that this intervention met Veterans needs and the impact of the level of structure that we imparted on the intervention. These were two important questions and why [unintelligible 30:11]. So if you look back at the literature on peer specialists there seems to be sort of two general categories in terms of structure. You have a whole host of studies that are super structured in which the peers have a very prescriptive intervention that they have to deliver. And they just deliver it and you know it’s unclear I think sometimes out of those studies whether it’s the curriculum that’s driving change or the fact that it’s peers or some kind of combination. And then there’s other studies that have almost no structure whatsoever. The peers just kind of meet with folks and they just sort of do whatever they want to do. And AMPS was a nice opportunity I think to find a middle ground between those two extremes and it’s because the structured sessions had all these discussion topics that peers were supposed to hit but they still did it in their own way. And also we had those unstructured sessions which allowed for the peers to kind of engage patients in any kind of way that they felt was appropriate. So we felt like it was important to ask about this level of structure.

So we focused on 20 Veterans who received the AMPS intervention, 8 case managers participated, and also the 3 peer specialists. And again we did interviews we created a codebook and the interviews were transcribed. And we focused on the structured aspect, unstructured aspect, and program satisfaction.

So the structured aspects of AMPS were really appreciated. Veterans, there was a workbook they liked the workbook felt it was useful. On the other side they felt like a year I think was too short. They liked the peers a lot and they were you know many of them were hoping to keep working with the peer you know even after the study ended. And they felt like the regularity of the intervention was crucial. One case manager said I think the thing that really worked was the kind of consistency and a kind of like showing up. I think that goes a long way with the population and kind of making sure that they’re kind of doing the same on their end, holding up the bargain of showing up regularly and being invested in it. That’s what one case manager observed.

But the unstructured aspects of AMPS were also valued. The flexibility of the intervention was important. We should say that the peers who were running this had the flexibility to do the structured and unstructured sessions in any order that they felt was appropriate for that Veteran. So sometimes peers felt like they needed to do a whole bunch of unstructured sessions first to kind of do that engagement and relationship building. And then work in the structured sessions. So, but there was a lot of different pathways that they chose over time. The unstructured sessions were also helpful in reducing isolation felt by the Veterans. One Veteran noted I was isolating some and then he would give me ideas like why don’t you go to the library, why don’t you go down, go to the zoo it’s free for Veterans. You know we could throw out ideas and try to get me out of the house to do stuff. So that was a big thing that the Veterans, that the peers did a lot with the Veterans is try to get the Veteran up, out, and into life. So they increased community integration and increased recovery activities. So one Veteran talked about how he actually met me at AA meetings because when like I was nervous to go by myself he would meet me there just for support. So again the unstructured aspects very much valued.

So satisfaction with the peers was definitely high among the case managers. One case manager said we really enjoyed having him I think he brought such a positivity to the team in general. Overall I think he really helped. He helped me and the team kind of feel better knowing that our Veterans were getting their needs met. We heard a lot, especially here in Pittsburgh from case managers just saying really nice things about the peer Fred Nardei who delivered most of the services. So that was really great to hear. And they all endorsed working with peer specialists in the future.

So I’m going to talk about some conclusions and then some future direction.

So we feel that those with dual diagnoses mental illness and substance abuse who engage in more peer specialist services can definitely benefit. So that reliable change analysis we did shows that and it really syncs up with the qualitative results that showed that the relationship was valued by the Veterans. The qualitative data showed that the both structured and unstructured aspects were valued. Which could make an argument for kind of a medium case of peer specialist services. You know giving them some structure, some structured things to do but also letting them pick and choose how they do it. Also peer specialists are good engagers but maybe best to use them with patients who are and be somewhat ready to engage. So a lot of times you hear about peer specialist doing, being put in an engagement role. And I think they are good engagers but I think some of our analyses shows that you know if someone is not ready to engage in services at all peer specialists don’t necessarily have special powers that’s going to like magically convert that person to be ready to engage. There needs to be some, I think willingness and ready to engage and that’s sort of a little bit that hope finding that we found. And so peer specialists I think if people have a little bit of hope there they’re really good then taking that and building on it and trying to get them into services. And the last bit is more for kind of thinking about research and peer specialist studies. So there’s a lot of, there’s a bunch of peer specialist studies that might not have found positive results in an intent to treat analysis. And I would wager that if those studies did a kind of reliable change analysis they would find something similar in that focusing on people who actually used the peer services you know would probably demonstrate outcomes. But when you mix those with people who didn’t use the peer services it kind of waters down the results. So I think in the future all peer specialist services, studies should use this kind of approach to make sure we’re really unlocking all we can from these studies.

In terms of future directions. There’s definitely, we published a paper in Psych Services kind of laying out a peer specialist research agenda. It’s got several items of things that we should be tackling. And the first is maybe empirically testing how theoretical mechanisms of peer support actually work. So you remember in the beginning of this I talked about these theoretical underpinnings and those are exactly theories. There’s never really been any kind of modeling work done to show how these theories connect up with outcomes. And that’s a piece of work that I think needs to be done. And I think using a measure of peer specialist fidelity we have now a sort of nascent measure of peer specialist fidelity that we’ve created and used in a study. I think all peer specialist studies going forward should have some sort of fidelity measure. In addition to recording the amount of services we should be recording the quality of services to make sure that they are exactly what we want them to be. So, and that will help with outcomes as well. So we’ll know that if peer specialist quality is high then we’ll be more confident in the findings we see from studies that use those measures. Some outcome studies have some methodological flaws that we should work to fix. And also I think we need to better synthesize studies on the factors that hinder and facilitate implementation. So there’s been a whole rash of studies that look at, as I mentioned earlier, all the different challenges of implementation that we face but it would be nice to better couch those studies in a sort of implementation framework that we now have lots of implementation frameworks. That we probably didn’t have when peer specialist research got started. And also I think we need to be cognizant of including peer specialists as part of the research team. We do that here in Pittsburgh but it should really be a standard operating procedure for all peer specialists research. So that is the peer specialists research agenda that we think of and be happy now to entertain, oh sorry no I’ve got a few more slides. Forgot about that.

So yes more future direction. So the peers on PACT project was a project that I co-led with Richard Goldberg from the VISN 5 MIRECC in Baltimore. That was, I mentioned earlier out of an executive action to put peers on PACT teams in 25 sites. It was actually then a QUERI study in which we compared, half the sites got implementation support and half the sites did not. And then we looked at the amount of services that got delivered and some outcomes. So we’re just working on that data now. We do know that the sites that got implementation help basically delivered more services and faster. And so that really does suggest that you know these implementation challenges that I mentioned are real and need to be dealt with. And that leaving sites sort of to kind of fend for themselves with no guidance can be challenging and they really, you really need to help them along in getting peers up and running in a new place. And peers have been, you know they’ve been going for a while in mental health but for PACT and primary care they were new. So we faced a lot of the same implementation challenges.

And this is the last slide I believe. So we’re also now, we just got funded to start thinking about using peer specialist for suicide prevention. I mentioned earlier that 7% of the Veterans that were served by peers in Fiscal Year 2018 had a suicide flag. So peers are already working with Veterans who have suicide issues. And so we were thinking we could do sort of a pilot and develop a prevention program that’s based on peer support. And when you think about suicide and all the factors that go into what makes suicide, so things like loss of connection with others, loss of self-worth, loss of hope these are actually things that we know peers can help with. And so we’re going to be working with a variety of stakeholders at the West Haven VA trying to develop and then do a pilot test of a peer-based suicide prevention program. And if it goes well we’ll do a larger trial. And that’s, I think that’s a nice future direction.

So now I think we will open it up for questions. So I don’t, I believe people are going to send questions to the chat and then Rob I think will let me know what they are.

Rob: Right Dr. Chinman. Actually not chat there’s a question section \_

Dr. Matthew Chinman: Oh a questions section.

Rob: [unintelligible 42:23] yeah. But yeah we do have a number of them queued up. So I’m not a, I’m not a content expert so I’m just going to go through them as they arrived.

Dr. Matthew Chinman: Okay.

Rob: And the first one. This came in fairly early on. Does the total number of PS include apprentices?

Dr. Matthew Chinman: It should yes, it should. So that question eludes to that there’s different GS levels and different types of peers. So the peer position description as I believe it can range from a GS-5 to a GS-9 so it’s scalable. GS-5s are what’s called a peer support apprentice. So there’s a certification training that all peers have to have. It’s a 40-hour course offered by a variety of organizations. The VA has also sponsored training. Then the peers have to then pass an exam. Once they do that than they are certified. And so once you’re certified you can be hired in as a 6 and then start to move up. You can be hired without certification as a GS-5 and then you have about a year to get your certification as this peer support apprentice.

Rob: Thank you. Next question. Were the peer encounters always aligned with the intervention content? In other words were each of the 12 encounters a session from MISSION or could it have been any type of encounter?

Dr. Matthew Chinman: So it was, it was definitely a MISSION encounter although because we had structured and unstructured sessions those unstructured sessions could really be whatever the peer and the Veteran determined was the most important at the time. And then the structured sessions were, you know there was like a topic of conversation that was set and that the peer was going to pursue with the Veteran.

Rob: Thank you. Another one that’s going to take me a moment to get through. If I understand correctly PS generally have SMI and are meant to help Vets with SMI or other of the very serious issues. I see that symptoms affected effectiveness but was there any separate analysis by a diagnosis? It seems like most Vets served in 2018 had PTSD or MDD not necessarily SMI.

Dr. Matthew Chinman: Yeah so I don’t, we, I don’t think we have, we really didn’t have enough of a sample I think to look by diagnosis but that definitely could be an issue. The amount, I mean I know the, the types of mental illnesses and definitely varied widely across the population, the sample. But I don’t think we were able to look by diagnosis.

Rob: Thank you. This person actually writes in a follow-up. Also \_

Dr. Matthew Chinman: I had a feeling.

Rob: \_ also you already have some hidden peers who do VA mental health services research. Have you thought about putting out a call for researchers who wear those two hats or have peer support experience from other settings?

Dr. Matthew Chinman: That’s a great idea. I mean we haven’t done that but that is actually a fantastic idea. I mean we, you know the way research happens though in the VA is, you know you need to get, you usually write a grant and put together a project and then you know people are sort of tapped to be part of that project. Get funded for it, then you, you know you submit it, you wait to hear and then if you’re fortunate you get funded and then everyone who worked on it gets to work on it. You know, everyone who works on the grant submission gets to work on the project. So yeah I mean if we, if it was sort of well-known who peers were who could work on these things it would be great to then work with them during the submission portion and then if that project gets funded then they could work on you know, then work on doing the project. One challenge is, is that if you’re a clinical hire versus a research hire. So you know we have a peer specialist here Fred Nardei who’s actually a research hire so he gets funded off of research grants so he can move around to different grants. If you’re a clinical hire you know we probably need to work out with that clinical setting some sort of like buyout or something to allow that peer enough time to work on our research project. And that setting may or may not want that to happen with any individual peer. You know sites that have peers and like them typically want their peers delivering services. But you know we’ve been able to kind of sometimes work out special circumstances where a site will kind of give a clinical peer some time to work on a research project.

Rob: Okay, thank you. Do we see peer support doing case management?

Dr. Matthew Chinman: Definitely. I mean that’s probably, I mean I think we probably mean a lot of different things by “case management” but yeah they do, they go out into the community and will be in people’s homes. They’ll take people to appointments. They’ll help get their medications sorted. They’ll help with housing. They’ll help with jobs. They’ll help with family. So all the things that I think we may think of as like case management they’ll definitely do. They definitely did those kinds of things in our AMPS study for sure and I think, you know we heard from the actual case managers in which you know the peers were almost like taking over and doing a lot of that case management work. I mean these HUD-VASH case managers are really strapped for time and so you know the availability of the peers really helped you know extend them and make them be more effective because they were doing a lot of those case management activities.

Rob: And this one might be a little bit of a review but this person asks, have you any thoughts on research on peers with substance abuse history or formerly homeless peers?

Dr. Matthew Chinman: Yes. So see this study, the, so this, basically this is exactly what this study just focused on. So all the people in the study were formerly homeless and had substance abuse issues. So we definitely think that peer specialists can be effective for that group per you know the results we found here.

Rob: Thank you, Dr. Chinman. Are the research efforts to augment the role of VA peer specialists in an effort to mitigate Veterans’ suicides, including reaching out to those Veterans not being treated in VA?

Dr. Matthew Chinman: That’s a great question. Part of the challenge there is finding them. So the study that we’re doing is going to focus on Veterans we actually know about. You know that we know and that, and have a suicide flag. And a suicide, you know for people who may or may not know a suicide flag is like when, it’s a way for the VA system to kind of formally acknowledge that we know this Veteran has had some issue with suicide in the past; either they’ve had an attempt or voiced ideation. So because we’re just kind of developing the intervention from scratch right now and we’re just kind of testing it we want to be able to get access to a population that we can more easily get access to. I think if this all goes well and it seems to work I think then we could kind of go on the road and try to be more aggressive and finding people who are not in the system as much. But in this early development phase we wanted to you know work with Veterans who we could more easily find.

Rob: Thank you, sir. What are the requirements for VA to hire lead CPS? CPs I guess.

Dr. Matthew Chinman: Uh lead CPs? I don’t know, I’m not familiar with the term lead, I think, so there is a way, so peers can keep going up the GS scale. And I believe and I’m not a hundred percent sure about this maybe someone else can chime in, I mean they can become supervisors themselves but I’m not a hundred percent sure about that, as they get higher up on the GS scale like into the eight, into the nine. I’m not exactly sure of all the requirements that, but maybe we could send that out I could look into that.

Rob: Somebody asked along the way, can someone explain what SMI is please? And I thought they meant SMI and I explained that that means serious mental illness but I didn’t catch is there a term MSI that you used in your presentation?

Dr. Matthew Chinman: Oh I don’t think so. If I did I misspoke. It’s SMI.

Rob: Okay then I explained it to it, it is serious mental illness. Hearing about the role of peer specialists in helping that’s, cultivate hope and a stronger sense of belonging I’m wondering if you know of collaborations between peer support specialists and chaplains?

Dr. Matthew Chinman: Hmm. I have not heard of that in particular but I don’t see why not, that would be a fruitful connection. So you know peers are as I mentioned before are often an additional service that’s added on and so just like, you know like the MISSION project which had a peer and a case manager sort of working side by side. It can go really well to have a peer, some other provider, and then the Veteran kind of be a threesome there. And they each have their own kind of role. And so you know the peers can do things out in the community and use their own experience in ways that people like chaplains might not be able to do. And but chaplains and other case, you know other providers offer a different set of skills that peers might not have. So I definitely think that could be a very fruitful dyad to work with a Veteran.

Rob: Thank you. In the interest of brevity I’m going to ask these two questions that came in back to back from two separate people, together. Have there been any studies on the impact of providing peer support services on the peer support specialist’s recovery, pretty metta? And the next question, have you tracked outcomes for individuals who are peer specialists? So similar.

Dr. Matthew Chinman: Yeah and you know that’s a good question. So there has, so Sue Eisen who is retired now but was in Bedford did a big survey of peers across the country, I think both in VA and non-VA and found some interesting things there about their own mental health. So one thing that I often say about peer specialists is that you know being a peer specialist is, it’s not a jobs program. You know like we don’t have VA peer specialists necessarily to offer as like a supportive employment kind of program. I mean they are hired to do a job. And so while we definitely want them to be you know happy and have good outcomes themselves they have to be able to do that job. So we haven’t done as much in terms of tracking the outcomes like the mental health outcomes of the peer specialists themselves. There actually could, I don’t know there could be actually legal issues there you know because they are a separate job class. They have, you know they are an employee and so it might be a little odd to kind of then survey them on their mental health and go into their medical records which I don’t really think you’re allowed to do. The other thing too is that you know it’s hard, you know like when we do studies with, these kind of studies you know we’ll have three, four, five peer specialists that’s kind of a small sample to actually do any research on. But I do think you know overall it’s probably you know worthy of study in terms of you know how are these folks doing in their life. And that’s something that maybe we could do some more of.

Rob: Thank you. We have about three minutes left and a number of questions, we’ll try to get through them all. Is it okay with you Dr. Chinman if we stay a couple minutes late?

Dr. Matthew Chinman: Sure!

Rob: Okay great. Do you believe that the peer specialist model could be used in a call center setting?

Dr. Matthew Chinman: Huh. That’s a really good question. So I and you, I’ve heard this question a lot in various forms. Sometimes peer specialists get like used as like greeters at like a hospital. Like they’ll be like the first person you see. And you know peers are very good at that. You know they’re engaging and warm and they, you know really, they care a great deal. So I think they would be sort of a nice face and early response system. But on the flipside I think some of the real power of peers comes from an ongoing relationship. Where they’re able to kind of meet with people over a period of time, get to know them. And then that’s I think where you see a lot of the benefits come out of. So I have sort of mixed feelings about using them, because you know there’s, I mean we have about 1,100. That’s not a ton of them. So I would prefer them out there kind of having good relationships with people as opposed to working in call centers. So I’m kind of a mixed mind of it, I guess.

Rob: Thank you. On the slide that showed the different percentages there was not a slide for female Veterans, what percentage do they fall in?

Dr. Matthew Chinman: So I think there’s 89% of the group were male so I would assume then the reverse you know 11% female. You know that’s, so I think you know most of it like the VA population in general most peer specialists are male and so we haven’t, you know that’s an area of research that we could look into in terms of you know do female Veterans do better with female peers’ specialists. Just because of the population in VA is so male it’s kind of hard to find female peer specialists to do that research with. So that’s something that could definitely be studied.

Rob: I don’t quite understand this question I think there’s a couple of typos in it but I’ll ask it as best I can. How many peers as supervisors be utilized in aiding outcomes overall?

Dr. Matthew Chinman: I don’t think we know. I mean I don’t know if I know how many peer, well I don’t know if we know how many peer specialists’ supervisors there are. That might be something that you know sort of who is, the National Director of Peer Support might know and that position is currently open and people are in line. I don’t know if I know that sitting here. I definitely think that, it’s probably not a ton of people across the 1,100 and we could definitely use some more. You know people, a lot of times supervision and this is not just with peers but supervision is often not something that’s just done a lot seems like in mental health. And peers, especially a peer who’s starting out and they’re new peers they definitely need a lot of supervision. And a lot of non-peer clinicians don’t always know how to supervise a peer and what makes sense. The folks in, at the Bedford VA Kevin Henze for example has done a lot with trying to think about peer supervision, and Patricia Sweeney. But the, and so I think we could definitely use more people who know about how to appropriately supervise peers and then do it consistently. So that’s something we could definitely know more about and do more of.

Rob: Thank you. Well it’s just past the hour so if, audience members if you do need to leave please remember to provide answers to the short survey that comes up when you quit the webinar. This is the last question and then we have a couple of comments afterwards. Is there support in the VA to help support research to evaluate peer support services programming? Our staff are mostly clinical but have some creative and impactful programming that could be researched.

Dr. Matthew Chinman: Yeah so a couple responses there. So there really isn’t like a dedicated pool of money to evaluate all the different kinds of peer services in VA. That was, so me and a bunch of other researchers along with Dan O’Brien-Mazza the former National Director of Peer Support had tried to kind of beg VA for money on an all different kinds of quarters to try to help like do some kind of broad evaluation. And what that did result in was roping in that center, Nick Bowersox’s team to at least do some broad base like tracking of services delivered and doing some other basic evaluation kinds of data analyses and you know Nick is basically kind of just carving that out of his hide and so it’s a little bit on a slow burn but we have gotten you know some nice information out of that. The other way and so but there’s more to come on that. And I think there’s going to be a report if it’s not already out. So the other thing is, the other way to get it funded is write research grants. You know which is a big undertaking and it’s more narrow. So like if you write a research grant you’re probably going to be studying like one kind of service at a couple different places so that won’t be sort of a broad-based evaluation. So I know that’s not sort of a satisfying answer. I wish there was more resources around too. So I share that sentiment.

Rob: Well thank you, sir. I just have a few comments that I think might be important to convey. One person says that they are so glad to hear about the possible pilot for peers in suicide prevention because they are currently a peer for a suicide prevention team and find themselves advocating for the work that they can do, how they can contribute. So this will help.

Dr. Matthew Chinman: Great.

Rob: And another person says that they have worked, had a peer support specialist on their team for many years and he’s probably one of the most important and effective members when it comes to connecting with the highest risk Veterans that they work with. And there was another comment that was very similar to that, that came in a little bit earlier. But with that I’d like to give you the opportunity to make closing comments if you’d like sir.

Dr. Matthew Chinman: Oh sure. Well just thanks again for having me. It’s just been a pleasure to be able to share all this with you. I tried to present some stuff that we’re doing right now and a general overview. And you know to that comment by, that last comment you know there was a story that we were told you know over the years about how you know there was this one peer specialist who the team did not like that peer to ever take a vacation because they didn’t want them not, you know sort of being on the clinical team and serving, you know serving all the patients that they did have. So I think it just sort of speaks to you know peers can be really a valuable asset. You know I think we need, there’s always more to know and more to research and we’re going to keep doing that and hope to have an opportunity to come back and share more with you in the future.

Rob: Well thank you once again Dr. Chinman. Thank you for preparing and presenting today. And once again audience members when I close the webinar you’ll be presented with a short survey. Please do take a few moments to provide answers to them. We rely on your answers to these surveys to continue to bring you high-quality Cyberseminars that help Veterans in the VA, such as this one. And with that I’ll just wish everyone a good day.

[ END OF AUDIO ]