

Mental Health and Quality of Life Among Veterans Employed as Peer and Vocational Rehabilitation Specialists

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Objective: The study compared employment experiences, mental health recovery, and quality of life among peer specialists and vocational rehabilitation (VR) specialists hired by the U.S. Department of Veterans Affairs (VA), the VR specialists under the Homeless Veterans Supported Employment Program. Employment characteristics associated with mental health recovery were examined.

Methods: The study was a national, observational survey of 152 peer specialists and 222 VR specialists across 138 VA health care systems in 49 states. The survey, administered over the Internet, included measures describing participant characteristics, employment factors, mental health, and quality of life. The two cohorts were compared by using t tests or chi square tests. Multiple regression analysis controlling for participant characteristics was used to identify employment factors associated with mental health and quality of life.

Results: Peer specialists were more likely than VR specialists to share recovery stories, serve as a role model or mentor, and advocate for veterans. Activities by VR specialists tended to focus more narrowly on job skills. Overall, after adjusting for multiple comparisons, the analysis found high levels of mental health and average quality of life for both cohorts, with no significant differences between the groups. Satisfaction with amount of supervision was consistently associated with aspects of mental health recovery, including work-related and helping-related quality of life, for both cohorts.

Conclusions: The results highlight the value of work and the importance of supervision in realizing both the adoption of recovery-oriented services and the promotion of mental health in a community of veterans serving each other.

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The President's New Freedom Commission on Mental Health (1) and the mental health strategic plan of the U.S. Department of Veterans Affairs (VA) recommend transforming the mental health system to pursue the goal of recovery. The incorporation of peer support is integral to this transformation. In the VA, veterans who currently receive or have received treatment for a mental illness have been serving as peer specialists for a number of years, providing limited services to other veterans with mental illness, often as volunteers. In 2005, the VA began hiring peer specialists as employees, and in 2008, it mandated that "all medical centers . . . must provide individual or group counseling from peer specialists for veterans treated for SMI [serious mental illness]" (2). The job description of the peer specialist includes assisting veterans with social skills, combating stigma, serving as a role model, informing veterans about community supports, assisting veterans in choosing jobs that match their strengths, overcoming job-related anxiety, and particularly important, sharing their recovery stories in order to model effective coping skills.

Three years after issuing the peer specialist mandate, the VA hired 400 vocational rehabilitation (VR) specialists through the Homeless Veterans Supported Employment Program (HVSEP). VR specialists are veterans with a history or risk of homelessness who provide employment services to homeless veterans. The VR specialists were hired under a U.S. Office of Personnel Management regulation for hiring persons with a severe physical, cognitive, or emotional disability or history of such a disability. The job description of a VR specialist includes assessing occupational areas to target job search activities, providing job skills training, assisting with search strategies and placement, helping veterans develop community supports, and persuading the individual to accept help. Although lived experience with homelessness is a hiring requirement, sharing one's own recovery stories while working with veterans is not explicitly part of the job description. That is an important difference between peer specialists and VR specialists.

Although their job descriptions differ, VR specialists and peer specialists have similar histories of mental illness, disability,

substance use disorders, and homelessness, and together they constitute a group of veterans employed by the VA in direct service roles to help other veterans in their recovery. They are peers in two respects: first, as veterans, and second, as individuals with mental health histories. However, little is currently known about their roles, their job satisfaction, or their own mental health recovery and quality of life.

The “helper” therapy principle suggests that helping someone else is associated with a therapeutic benefit to oneself (3–5). Personal accounts highlighting peer providers’ improved mental health and functioning—including fewer psychiatric hospitalizations and increased confidence, well-being, and job skills—support this principle (6–14). Being paid is also important, bringing better living conditions, better quality of life, and a sense that one’s work has purpose (15–19). A survey of peer providers in Pennsylvania concluded that working as a peer provider reduced dependence on Social Security benefits and decreased need for case management, crisis services, and inpatient hospitalization (20). Moran and others (5) noted that peer providers receive 17 different types of benefits across five broad domains.

However, the specific job functions of peer providers and the extent to which they are associated with the therapeutic benefit of working as a peer remain poorly characterized, both within and outside the VA. Peer specialists, for example, are deployed in a variety of mental health programs, and their responsibilities vary. Chinman and colleagues (21) described early experiences of employing VA peer specialists to lead support groups, empower veterans to pursue goals, serve as role models, complete intakes, assist with housing, and provide advocacy. According to a survey of 291 peer providers in 28 states who were not affiliated with the VA, providing support, encouraging self-determination and personal responsibility, addressing hopelessness, communicating with providers, managing illness, addressing stigma, and developing friendships are the most prevalent activities of peer specialists (22). Jacobson and colleagues (23) reported that peer specialists provide direct service activities (experiential sharing, relationship building, and socialization and self-esteem building) and indirect activities (administration, team communication, and information gathering). These studies suggest that there continues to be variability in the mental health services provided by peers.

As the largest single health care provider in the United States, the VA offers a valuable opportunity to characterize peer support services and their effects on recovery among peer support providers. The goals of this study were to document the range of job activities performed by peer specialists and HVSEP VR specialists in the VA, compare mental health and quality of life among peer specialists and VR specialists, and explore employment characteristics associated with mental health recovery. We examined four aspects of mental health recovery: overall mental health, general self-efficacy,

work-related quality of life, and helping-related quality of life. We chose these four recovery domains because they are most likely to be affected by employment according to the helper therapy principle, previous literature, and expected associations between peer support work and these domains (3,5,8,18).

This study examined important domains of mental health and quality of life that were not examined in previous studies of peer support specialists. The comparison of mental health and quality of life among peer specialists and VR specialists is of interest because the individuals who serve in these capacities have similar characteristics, yet the two jobs treat mental health histories differently. Thus the comparison can begin to answer whether the jobs are associated with differences in work satisfaction, quality of life, and mental health.

METHODS

This study was a national, observational survey of VA-employed peer specialists and VR specialists and was approved by the Institutional Review Board of the Edith Nourse Rogers Veterans Hospital in Bedford, Massachusetts. Data were collected between December 2011 and June 2013.

Sample

The eligible sample included all peer specialists (N=279) and HVSEP VR specialists (N=378) employed by the VA nationwide when the study began in December 2011. Of these, 159 peer specialists (57%) and 230 VR specialists (61%) responded. Seven peer specialists and eight VR specialists were excluded from the analysis because they completed less than 50% of the survey or because they were no longer working in these roles. The final sample (N=374) consisted of 152 peer specialists and 222 VR specialists across 138 VA health care systems in 49 states.

Survey

The survey contained questions about demographic and employment information, including job tenure, hours worked per week, supervision received, and absences for general medical or mental health reasons. A checklist of job responsibilities was developed with input from VA leadership. Validated self-report instruments were used to assess employment experiences and aspects of mental health recovery. Study instruments were selected after thorough review of available measures on the basis of their relevance to the study objectives. The survey was pilot-tested on a sample of veterans employed at our research center who were not involved in the study. The survey took approximately 30 minutes to complete.

Work Limitations Questionnaire (WLQ). The WLQ includes 25 items measuring how much health problems interfere with job performance (24). Reliability (Cronbach’s alpha) was $\geq .90$, with strong validity (25).

Job Satisfaction Index (JSI). The 12-item JSI assesses satisfaction with type and amount of work, pay, coworkers, supervision, senior management, promotion opportunities, working conditions, customer satisfaction, praise, quality of work, and overall satisfaction (26).

Maslach Burnout Inventory (MBI). The MBI assesses burnout among persons employed in human services occupations, including emotional exhaustion, depersonalization, and reduced personal accomplishment, with good reliability and convergent validity (27,28).

General Self-Efficacy Scale (GSS). GSS items reflect problem-solving and positive coping skills. Internal consistency reliability coefficients range from .76 to .90. Criterion-related validity studies have demonstrated positive correlations with optimism, favorable emotions, and work satisfaction (29).

Basis-24. The 24-item Behavior and Symptom Identification Scale (Basis-24) is a widely used, multidimensional mental health assessment instrument that was validated in a national sample of 5,800 recipients of mental health and substance abuse services and also used in several VA studies (30,31). Subscale reliability ranged from .77 to .91, with good concurrent and discriminant validity (30).

Stigmatization Scale. The Stigmatization Scale measures personal experience of stigma (32). Scale reliability (Cronbach's alpha) was .94, with good convergent and divergent validity (32).

Quality of Life Inventory (QOLI). The QOLI assesses importance of and satisfaction in 16 areas of life: health, self-esteem, goals and values, money, work, play, learning, creativity, helping, love, friends, children, relatives, home, neighborhood, and community (33). It has been validated in clinical and nonclinical populations, including veterans (34). Test-retest reliability was .73; internal consistency reliability was .79 (33). Good predictive, convergent, and discriminant validity have also been demonstrated (33).

Housing stability and satisfaction. The eight-item Housing Satisfaction Scale assesses housing satisfaction, with good reliability ($\alpha=.91$) and validity (35).

Procedures

Facility directors and supervisors of eligible employees were first informed about the study; concerns were addressed by study investigators. Eligible employees were then invited to participate by an e-mail letter with a unique study ID and link to the survey Web site. The letter provided details about the voluntary and confidential nature of the study. An information sheet provided all the information about the study. Participants were instructed to complete the survey outside work hours. Nonrespondents were sent up to six

reminders by e-mail or telephone. Participants received a \$20 gift card.

Data Analysis

Frequency distributions were used to describe employment experiences, mental health, and quality of life of the two cohorts. Chi squares and t tests were used to assess differences in these variables between the cohorts. To account for multiple bivariate comparisons, we used a p value of .001 for reporting statistically significant differences.

To identify employment characteristics associated with mental health recovery, we first computed bivariate correlations between employment and sample characteristics with the four recovery outcomes: overall mental health, general self-efficacy, work-related quality of life, and helping-related quality of life. Employment characteristics examined included hours worked per week, hours of direct service to veterans, supervision hours, and satisfaction with amount of supervision. Time in job was not included because it was confounded with cohort; that is, most peer specialists had been employed for more than a year, whereas most VR specialists had been employed for six to 12 months, resulting in little variation within each cohort. We fit multiple regression models to identify employment characteristics associated with mental health recovery measures, controlling for sample characteristics that were significantly correlated with the recovery measures in the bivariate analysis. Separate regression models were fitted for each cohort.

RESULTS

Sample Characteristics

A majority of peer specialists and VR specialists were men. Of the sample, African Americans constituted 41% (N=153); Latinos, 7% (N=23); and members of other racial-ethnic minority groups, 3% (N=9). Although a majority (N=308) received VA health care, more than one-third of the sample (N=133) also had private health insurance through their VA employment (Table 1).

Work Experience

A majority of both cohorts worked full-time (≥ 31 hours per week), with more than half their time devoted to direct service to veterans. Seventy-four percent (N=110) of the peer specialists were certified peer specialists, compared with 14% (N=32) of VR specialists. Peer specialists (N=116, 76%) were more likely than VR specialists (N=35, 16%) to have tenure of longer than a year. Peer specialists reported fewer hours of supervision compared with VR specialists, with 19 (13%) reporting none. Most respondents reported missing no more than one week of work in the previous six months for general medical, mental health, or other reasons, with no difference between cohorts. [A detailed summary of work characteristics of both cohorts is provided in a table in the online data supplement to this article.]

TABLE 1. Characteristics of veterans employed as peer specialists or vocational rehabilitation (VR) specialists

Characteristic	Peer specialists (N=152)		VR specialists (N=222)		χ^2	df	p
	N	%	N	%			
Age (M±SD)	52.0±8.52		49.7±9.49		2.42 ^a		≤.02
Gender					2.16	1	ns
Male	121	80	162	73			
Female	31	20	60	27			
Race					1.05	2	ns
White	86	57	121	54			
African American	61	40	92	41			
Other	4	3	5	2			
Latino ethnicity	8	6	15	7	.32	1	ns
Marital status					6.26	2	≤.04
Never married	21	14	41	18			
Married or with partner	64	42	66	30			
Separated, divorced, or widowed	67	44	115	52			
Education					.40	2	ns
High school graduate, GED, or less	22	14	31	14			
Some college	80	53	116	52			
Bachelor's degree or more	50	33	75	33			
Homeless in past 12 months	6	4	19	9	2.91	1	ns
Health insurance					10.4	4	≤.04
VA	52	34	101	46			
Federal employee	58	38	75	34			
Other private	15	10	7	3			
Other public (Medicare or Medicaid)	19	13	26	12			
None	7	5	12	5			
Disability benefits					.331	1	ns
Yes	76	50	105	47			
No	75	50	117	53			
Services received in past 6 months							
Any VA medical care	109	72	199	90	19.9	1	≤.001
Any non-VA medical care	53	34	53	24	5.37	1	≤.02
Any VA mental health care	63	41	79	36	1.32	1	ns
Any non-VA mental health care	11	7	12	5	.52	1	ns
Any VA alcohol or drug use disorder treatment	5	3	4	2	.85	1	ns
Any non-VA alcohol or drug use disorder treatment	1	1	1	1	.07	1	ns

^a t test, df=366

Job Activities

Attending staff meetings, writing progress notes, and using the computerized record system were reported by more than 80% of both cohorts (Table 2). However, peer specialists were more likely than VR specialists to share recovery stories, serve as a role model or mentor, teach social skills, advocate for veterans, and perform other activities related to their role as a peer. Although many VR specialists also endorsed these activities, more VR specialists than peer specialists reported activities focused on helping veterans find and keep jobs.

Job Satisfaction, Work Limitations, and Burnout

Both peer specialists and VR specialists reported high overall job satisfaction, with no difference between cohorts. VR specialists reported significantly greater satisfaction with

pay and promotion opportunities compared with peer specialists (Table 3). Cohen's effect sizes (ES) for differences in satisfaction with pay (ES=.63) and promotion opportunities (ES=.74) were considered medium to large (36). There were no differences between the cohorts in work limitations or job burnout [see table in the online data supplement].

Mental Health and Quality of Life

Low levels of mental health problems (BASIS-24 scores) were reported across cohorts (Table 4). Quality-of-life scores were categorized into four levels (very low, low, average, and high), each with corresponding score ranges. Both cohorts scored high on helping-related quality of life. VR specialists also scored high on work-related quality of life based on normative data (33). In most other areas, scores were average. However, scores were in the low range for health and play and in the very low range for money. After adjustment for multiple comparisons with a significance level of p<.001, there were no significant differences between the cohorts in mental health or quality of life.

Employment Characteristics and Mental Health Recovery

Three employment characteristics—satisfaction with amount of supervision, hours of direct service provided, and hours of supervision received—showed significant correlations with aspects of mental health recovery at the bivariate level and were included in the regression analysis. The regression analysis controlled for demographic characteristics, mental health services received in the past six months, and disability status. Satisfaction with amount of supervision was positively associated with both work-related and helping-related quality of life for both cohorts (Table 5). Satisfaction with amount of supervision was also significantly associated with self-efficacy among VR specialists but not among peer specialists. Hours of direct service provided were positively associated with work-related quality of life,

but the association was significant only for VR specialists. Hours of supervision received were not significantly associated with any of the recovery outcomes in the multivariate analyses.

DISCUSSION

The main goal of this study was to examine employment experiences, mental health, and quality of life among veterans employed as peer or VR specialists with similar lived experiences of mental illness, substance abuse, and homelessness. Consistent with the helper therapy principle and the understanding that recovery is possible, the results suggest that both cohorts had high levels of job satisfaction, mental health, and quality of life, with very few differences between the cohorts. BASIS-24 scores indicated that the participants had better mental health than several other VA samples, including veterans who participated in a compensated work therapy program and a national sample of veterans who had recently returned from deployment (37,38), but their mental health was not as good compared with a national community sample (39).

Participants' quality-of-life scores were substantially higher than scores of veterans and nonveterans in clinical samples (40,41). The high scores for helping- and work-related quality of life were consistent both with the idea that the work was valued (20,42) and with the fact that 50% to 60% reported not receiving mental health or substance abuse services in the past six months, suggesting that many participants had experienced a remission of their mental health condition.

Differences in how participants described their roles were consistent with the importance of sharing recovery stories as part of the peer specialist job description (21,23). VR specialists were also less likely to report one-to-one mentoring, teaching problem-solving and social skills, and helping with community integration, even though these are important competencies for employment. It is possible that VR specialists performed these tasks, but because of differences in training, they did not use the same language as peer specialists to describe these skills. For example, the peer-related job activities mentioned in the survey are explicitly taught in the peer specialist certification training, which was completed by peer specialists at five times the rate among VR specialists. Differences in

TABLE 2. Job activities reported by veterans employed as peer specialists or vocational rehabilitation (VR) specialists

Activity	Peer specialists (N=152)		VR specialists (N=222)		χ^2 ^a	p
	N	%	N	%		
Attend staff meetings	136	89	201	91	<1.00	ns
Use computerized record system	132	87	193	87	<1.00	ns
Provide 1:1 mentoring	133	87	131	59	35.27	≤.001
Share recovery experiences	130	85	111	50	49.69	≤.001
Write notes, memos, etc.	128	84	191	86	<1.00	ns
Challenge negative self-talk	128	84	122	55	34.84	≤.001
Teach social skills	124	82	131	59	21.19	≤.001
Serve as role model	125	82	64	29	102.95	≤.001
Help veterans set goals	123	81	175	79	<1.00	ns
Advocate for veterans	121	80	98	44	46.75	≤.001
Participate in conference calls	118	78	206	93	17.91	≤.001
Lead groups	117	77	26	12	162.70	≤.001
Teach problem solving	113	74	91	41	40.47	≤.001
Help community integration	109	72	96	43	29.52	≤.001
Transport veterans	88	58	160	72	8.12	≤.002
Conduct outreach activities	86	57	137	62	<1.00	ns
Help regarding disability benefits	73	48	94	42	1.18	ns
Help veterans find work	59	39	217	98	162.05	≤.001
Help with job skills	59	39	195	88	99.50	≤.001
Facilitate peer training	54	35	13	6	54.01	≤.001
Perform clerical work (copying and filing)	47	31	94	42	5.01	≤.025
Serve on committees	44	29	17	8	29.96	≤.001
Present at conferences	42	28	43	19	3.51	≤.06
Perform other patient care activities	27	18	37	17	<1.00	ns
Supervise peer providers	11	7	1	1	13.38	≤.001

^a df=1

the specific language used to describe job activities, therefore, could explain why VR specialists did not endorse all of their job activities.

The differences in the job descriptions of the two cohorts, especially regarding disclosure and sharing of recovery stories,

TABLE 3. Mean scores on the 12-item Job Satisfaction Index among veterans employed as peer specialists or vocational rehabilitation (VR) specialists^a

Item	Peer specialists (N=152)		VR specialists (N=222)		t test ^b	p
	Mean	SD	Mean	SD		
Type of work	4.42	1.00	4.39	.94	<1.00	ns
Amount of work	4.20	1.07	4.21	1.03	<1.00	ns
Pay	2.98	1.37	3.64	1.26	-4.65	≤.001
Relationships with coworkers	4.23	1.12	4.29	.97	<1.00	ns
Quality of direct supervision	4.07	1.33	4.35	.96	-2.19	≤.03
Quality of senior managers	3.58	1.36	3.97	1.14	-2.88	≤.004
Opportunities for promotion	2.44	1.44	3.42	1.26	-6.73	≤.001
Working conditions	3.89	1.31	4.04	1.05	-1.12	ns
Perceived customer satisfaction	4.22	.98	4.16	.83	<1.00	ns
Amount of praise you receive	3.93	1.25	4.10	1.05	<1.00	ns
Quality of your work	4.55	.75	4.41	.76	1.70	ns
Overall satisfaction	4.26	.94	4.37	.88	-1.17	ns

^a Possible scores range from 1, not at all satisfied, to 5, very satisfied.

^b df=369

TABLE 4. Mean scores on measures of mental health and quality of life among veterans employed as peer specialists or vocational rehabilitation (VR) specialists

Measure	Peer specialists (N=152)		VR specialists (N=222)		t test ^a	p
	Mean	SD	Mean	SD		
Self-efficacy ^b	34.24	3.85	33.86	3.73	<.001	ns
Stigma ^c	25.24	5.62	23.81	5.57	2.48	.01
Housing satisfaction ^d	4.00	.82	3.97	.81	<1.00	ns
Mental health domain ^e						
Overall	.93	.62	.80	.59	2.06	.04
Depression/functioning	1.02	.78	.90	.76	1.54	ns
Interpersonal relationships	.95	.76	.93	.71	<1.00	ns
Emotional lability	1.04	.85	.83	.74	2.50	.01
Psychotic symptoms	.49	.62	.37	.64	1.87	ns
Alcohol or drug use	.35	.59	.23	.49	2.16	.03
Quality of life domain ^f						
Health	1.49	3.54	1.43	3.44	<1.00	ns
Self-esteem	3.07	2.99	3.18	3.02	<1.00	ns
Goals and values	3.33	2.54	3.27	2.61	<1.00	ns
Money	.31	2.55	.72	2.46	1.56	ns
Work	3.22	2.78	3.87	2.45	2.45	.01
Play	1.51	2.96	1.57	2.86	<1.00	ns
Learning	2.61	2.78	2.68	2.64	<1.00	ns
Creativity	2.08	2.37	2.42	2.49	1.32	ns
Helping	3.95	2.00	3.73	2.41	<1.00	ns
Love	2.19	3.62	1.58	3.89	1.53	ns
Friends	2.33	3.04	2.35	2.88	<1.00	ns
Children	2.22	3.21	2.39	3.40	<1.00	ns
Relatives	1.89	2.64	2.29	2.81	1.40	ns
Home	2.49	3.29	2.39	3.30	<1.00	ns
Neighborhood	2.24	2.66	1.81	2.75	1.53	ns
Community	1.98	2.35	1.77	2.73	<1.00	ns

^a df=372

^b Measured by the General Self-Efficacy Scale. Possible scores range from 10 to 40, with higher scores indicating greater self-efficacy.

^c Measured by the Stigmatization Scale. Possible scores range from 9 to 45, with higher scores indicating greater stigma.

^d Measured by the Housing Satisfaction Scale. Possible scores range from 1 to 5, with higher values indicating greater satisfaction.

^e Measured by the Behavior and Symptom Identification Scale. Possible scores range from 0 to 4, with lower scores indicating better mental health.

^f Measured by the Quality of Life (QOL) Inventory. Possible scores are grouped by QOL level (very low, -6.0 to .8; low, .9 to 1.5; average, 1.6 to 3.5; and high, 3.6 to 6.0).

raise the question of whether disclosure is more appropriate or beneficial in some positions than in others. Traditionally, mental health providers do not routinely disclose personal information, and they are prohibited from doing so in some treatment traditions. It may be important to revisit whether more reciprocal relationships are beneficial to both recipients and providers of care and, if so, when and how the provider should disclose personal information.

Although there were no significant differences between the cohorts in overall or in most specific aspects of job satisfaction, there were significant differences in satisfaction with pay and opportunities for advancement, with VR specialists rating these areas higher compared with peer specialists. The VR specialists were hired at higher pay grades with an established promotion track, whereas the peer specialists were

hired at lower pay grades with little or no promotion potential. To address this disparity, in 2012, the VA began to upgrade peer specialist positions, which may diminish differences in satisfaction with pay and promotion.

A recent qualitative study identified occupational characteristics associated with recovery among peer specialists, including developing skills and competencies, feeling respected as a professional, career development, finding meaning, and developing a sense of identity as a peer provider (5,43). Optimal supervision may help individuals develop these skills. In our sample, the relationship between satisfaction with amount of supervision and recovery was more consistent among VR specialists than among peer specialists. One explanation for the stronger association among VR specialists is that they required more supervision to address training needs because significantly fewer VR specialists than peer specialists were certified peer specialists. Another factor could be that VR specialists required supervision to develop sufficient competence in specific vocational skills, for example, job development, contributing to improved self-efficacy and work- and helping-related quality of life. However, because this study is cross-sectional, causality cannot be inferred from the significant associations we found. In other words, individuals with higher self-efficacy and better mental health may be more satisfied with the supervision they receive.

Concerns about quality, consistency, and quantity of supervision by peer specialists and their supervisors are documented in the literature (21,44). The VA has taken steps to address these concerns, including development of a peer support training manual for veterans and their supervisors and a contract with the Depression and Bipolar Support Alliance to provide certified peer specialist training and national conferences for training of peer specialists.

Although this was a national survey of peer specialists and VR specialists from 92% of VA hospitals in 49 states, it had limitations. The survey response rate was only 59%, and we did not have information about nonrespondents. Thus results may not be generalizable to all VA peer specialists and VR specialists. Similarly, results may not be generalizable to peer specialists employed in non-VA health care systems. Although the percentage of women (24%) in our sample was greater than the percentage of women veterans (10%), it was far smaller than the percentage of women in other recent studies of peer specialists (55%–64%) (20,42,43). Exploration of gender differences would further enhance our

TABLE 5. Association of employment characteristics and indicators of mental health recovery among veterans employed as peer specialists or vocational rehabilitation (VR) specialists^a

Employment characteristic	Overall mental health				Self-efficacy				Work-related QOL ^b				Helping-related QOL ^b			
	Peer specialists		VR specialists		Peer specialists		VR specialists		Peer specialists		VR specialists		Peer specialists		VR specialists	
	β^c	SE	β^c	SE	β^c	SE	β^c	SE	β^c	SE	β^c	SE	β^c	SE	β^c	SE
Hours of direct service	-.002	.051	.02	.04	-.17	.35	.02	.28	.45	.25	.39*	.16	-.01	.19	.01	.18
Hours of supervision received	.02	.05	-.02	.05	-.17	.36	.11	.31	-.19	.27	-.05	.18	-.23	.19	-.12	.20
Satisfaction with amount of supervision	-.09	.04	-.05	.04	.52	.30	.88**	.29	.56*	.22	.99***	.17	.33*	.16	.91***	.19
Intercept	1.68***	.42	1.61***	.36	39.8***	2.87	30.6***	2.48	-.79	2.1	-3.63*	1.43	3.34*	1.54	-.97	1.60

^a Employment characteristics were measured as ordinal variables and treated as continuous in the analysis. The regression model included age, gender, race, education, use of mental health services in past 6 months, and disability status as controlling variables.

^b Quality of life

^c Regression coefficient

* $p < .05$, ** $p < .01$, *** $p < .001$

understanding of how these roles can best help both recipients and providers of care.

CONCLUSIONS

Health care systems have moved to adopt the recovery model by hiring individuals with lived experience of mental illness. Peer providers deliver unique services, and working as a peer provider enhances one's own recovery. As the largest single health care system in the United States, the VA is in a position to address challenges of employing peer specialists (45), including fostering a recovery environment in which the roles of peers are understood and valued. Our findings highlight the generally successful recovery of veteran peer specialists and the important role that supervision may play in a community of veterans serving each other. Further research would help clarify the role of supervision and its association with recovery both within and outside the VA.

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