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

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Center for Health Equity Research and Promotion

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VA HEALTH CARE Defining EXCELLENCE in the 21st Century

Spotlight on VA Mental Health Centers of Excellence

- **VA Mental Health Centers of Excellence** (including Mental Illness Research, Education and Clinical Centers [MIRECCs]) are critical to VA's response to meeting the mental health needs of Veterans.
  - **Shared mission:** To improve the health and well-being of Veterans through world-class, cutting-edge science, education, and enhanced clinical care.
  - **Shared structure:** To combine education, research, and clinical care into a single program to dramatically reduce the length of time between scientific discovery and implementation.

- **15 Centers** located across the country

- **Distinct specializations** (specific disorders, type of problem, populations, settings) to best understand the complex context of health care services access and delivery.

- **Significant collaborative partnerships** with clinical, research, and educational experts from academic affiliates and other organizations

- Learn More at www.mirecc.va.gov

Agenda

1. Peer Specialist background
2. Literature on Peer Specialists
3. Study of HUD-VASH Peer Specialists
4. Conclusions
5. Future Directions

POLL QUESTION

- What has been your experience with VA Peer Specialists?

- Possible Answers (Check the best answer)
  - I have worked with Peer Specialists in clinical setting
  - I have met Peer Specialists, but have not worked with them
  - I have heard about Peer Specialists, but have not met any
  - This is the first time I am learning about Peer Specialists

Peer Specialists: Key part of recovery in serious mental illness

- "Peers" are individuals in recovery from serious mental illness (SMI) trained to work in traditional clinical settings
- Proactive form of peer support
  - Key component to VA's move to recovery-oriented care
- Full-fledged VHA employees (e.g., chart in medical record)

*Davidson et al. (1997); Chinman et al. (2006; 2008); Dixon et al. (1994); Fisk et al. (2000); Gates & Akabas (2007); Manning & Suire (1996); Miya et al. (1997); Mowbray et al. (1996); Solomon & Draine (1996)

Literature review, expert panel and factor analysis defined Peer Specialists activities

Core PS activities

- Share story
- Encourage hope
- Role model
- Encourage vets to seek more treatment
- Learn about Vets strengths
- Use vets strengths to promote healthy living
- Show empathy
- Build skills
- Develop trusting relationship
- Work on problem solving skills

SXs/RXs

- Managing Symptoms
- Managing meds, side effects

Joint goal making

- Help manage health
- Establish personal goals
- Follow up on goals
- Help to create goals
- Reflect wishes of Vet
- Breaking down goals into parts
- Help with measurable goals
- Maintain healthy behaviors

Resources

- Connect vets to community resources
- Provide info to vets on services

Liaison

- Raise issues with Tx team
- Prepare Vet to meet w provider

Who can be a Peer Specialist?

A Veteran

- In personal recovery for at least a year
- Usually not hospitalized or had legal issues due to mental health in past year

Who is

- Able to talk candidly about condition
- Provide helpful tools, resources, strategies

In Recovery

- May still sometimes have symptoms
- May still be taking medicines

History of Peer Specialists in VA

2006 About 125 'Peer Support Techs' First Hired in VA

2008 First Director of Peer Support Hired

2012 About 150 More Peer Support Techs Hired in VA

2012 Executive Order to hire 800 PSs

2013 956 PSs on board

2014 2019 Obama Executive Action to place PSs on PACT at 25 VAMCs

2015 1,095 PSs on board

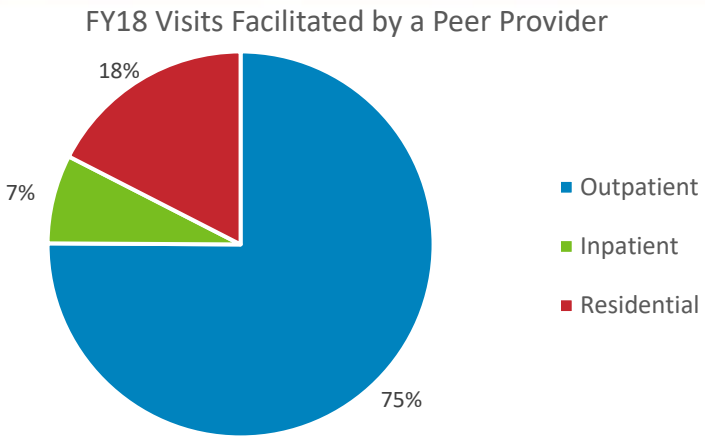
Each VAMC and Very Large CBOC must have at least 2 PSs

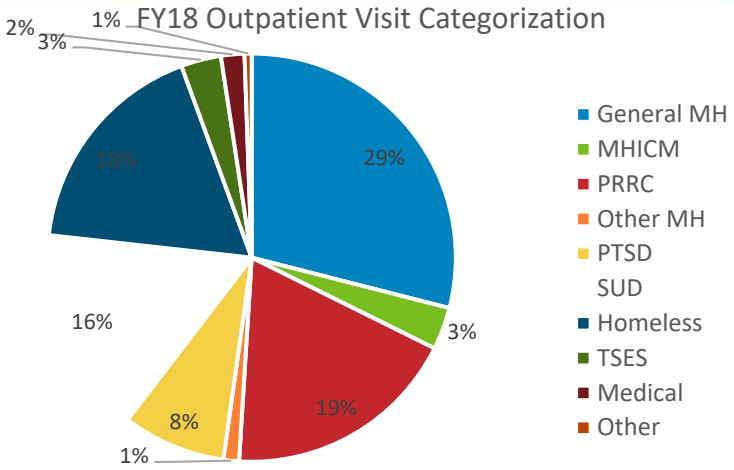
In addition to the minimum of two per facility, each VISN must have a certain quota of PSs that is based on total number of Veterans in a catchment area that have mental health conditions

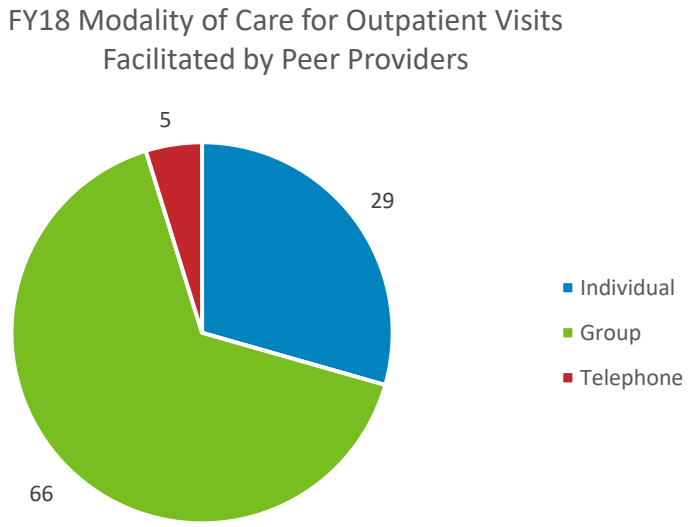
2019 MISSION Act: Hire 2 PSs at 30 VAMCs for primary care

Peers work with many different Veterans (FY18)*

Of ~350K visits







*Center for Evaluation and Implementation Resources (CEIR)

<u>Of ~80,000 Vets in FY18, % with:</u>

- SMI – 25
- PTSD – 48
- SUD – 54
- MDD – 53
- White – 57
- Black – 33
- Male – 89
- Suicide Flag – 7

What is the underlying psychosocial process behind Peer Specialists? (Solomon 2004)

- Social Support
- Experiential Knowledge
- Social learning theory
- Social comparison theory

The theories supporting Peer Specialist Services

Social Support

"Peer Services enhance the number of individuals that a person with a psychiatric disorder can turn to for support and assistance, offer a sense of belonging, and positive feedback of a person's own self-worth" (Solomon, 2004).

The theories supporting Peer Specialist Services

Experiential Knowledge

- People gain specialized information and perspectives from living through the experience of a psychiatric disorder
- Working with someone who has this experience shows common elements and strategies
- Enables choice and self-determination in care

The theories supporting Peer Specialist Services

Social comparison theory

- Theorizes that individuals are attracted to others who share commonalities, like psychiatric illness, to establish a sense of normalcy for themselves. (Festinger, 1954)
- Interacting with others who appear to be “doing better” than them gives a sense optimism and something to strive for.

The theories supporting Peer Specialist Services

Social learning theory

"…peers, because of their experiences …are more credible role models for others with psychiatric diagnoses, and therefore, interaction with peers who are successfully coping with their illness are more likely to result in positive behavior change…" (Solomon 2004)

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Research shows: Peer Specialists' 'been there' support leads to improved outcomes

Medically

Fewer inpatient days (Clarke et al., 2000; Klein et al., 1998; Min et al., 2007; Landers and Zhou, 2009; O'Connell et al., 2018; Sledge et al., 2011)

Improved Symptoms (Chinman et al., 2018)

Better engagement with care (Cook et al, 2012; Craig et al., 2004; Chinman et al., 2015; Druss et al., 2010; Sells et al., 2006; Felton et. al, 1995)

Quality of Life

- Greater satisfaction with life (Felton et. al, 1995)
- Greater hopefulness (Cook et al, 2012; Klein et al., 1998)

Socially

- Better social functioning (Klein et al., 1998; Van Vugt et al 2013)
- Fewer problems and needs (Craig et al., 2004; Felton et. al, 1995; Van Vugt et al 2013)

Peer Specialists can face implementation challenges

Role confusion	• Lack of clarity about duties • Scope of work unclear
Staff Resistance	• Inadequate support, or supervision • Exclusion from team meetings
Unequal treatment	• Lack of access to medical records • Relegated to grunt work

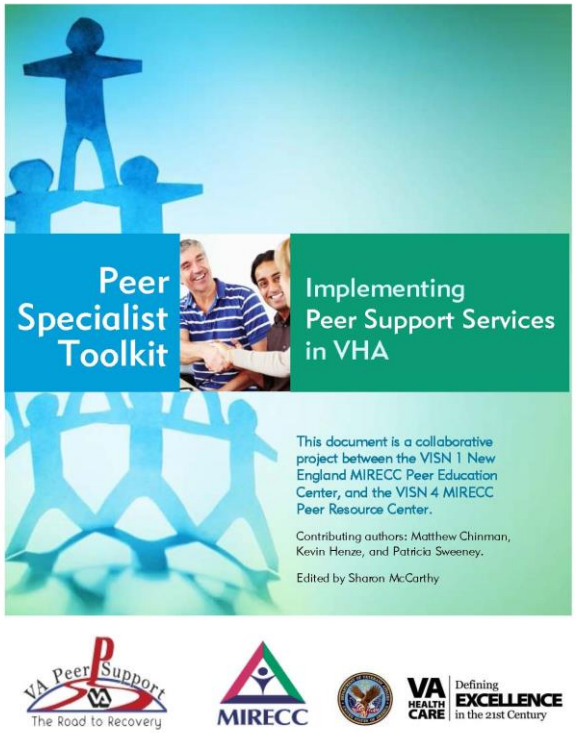
*Davidson et al. (1997); Chinman et al. (2006; 2008); Dixon et al. (1994); Fisk et al. (2000); Gates & Akabas (2007); Manning & Suire (1996); Miya et al. (1997); Mowbray et al. (1996); Solomon & Draine (1996)

What helps to improve implementation?

Planning	• Involve staff • Determine specific needs
Training	• What training is needed • Who will provide it
Supervision	• Understand the requirements • Who will provide supervision

Chinman, Shoai, Cohen, 2010

The Peer Specialist Toolkit can answer questions



https://www.mirecc.va.gov/visn4/docs/Peer_Specialist_Toolkit_FINAL.pdf

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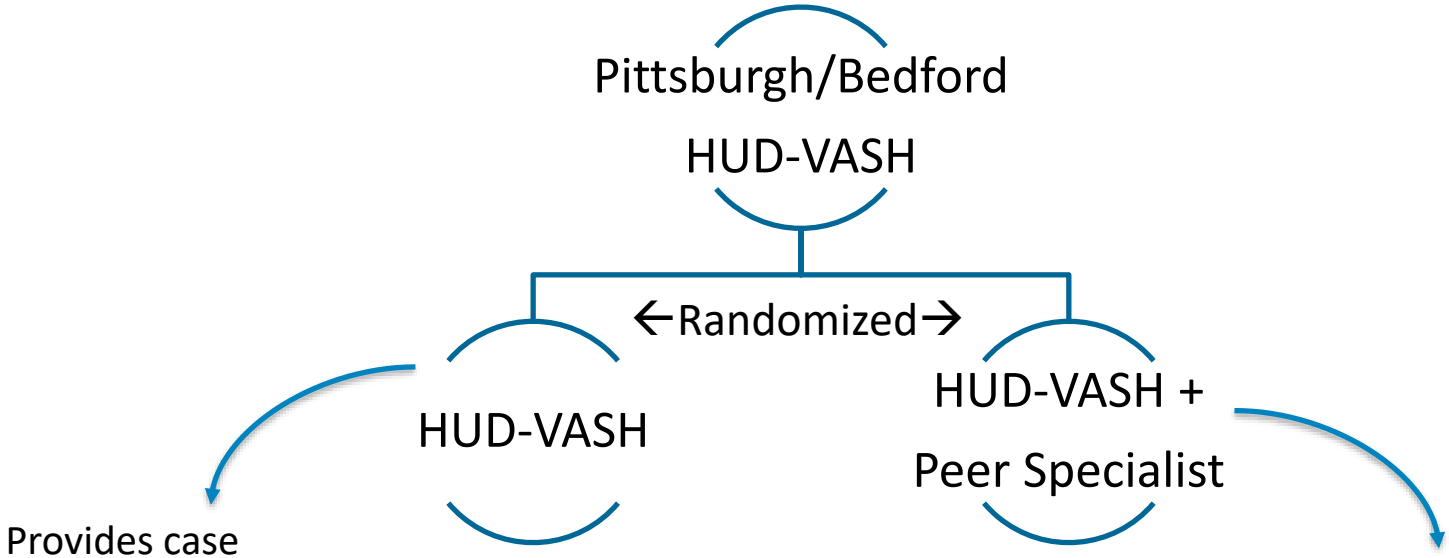
Administering MISSION Peer Support (AMPS): Design compared HUD-VASH Veterans with and without Peer Specialist services



Provides case management + rental assistance to homeless Vets

Alternating *structured* and *unstructured* sessions for 1 year

- *Structured sessions* follow exercises and worksheets from MISSION (e.g., Developing a personal recovery plan)
- *Unstructured sessions*: assist with emergent needs; facilitate treatment and community engagement including transportation

AMPS inclusion criteria and measures were broad

- Inclusion criteria
  - Meet DSM-IV diagnostic criteria for
    - Any substance abuse or dependence disorder
    - Any mood, anxiety, post-traumatic stress, personality or Axis I psychotic disorder
  - In HUD-VASH

- Measures (n=81 control, n=85 intervention)
  - BASIS-24
  - Addiction Severity Index
  - Housing Status
  - Life Skills Profile
  - Herth Hope Index
  - Temple Collaborative Community Participation Assessment
  - VHA services data from the CDW

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Intent to Treat analyses showed no difference between the groups over time

Lack of ITT results prompted a different research question

Is there a subgroup of Veterans assigned to receive Peer Specialist services who improved (despite the lack of Intent- to-Treat results)?

- Why ask this question?
  - Peer Specialists are an adjunct service predicated on a *voluntary relationship*
  - Its possible that Peer Specialists can have a positive impact for some, but not all, who are assigned to receive it

Use Reliable Change Index (RCI) to identify 'positive changers' on Herth Hope Index (HHI) and BASIS

- Subtracts the post-test score on an outcome measure from the baseline score and then divides by the standard error of the differences
- Adjusts the pre-post difference score for regression to the mean due to measure unreliability (used published reliability)
- Used to determine if the amount of change, in either direction, is statistically reliable
- Chose HHI/BASIS b/c address recovery & SXs; high reliability

- Jacobson NS, Truax P: Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. J Consult Clin Psychol 59:12-9, 1991
- Jerrell JM: Behavior and symptom identification scale 32: sensitivity to change over time. J Behav Health Serv Res 32:341-6, 2005
- Eisen SV, Ranganathan G, Seal P, et al.: Measuring clinically meaningful change following mental health treatment. J Behav Health Serv Res 34:272-89, 2007

Use logistic regression to predict being in the positive change group (vs. no/neg change) on HHI & BASIS

Predictors

- Peer Specialist engagement groups (via median split) vs. control
  - High >12 contacts
  - Low <=12 contact

- Receipt of homeless, mental health, substance abuse services during study

- Baseline assessment of histories of drug and alcohol use, homelessness, mental health problems, preference for help, site

Results: χ^2 shows more "high peer engagers" have BASIS improvement

Variables	High Engagement (N=38)		Low Engagement (N = 37)		Control (N = 65)		Test Statistic	Df	p value
	N	%	N	%	N	%			
Sex, % Male	36	94.74%	35	94.59%	58	89.23%			0.55[b]
Race, % White	18	47.37%	17	45.95%	39	60.00%	$X^2 = 2.50$	2	0.29
Site, % Site 1	24	63.16%	12	32.43%	31	47.69%	$X^2 = 7.09$	2	0.03
Homelessness, lifetime (% ≥ 1yr)	21	55.26%	24	64.86%	49	75.4%	$X^2 = 4.52$	2	0.10
Herth Hope Index, % positive change	10	27.03%	4	11.11%	12	18.75%	$X^2 = 3.01$	2	.22
BASIS, % positive change	15	40.54%	9	24.32%	7	11.48%	$X^2 = 11.05$	2	.004
	Mean±SD		Mean±SD		Mean±SD				
Age	54.08±6.86		54.00±8.97		52.51±8.81		$X^2 = 2.41$†	2	0.30
Preference for help[c]	1.97±1.13		2.22±1.13		2.02±1.04		F = 0.55	2,137	0.58
Alcohol intoxication, yrs. lifetime	16.97±15.48		19.16±16.63		13.95±13.43		F = 1.52	2,137	0.22
Drug use, yrs. lifetime	3.66±4.43		3.34±3.65		3.13±3.09		$X^2 = 0.009$†	2	0.995
Days with psychiatric problems in last 30	9.61±12.19		12.95±12.74		9.94±11.81		F = 0.90	2,135	0.41
Peer Specialist engagement[d]	25.55±8.82		5.19±3.89		--		t = -13.49	111	<0.0001

Logistic regression shows high peer engagement predicts being a positive BASIS changer

	HHI Positive Change			BASIS Positive Change		
Variable	OR	95% CI	p	OR	95% CI	p
Age	0.98	0.93-1.04	0.58	0.98	0.92-1.05	0.57
Race	2.26	0.65-7.89	0.20	**0.13**	**0.03-0.56**	**0.01**
Site	1.47	0.40-5.46	0.57	0.31	0.08-1.28	0.10
Homelessness, lifetime (% > 1yr)	1.28	0.37-4.41	0.70	0.35	0.10-1.16	0.09
Alcohol intoxication, yrs. lifetime	**1.04**	**1.00-1.07**	**0.05**	1.02	0.98-1.06	0.31
Drug use, yrs. lifetime	1.02	0.88-1.17	0.83	0.96	0.80-1.16	0.70
Days with psychiatric problems in last 30	1.04	1.00-1.08	0.06	1.03	0.99-1.07	0.11
Preference for help	0.79	0.49-1.27	0.33	0.64	0.37-1.13	0.13
Mental health service utilization	0.86	0.58-1.29	0.46	1.28	0.95-1.71	0.10
Homelessness service utilization	0.80	0.55-1.15	0.22	0.87	0.59-1.26	0.45
Substance use service utilization	0.95	0.81-1.12	0.50	0.79	0.59-1.07	0.14
	1.99	0.64-6.19	0.23	**5.52**	**1.61-18.94**	**0.01**
Control v. Peer Specialist no/low engagement	0.52	0.13-2.09	0.36	1.64	0.46-5.84	0.45

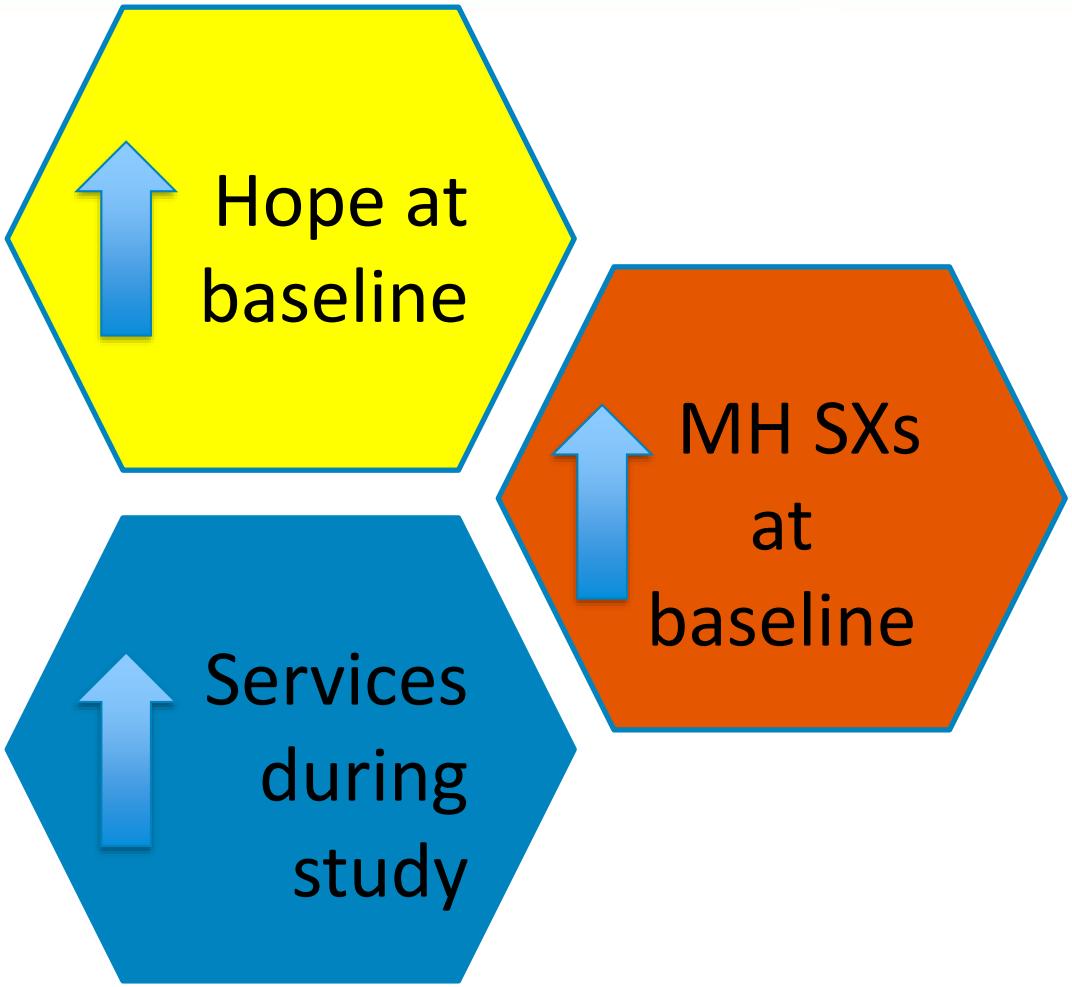
Chinman M, McCarthy S, Bachrach R, Mitchell-Miland C, Schutt RK, Ellison M. (2018). Investigating the degree of reliable change among those assigned to mental health peer specialists services. Psychiatric Services, 69, 1238-1244.

If greater use predicts positive Sx change, what predicts use?

- Used negative binomial regression to predict engagement (number of peer specialist contacts)

- Used similar variables
  - Receipt of homeless, mental health, substance abuse services 6 mo before study
  - Baseline assessment of histories of drug and alcohol use, homelessness
  - Added community participation, baseline mental health symptoms, hope

Three factors predicted more Peer Specialist engagement



Chinman M, McCarthy S, Bachrach R, Mitchell-Miland C, Schutt RK, Ellison M. (2019). Predicting engagement with mental health peer specialist services. Psychiatric Services, 70, 4, 333-336.

Qualitative research questions focused in needs met and impact of structure

- **How well did AMPS meet the needs of Veterans, Case Managers, and Peer Specialists?**

- **How did the *structure* of AMPS influence the experience of each of these groups?**

- Why ask this question?
  - Research suggests that having Peer Specialists deliver more structured programs may improve outcomes
  - Most research focuses on highly structured or completely non-structured services
  - AMPS provides a “mid-level” of structure

Qualitative analysis focused on structure, satisfaction

- Semi-structured interviews conducted at both sites:
  - 20 Veterans who received the AMPS intervention
  - 8 Case managers
  - 3 Peer Specialists

- Interviews were transcribed and a code book developed:
  - Structured aspects
  - Unstructured aspects
  - Program satisfaction

McCarthy S, Chinman M, Mitchell-Miland C, Zickmund, S, Schutt R, Ellison M. (In press). Peer Specialists: Exploring the influence of program structure on their emerging role. Psychological Services.

Structured aspects of AMPS were appreciated

- Veterans liked the work book and felt it was useful
- Many felt the overall time frame was too short

- The regularity of the intervention was crucial

"I think the thing that really worked was kind of consistency and kind of just 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" (Case manager.)

Unstructured aspects of AMPS were also valued

- The flexibility of the intervention was important
- Reduced isolation
- Increased community re-integration
- Increased recovery activities

"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, he would throw ideas out there, try to get me out of the house to do stuff." (Veteran)

"He's actually met me at AA meetings, 'cause when I like was nervous to go by myself, he would meet me there just for support…" (Veteran)

Satisfaction with Peer Specialists/AMPS was high among HUD-VASH Case Managers

- High satisfaction with the Peer Specialists

"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." (Case manager)

- Overall high satisfaction with the AMPS model
  - All strongly endorsed working with Peer Specialists in the future

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Conclusions

- Those with dual diagnoses who engage in more Peer Specialist services can benefit
  - Syncs with qualitative results that showed the relationship was valued by Vets
- Qualitative data shows that both structured and unstructured aspects values
  - Could argue for more 'medium case' Peer Specialist services
- Peer Specialists are good engagers, but maybe best to use them with patients who are ready to engage
- Argues for conducting similar RCI analyses in all Peer Specialist studies

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The Peer Specialist research agenda has several items

- Empirically testing how theoretical mechanisms of peer support services work
- Using a measure of peer specialist fidelity
- Conducting outcome studies that address the identified methodological shortcomings
- Better synthesizing studies on the factors that hinder or facilitate implementation of peer specialist services
- Including peer specialists as part of the research team

Chinman M, McInnis K, Eisen S, Ellison M, Farkas M, Armstrong M, Resnick S. (2017). Establishing a research agenda for understanding the role and impact of mental health peer specialists. Psychiatric Services, 68, 9, 955-957. PMC5638298

The Peers on PACT project

- **2014**
- Executive Action to move Peer Specialists into VA PACT Teams
- VACO 'Genesis Group' charged to implement

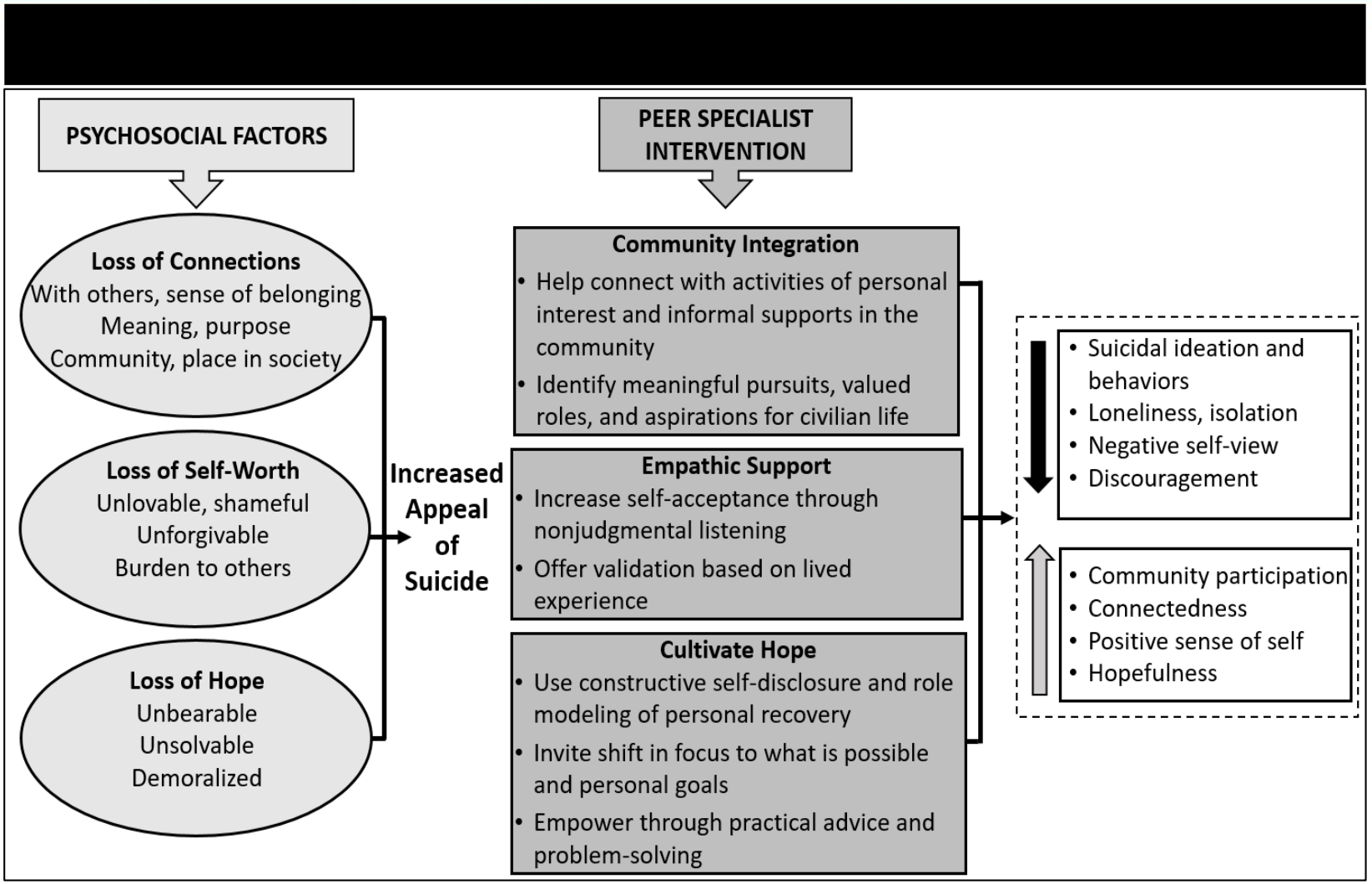
- **2015**
- Drs. Chinman and Goldberg initiate Peer Specialist Implementation Evaluation

VA QUERI
Quality Enhancement Research Initiative

- **2015-2019**
- 25 sites participate
- 12 receive facilitation vs 13 implement on their own
- Collect services, fidelity, and Vet outcomes

Chinman M, Daniels K, Smith J, McCarthy S, Medoff D, Peeples A, Goldberg R. (2017). Provision of Peer Specialist services in VA patient aligned care teams: Protocol for testing a cluster randomized implementation trial. Implementation Science, 12, 57. PMC5414325

Exploring the use of Peer Specialists for suicide prevention



Questions?

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