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"It gave me an excuse to get out into society again": Decreasing Veteran Isolation through a Community Agricultural Peer Support Model

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Reintegration is known to be a difficult time for veterans. Peer support programs offer a good strategy for military and veterans, particularly as it relates to reintegration. We review an innovative, peer support program implemented at a veteran run community agricultural initiative (CAI). This project was a case-study evaluation using a mixed methods design including participant observations; qualitative interviews with a total of 34 CAI members and affiliates; and administered surveys to a total of 67 CAI members and affiliates. Survey results suggested that CAI participation contributed to improvements in communication, forming bonds, and developing new friendships with veterans, non-veterans, family members, and strangers, as well as increased involvement in community events. Interviews revealed that the CAI's informal peer-support culture and intentional normalization of sharing stories helped promote wellness and reintegration. The CAI continues to refine its peer support model. The organization is overcoming common barriers by leveraging community partnerships to bring veterans into the fold and expanding their peer support model to veteran organizations with similar missions. This approach will ultimately lead to a culture of peer support across agencies and spread the reach of the CAI's mission for veterans.

Keywords: reintegration, agriculture, military, community, veteran, peer support

Introduction

Following their separation from the military, veterans face the necessary and sometimes difficult task of transitioning from military to civilian life. This process is most commonly referred to as "reintegration" and has been described by many veterans as something akin to culture shock. Research suggests that reintegration difficulties can negatively impact veterans' physical and mental health, emotional wellbeing, and social life. (Sayer et al., 2010) Social isolation, a social state characterized by limited to no contact with other people, is a significant concern for transitioning veterans because it compounds existing difficulties they may face and further challenges successful community reintegration. (Morin, 2011; Solomon et al., 1992) To prevent social isolation, it is critically important for veterans to access resources and support.

Peer support programs have been proven to successfully aid veteran reintegration by promoting self-care, sustained behavioral change, and relationship building, while also acting as a bridge to important healthcare, employment, and community resources. (Institute of Medicine, 2014; Money et al., 2011) In this article, we provide background information about common reintegration challenges faced by veterans and an historical overview of peer-support programs and their use with veteran populations. Additionally, we describe best practices and lessons learned from an innovative veteran peer-support model being implemented at a community agriculture initiative (CAI) in Western Washington State. We conclude with a discussion of recommendations for developing and sustaining similar peer-support programs and future directions for research in this area.

Background

Reintegration is the stage of the deployment cycle characterized by the service member's reentry into his or her daily life as experienced prior to deployment, or into a new civilian life, including the domains of work, family, and personal experiences. (Marek et al., 2012) Studies have chronicled historical challenges with veteran reintegration across all combat eras in the United States. (Amdur, 2011; Sayer, Carlson, & Frazier, 2014; Thomas, 2014) Indeed, in a recent study 27% of all veterans across various combat eras experienced reintegration difficulties, a number that increased to 44% when the sample focused only on Operation Enduring Freedom (OEF) / Operation Iraqi Freedom (OIF) veterans. (Morin, 2011) While previous literature suggested that the reintegration stage lasts several months, this stage can actually persist for months to years depending on the individual service member, his or her family, and the fuller context of the service member's life. (Marek et al., 2012) Accordingly, four factors predict *an easier* veteran reintegration: (1) being a commissioned officer; (2) being a college graduate; (3) having clearly understood the mission while serving; and (4) (for post 9/11 veterans only) having a higher degree of religiosity. In contrast, six variables predict reintegration *difficulties* if the veteran: (1) served in a combat zone; (2) knew

someone who was killed; (3) endured emotional or physical trauma while serving; (4) is currently suffering from post-traumatic stress; (5) suffered serious service-related injury while serving; and (6) (for post 9/11 veterans only) married while serving. (Morin, 2011)

The long-term effects of multiple deployments and physical and mental health conditions, such as post-traumatic stress disorder (PTSD), depression, anxiety, polytrauma, and traumatic brain injury (TBI) often disrupt work and family life and hinder reintegration. (Sayer, Carlson, & Frazier, 2014) Even in the absence of diagnosable disorders, many veterans experience issues that stall their reintegration into civilian life, including financial problems, under or unemployment, housing instability, marital issues, diminished community involvement, and social isolation. (Hoerster et al., 2012; Seal, Bertenthal, Miner, Sen, & Marmar, 2007) Evidence suggests that social support and integration are critical determinants of overall health and wellbeing among a diverse range of populations and that social isolation is a substantial mortality risk. (House, Landis, & Umberson, 1988) In fact, the mortality risks of social isolation are comparable to those of substance abuse and smoking. (Holt-Lunstad, Smith, & Layton, 2010)

Because social isolation impacts a wide range of health, functioning, and quality of life outcomes and risks (Maher, 2014), community engagement is a key element of numerous veteran reintegration programs. (Capra, 2014; Kudler & Straits-Tröster, 2009; ORH, 2014) A comprehensive approach to reintegration that includes partnership among the government, private sector, and the public is necessary to address multiple reintegration barriers and improve health care services and benefits for veterans and their families. (Hoerster et al., 2012) Thus, community reintegration efforts must engage with community, peers, and family to close the gap between treatment activities and functional competence in the individual's natural environment. (Sayer et al., 2014) One way to bridge the gap between community and treatment activities is through peer support, based on the

mutually beneficial exchange of experiences or knowledge for the purposes of promoting self-care and sustained behavioral change.

Peer support overview

Peer support is social emotional support coupled with instrumental support mutually offered or provided by persons sharing a similar condition to bring about change. (Gartner & Riessman, 1982) The approach of peer support assumes that people who have similar experiences can better relate and thus offer more authentic empathy and validation. (Mead & MacNeil, 2006) As a "system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement as to what is helpful" (Mead, Hilton & Curtis, 2001; p. 135), peer support leverages shared experiences to foster trust, decrease stigma, and create a sustainable forum for seeking help and sharing information about support resources and positive coping strategies. (Money et al., 2011) Importantly, peer support promotes a wellness model that emphasizes people's strengths and the positive aspects of their ability to function supportively, as opposed to an illness model that focuses on an individual's symptoms and problems. (Carter, 2000)

Peer support began in the form of peer support groups, where participants with similar difficulties met to provide mutual support and discuss their common problems and strategies while receiving empathy from other members based on shared experiences. (Chinman, Young, Hassell, & Davidson, 2006) Applications for this evidence-based practice have expanded from mental health to chronic disease management (e.g., diabetes, mental health, heart disease, cancer, asthma, HIV/AIDS, substance abuse), screening and prevention (e.g., cancer, HIV/AIDS, infectious diseases), and maternal and child health (e.g., breastfeeding, nutrition, post-partum depression). (Tang, 2013)

Three broad groups of peer support exist: informal (i.e., naturally occurring); peers participating in consumer or peer-run programs; and the employment of consumers/users as providers of services and supports within traditional services. (Davidson et al., 1999) Peer support

categories include: self-help groups; peer delivered services; peer run or operated services; peer partnerships; and peer employees. (Solomon, 2004) Peers can be voluntary or employed. As an evidence-based intervention, peer support is especially effective for hard to reach audiences such as those at risk, disengaged, distrustful, and difficult to access. (Flanagan & Hancock, 2010; Health and Safety Executive, 2004; Peers for Progress, 2016) Strong evidence exists that peer support/peer-provided services result in benefits to peer recipients, peer providers, and to the health care system. These benefits include empowerment, improved self-esteem, improved social functioning of both provider and recipient, decreased social isolation, increased feelings of acceptance, increased hope, reduced stigma of the recipient, and maintaining readmission rates and recovery as well or better when compared to professional services. (Repper & Carter, 2011; Solomon, 2004)

The spread of peer support has been attributed to the mental health services user movement that began in the 1970's. (New Freedom Commission on Mental Health, 2003; Tang, 2013) This movement empowered former mental health service users to help each other and advocate for themselves. The first published account of peer support among individuals with mental illness appeared in 1991(Sherman & Porter, 1991); however, peer support among individuals with mental illness and accounts of the practice goes back centuries throughout the history of psychiatry. (Davidson, Bellamy, Guy, & Miller, 2012) In the last twenty years, the practice of peer support has increased globally with a recent estimate of over ten thousand peer support staff in the U.S. alone. (Goldstrom et al., 2006) This increase in peer support practice aligns with the broad adoption of the recovery treatment model advocated by behavioral health systems and based on the concept of strengths and empowerment of the individual with a goal of recovery. (National Association of Social Workers Practice Snapshot: The Transformation of the Mental Health System, 2006; Substance Abuse & Mental Health Services Administration, 2012) In this model, the concept of "recovery" established by the Substance Abuse and Mental Health Services Administration (SAMSHA) is "a

process of change through which individuals improve their health and wellness, live self-directed lives and strive to reach their full potential" (Substance Abuse & Mental Health Services Administration, 2012, p3). Recovery builds on access to evidence-based clinical treatment and recovery support services, which includes dimensions of health, home, purpose, and community. The process of recovery can occur via many pathways, one of which is peer support. (Substance Abuse & Mental Health Services Administration, 2012)

Peer support is understood to be so successful because of the non-hierarchical, reciprocal relationship formed among peers as they share experiences and knowledge with others who have faced similar challenges, an exchange which facilitates mastery of self-care behaviors and improves disease outcomes. (Broadhead et al., 2002; Heisler, 2006; Wilson & Pratt, 1987) A recent review of over 1000 peer support studies concluded that peer support has the potential to improve experience, psychosocial and health outcomes, and service use among people with long-term physical and mental health conditions. (Nesta & National Voices, 2015) Peer support also improves experience and emotional aspects for caregivers, people from certain age and ethnic groups, and those at risk. The model is most effective for improving health outcomes when facilitated by trained peers, lay people (not necessarily peers), or professionals, when delivered one-to-one or in groups of more than ten people, and when it is based around specific activities that focus on education, social support, and physical support. Peer support works well when delivered in multiple ways (e.g., face-to-face, by telephone or online) and in a range of venues (e.g., people's own homes, community venues, hospitals and health services in the community). Overall, evidence suggests that peer support is a critical and effective strategy for ongoing health care and sustained behavior change for people with mental health, chronic diseases, and other conditions. (Peers for Progress, 2016)

Peer support and veterans

In individuals with mental health issues, including PTSD, peer support programs facilitate social functioning, quality of life, engagement in treatment via promotion of social bonds, recovery orientation, and knowledge about the healthcare system. (Chinman et al., 2006) Peer support programs are good for service-members and veterans indoctrinated into a military culture, which places the onus on service-members to care for each other and rely on the natural support of their colleagues to cope with stress. (Institute of Medicine, 2010; Money et al., 2011) As veterans are often reluctant to seek out mental health care, peer support in this population enhances access to mental health treatment due to greater credibility associated with peers over non-peers, which can reduce stigma related to mental health seeking behavior. (Jain et al., 2013; Money et al., 2011) In fact, a recent presidential mandate for the Department of Veterans Affairs (VA) required the VA to hire 800 new peer support specialists nationwide. (Office of the Press Secretary, 2012) The VA's peer support specialists are paid employees who are integrated into healthcare teams at VA Medical Centers (VAMCs) and often supervised by a social worker with the title of "Local Recovery Coordinator." Thus, the VA's peer support specialists fall within the group of employment of consumers/users as providers of services and supports within traditional services (Davidson et al., 1999) and the category of peer employees. (Solomon, 2004)

Numerous successful peer support programs for veterans and service-members tailor their programs for the unique issues of their program participants. For example, evaluation of the Michigan Army National Guard Buddy-to-Buddy program found that over half of their participants receiving calls from the peer "buddy" used recommended resources, and 20% had been referred for formal treatment. (Greden et al., 2010) Upon systematic review of these programs, the Department Centers of Excellence (DCoE) determined benefits of peer support programs for veterans and service-members to include self-empowerment, increased social support, and experiential learning.

(Money et al., 2011) Five elements are essential to a successful veteran/military peer support program, including: (1) Adequate planning and preparation; (2) Clearly articulated policies to avoid confusion; (3) Systematic screening with defined selection criteria for peer supporters; (4) Leveraging benefits from "peer status"; and (5) Enabling continued learning through structured training. (Jain et al., 2013; Money et al., 2011)

A lesser-known example of a successful veteran peer-support program is the VA's Vet Centers, which falls under the Readjustment Counseling Services arm of the Veterans Health Administration and has existed as semi-autonomous facilities throughout the country since 1979 by Public Law 96-22. Vet Centers grew from grass roots peer support groups started by Viet Nam era veterans who felt rejected and disenfranchised from the VA and society. ("Vet Centers and the Social Contract," 2015) Congressional hearings held from 1969 through 1979 identified readjustment difficulties in some veterans returning from duty during the Vietnam era. These hearings led to the passing of legislation in 1979 for the VA to provide readjustment counseling to eligible combat veterans. In response to this legislation, the Department of Veterans Affairs' Veterans Health Administration (VHA) established a nation-wide system of community based programs separate from Veterans Affairs Medical Centers (VAMC's) which became Vet Centers. Currently 300 Vet Centers operate in every state, District of Columbia, American Samoa, Guam and Puerto Rico. (Office of the First Lady, The White House, 2015)

Introducing a community agriculture peer-support model

As previously mentioned, peer support programs are most effective for improving health outcomes when they occur within the context of specific activities and focus on education, social support, and physical support. (Nesta & National Voices, 2015) When considered alongside evidence that supports the health, educational, and social benefits of ecotherapies and agricultural programs,

community agricultural initiatives (CAIs) provide a uniquely beneficial environment within which peer-support activities can occur.

Ecotherapy is the umbrella term for treatment modalities that include the natural world in relationships of mutual healing and growth. (Chalquist, 2009) Whereas ecotherapy has a therapeutic orientation, agricultural programs have a range of goals and foci that may not be specifically focused on therapy or treatment, but similarly demonstrate the connection between nature, human health, and resilience. (Fusaro, 2010) Historically, ecotherapies presupposed that contact with the natural environment brings about cognitive, behavioral, and physical changes. (Burns, 2012) There is extensive research documenting the benefits of participating in community agricultural programs, which most commonly include: (1) improvements in mental health (Brown, Worden, Frohne, & Sullivan, 2011; Herzog, Maguire, & Nebel, 2003); (2) emotional issues (Fried & Wichrowski, 2008; Twill, Norris, & Purvis, 2011) ; (3) physical health (Chalquist, 2009; National Wildlife Federation, 2012); (4) vocational skills (Fusaro, 2010; Kaplan & Talbot, 1983); and (5) promotion of the formation of trusted interpersonal relationships and community connectedness. (Fetherman, Levine, Burke, & Golden, 2005; Krasny, Pace, Tidball, & Helphand, 2014; Sandel, 2004)

Additionally, researchers have long documented the healing benefits of ecotherapies as they relate to the treatment and rehabilitation of civilians and veterans with disabilities. (Besterman-Dahan, Chavez, Bendixsen, & Dillahunt-Aspillaga, 2016) A wide-range of these documented physical and mental health benefits are relevant to many veteran reintegration issues. Benefits include: increased socialization; peer support; feelings of connection to and responsibility for others (Sandel, 2004; Szofran & Meyer, 2004); improved self-concept, self-esteem, and confidence (Szofran & Meyer, 2004; Twill et al, 2011); increases in energy, concentration, the ability to stay on task, and levels of self-responsibility (Rapper et al 2008; Szofran & Meyer, 2004). Many of these cited benefits connect specifically to the informal and natural environments where activities take place.

Participants, including veterans with stress and combat exposure, have reported feeling relaxed, secure, safe, calmer, and more self-aware as a result of participating in wilderness, agriculture, and adventure programs. (Atkinson, 2009; Besterman-Dahan et al., 2016; Sandel, 2004; Szofran & Meyer, 2004; Westlund, 2012)

Growing Veterans (GV), a CAI in Washington State has developed a veteran peer-support model that incorporates the best practices for veteran reintegration and peer-support within the context of community agriculture. The organization's mission is to empower military veterans to grow food, communities, and each other. The long-term vision is to end the isolation that leads to suicide and make sustainable agriculture the norm. Using a therapeutic outdoor setting, the farm, as the catalyst, GV, a nonprofit, provides weekly opportunities for veterans to engage with the broader community and provide each other with peer-support. Combining veteran reintegration with sustainable agriculture, GV creates space for veterans to re-experience the purpose and camaraderie they often miss from their time in the military. Working alongside civilians, they bridge the gap of misunderstanding between military and civilian populations and provide opportunities for veterans and civilians to learn from each other, and support each other. The veterans and volunteers at GV raise organic produce and distribute it through their farmer's market stand once a week at the VA Puget Sound Medical System's Seattle Hospital. The market provides GV with an opportunity to share their mission and delicious produce with veterans and care-providers throughout the region as well as to perform outreach to recruit new members. To accomplish their mission of empowering each other, GV has created a Peer Support Training program and curriculum for their leadership and community stakeholders to help foster a culture of peer-support, both on and off their farm.

GV acknowledges the negative stigma the veteran population places on traditional therapies (Goldberg Looney, 2014) and has adopted an informal peer-support approach to address that phenomena. The open setting of their farm activities helps remove stigma that may often be an

unintentional barrier toward seeking wellness at a traditional "brick-and-mortar" health or mental health institution. Additionally, GV's peer-support approach is inclusive of both those who have and have not experienced trauma. GV recognizes that while peer support can greatly improve trauma outcomes, it also increases wellness for all participants. As a result, GV's peer support model does not solely target people who have experienced trauma; it also emphasizes inclusion of that population.

Evolution of community agriculture peer support program

GV originally started under the very informal assumption that if they provide space in an agricultural setting for veterans to gather and work alongside civilian community members, positive outcomes toward wellness would result. Researchers from the Veterans Health Administration (VHA) funded by the VHA Office of Rural Health (ORH) conducted formal mixed-methods, case study evaluation of the CAI to better understand the veteran health and reintegration outcomes of this program. (Besterman-Dahan et al., 2016) The results of this evaluation contributed to the evolution of GV's peer-support program.

Evaluation methods

The VHA's evaluation specifically aimed to:

- Identify the barriers and facilitators associated with participating in the CAI for transitioning rural veterans
- Describe experiences of transitioning veterans, their families, and community stakeholders who participate in a CAI (including impact, benefits, expectations, preferences, meaning making)
- Describe the satisfaction with participation in the CAI for transitioning veterans, their families, and community stakeholders

Data was collected from both veteran and non-veteran GV members using the following qualitative and quantitative methods:

- A reintegration measure (Military to Civilian Questionnaire -M2C-Q) with 40 veterans)
- A health quality of life measure (VR-12)

- A general satisfaction survey with 67 GV participants (43 veterans and 24 non-veterans)
- Semi-structured interviews with 11 veterans and 32 non-veterans (i.e., family members, stakeholders, non-veteran GV members)
- Participant observation

A convenience sample of 67 participants completed surveys: 40 completed the Military to Civilian Questionnaire (M2C-Q); 40 completed the Veterans RAND 12 (VR-12); 43 veterans completed the satisfaction survey; and 24 non-veterans completed the satisfaction survey. Using a locally developed questionnaire with veterans and non-veterans, researchers collected socio-demographic data which included age, race, level of education, employment status, household members, veteran status, and benefits. Table 1 below illustrates how each data collection instrument was used to answer the three evaluation objectives.

Table 1. Evaluation objectives and corresponding data collection methods

Evaluation Objectives	Data Collection Methods				
	M2C-Q	VR-12	Satisfaction Survey	Interview	Observation
Identify the barriers and facilitators associated with participating in CAI for transitioning rural veterans			X	X	
Describe experiences of transitioning veterans, their families and community stakeholders who participate in a CAI	X	X	X	X	X
Describe the satisfaction with participation in CAI for transitioning veterans, their families and community stakeholders			X	X	

N= 67

The military to civilian questionnaire (M2C-Q) is a 16-item tool rated on a 5-point Likert scale. (Sayer et al., 2011) The responses ranged from 0-4 (0=No difficulty, 1=A little difficulty, 2= Some difficulty, 3=A lot of difficulty, 4=Extreme difficulty). In addition, four items assessing the relationship with spouse, child/children, work, and school functioning can be answered as "Does not apply." The published internal consistency coefficient is 0.95. (Sayer et al., 2011)

The veterans RAND 12-item health survey (VR-12) is a questionnaire generated from the VR-36 and modified from the SF-36. (Iqbal et al., 2009). Two question responses differ on the VR-36 and SF-36 (Iqbal et al., 2009). Rather than a dichotomous "yes/no" option for the role limitations due to physical and the emotional problems, the VR-36 uses a 5-point response option that ranges from "No, none of the time" to "Yes, all of the time." (Iqbal et al., 2009)

The semi-structured interview guide targeted, but did not limit its questions to the benefits of and barriers to participating in CAI activities. Interviews included follow-up questions about the then fledgling, informal peer-support program. The research team interviewed and audio-recorded participants and analyzed transcriptions in Atlas.ti (a computerized qualitative data analysis program), using an iterative coding process. (Friese, 2013)

Evaluation results: Quantitative

Quantitative measures of reintegration suggest that the veteran GV members experienced "little to some difficulty" reintegrating post-military. In particular, results from the M2C-Q revealed that these respondents perceived the most difficulty with reintegration domains related to: (1) making and maintaining friendships; (2) confiding or sharing personal thoughts and feelings; and (3) taking part in community events or celebrations (see Table 3, Appendix A). Although this tool was originally validated with post-deployed OEF/OIF veterans, all veterans participating in the project completed the measure. Furthermore, the characteristics of veteran respondents suggest that they are also at risk of experiencing similar reintegration difficulties as those outlined in Morin's (2011) study because:

- 87.9% (n=29) of those veterans who deployed were in combat zones (see Table 4, Appendix B)
- The population's VR-12 scores indicate that their mental health component is similar to veterans clinically diagnosed with PTSD (see Table 5, Appendix C),

- The majority (51.2%, n=22) of the respondents reported 30%-90% service-connected disability, indicating they sustained some form of combat or work-related injury while in the military (see Table 6, Appendix D).

Difficulties forming and maintaining meaningful relationships is a hallmark of social isolation, which GV actively seeks to diminish among its veteran members. Satisfaction survey results suggested that because of their participation in this CAI, veteran members self-reported improvements, communicating and forming bonds with veteran, non-veteran, and family members (See Table *7* "Satisfaction" Appendix E). In particular, veterans reported improvements in their ability to communicate with people they know (63%) as well as with strangers (*7*1%); improvements in their relationships with family members (56%); their ability to form new friendships with (82%) and without (64%) military experience; and increased their involvement in community events (68%).

Evaluation results: Qualitative

Interviews: Qualitative responses to interview questions supported quantitative findings about the primary reintegration barriers and the positive benefits of participating in GV activities. Respondents spoke of their reluctance to communicate with others, especially non-veterans, and the difficulties they faced during daily interactions. One veteran explained, "Before [coming to GV] I wouldn't talk to [non-veterans] and when I would, it would be hard to relate to them because I thought that they had never experienced anything that I have." Interview data suggested that GV's burgeoning culture of informal peer support, which emphasized "checking in" with peers and sharing stories while engaging in mission-oriented work, increased veterans' abilities to connect to other veterans and non-veterans through meaningful socialization that occurs within the context of a shared cause. As one veteran explained:

> I would say that I'm an introvert, but the thing about introverts is that when you get them talking about a cause or something they believe in, they'll talk for hours. My thoughts are generally swirling in my head, which—when you have trauma—is not a great combination. [This program] does get me talking more because I believe in something that feels real and important to me. It has allowed me to be more comfortable identifying with a veteran and with strangers.

Commonly, veterans described this combination of meaningful socialization and informal peer-support as a catalyst for helping them come to terms with their military pasts and their veteran identities in a way that was not based solely upon "war stories." According to one veteran, "rather than sitting around talking about war stories, we're talking about how we help other people and that's the focus." Several respondents felt that GV's culture of peer support and intentional normalization of sharing stories helped promote recovery and reintegration in a more naturalistic way than other clinical treatments they had undergone previously. Additionally, the practice of including veteran and non-veterans in program activities allowed veterans to discuss their experiences publically, among people with diverse backgrounds, without fear of judgment or stigma. According to one veteran:

> There's a lot more support here than I ever had during treatment, more helpful than any of the meds. I think part of it is—particularly with PTSD—[this program] is kind of normalizing it. Like, if other people don't understand [PTSD] and get it, there's not the fear of judgment here or being in the spotlight that would normally trigger that.

Veterans explained that this process of normalization coupled with helping one another was critically important to reintegration:

> I think [GV] plays a really significant role in [reintegration] as far as its model through peer support. As veterans we're working alongside other Vets and students and community

members. It's about sharing those stories and just contributing to society. There's selflessness about it that I think is generally a trait of a lot of veterans and I think just knowing that you're an asset like advocating the veterans is a part of it.

Observations of the peer support program

Despite the many beneficial outcomes of the initial stages of the program, specific areas for improvement emerged from the evaluation process: (1) many veterans did not seem comfortable sharing their stories; (2) many veterans did not have the communication skills required to hold a healing space for other veterans who were struggling; and (3) the program did not have enough structure in place to make it easy for veterans to have a successful experience in the first two areas.

GV took an innovative approach to creating more structure within their peer-support program while ensuring it would remain informal enough to avoid any perceived negative stigma by new members. Over the course of one year, GV curriculum developers recorded observations and feedback from veteran members, staff leadership, and mental health counselors who have worked with veterans for a cumulative 80+ years, and academic instructors with over 20 years of experience. They also followed best practices already identified for military veteran peer support programs. (Money et al., 2011) GV had a few veteran members with formal backgrounds in psychology who took on the task of incorporating all of these observations and feedback into a curriculum for their peer support training. These curriculum developers—mostly combat veterans of the wars in Iraq and Afghanistan—produced a training course created by peers themselves for their fellow peers.

Once created, GV tested the curriculum by bringing in focus groups of representatives from the observers mentioned in the previous paragraph. The key developer of the curriculum led participants through each module of the training and recorded additional feedback to ensure the curriculum catered to the population the CAI targeted for their peer support. After this exercise was completed, GV held their first formal peer support training for all of their staff and key volunteers.

Included in the curriculum is the opportunity for training participants to provide even more feedback. The approach GV has taken for their peer-support training will lead to an evolving curriculum created, tested, and refined by a cadre of experts, as well as the peers who the training serves.

Growing Veterans' Peer Support Training is still evolving. As of this writing, GV has only hosted two trainings for 30 participants. From the first 12 participants, a three-month follow up survey indicates those 12 individuals have provided peer-support to an estimated 90 veterans, and 64 civilians, for a total of 154 people.

Future of GV's peer support program

Peer Supporter refers to anyone who obtains a Certificate of Completion for GV's Peer Support Training. In addition to the general *Peer Supporter* title that participants earn after completing their training, GV is developing a system of tiers to acknowledge greater competencies in peer-support roles. The objective for the Peer Support Mentor (PSM) Tier system is to recognize and encourage ongoing self-growth and greater competencies as a peer-supporter. Table 2 below shows the expanding criteria for each level of peer training for Peer Support Mentor, Tiers 1, 2, and 3:

Table 2. Criteria for GV peer support mentor program tiers

	Peer Support Mentor		
	Tier 1	Tier 2	Tier 3
Certified Growing Veterans' Peer-Support Training	X	X	X
Demonstrate completion of trauma work/counseling and the ability to use their story to encourage others to do the same	X	X	X
Certified in ASIST Training *OR* Psychological First Aid Training		X	
Certified in ASIST Training *AND* Psychological First Aid Training			X

If a member completes GV's peer support training *and* demonstrates successful outcomes in recovery through work with a mental health professional, he or she will be classified as a *Peer Support Mentor (PSM) - Tier 1* designation

- If a member completes both requirements for PSM - Tier 1 classification, *and* obtains certification in Applied Suicide Intervention Skills Training (ASIST) (Turley, Pullen, Thomas, & Rolfe, 2000) *or* Psychological First Aid training (Everly Jr & Flynn, 2005), he or she will be classified as a *PSM - Tier 2* designation
- Finally, if a member completes all requirements for PSM - Tier 2 designation, *and completes both* ASIST *and* Psychological First Aid training, he or she will be classified as a *PSM - Tier 3*, the highest classification for PSM's with GV. Individuals with PSM - Tier 3 would become ambassadors for the organization while interacting with individuals or groups from other agencies, who are collaborating with GV in a peer support capacity

To ensure that future participants of their training might also be eligible to work in a clinical setting as a peer supporter, GV's training developers are incorporating national standards and competencies for peer support trainings (Creamer et al., 2012; International Association of Peer Supporters, 2012; Mental Health America, 2016) in future iterations of its training. They are also actively engaged in conversation with the federal VA's Peer Support leadership staff and are identifying national peer support training certifying bodies. They intend to submit their training curriculum for third party approval and certification by a recognized peer-support certifying agency.

GV aims to train as many of their members as peer supporters as they can. Additionally, they are training members of other veteran nonprofits throughout their region, with goals to partner with groups from around the United States. With each training, feedback is solicited from the peers they assist to further refine the curriculum and continuously improve outcomes. GV's long-term goal is not only to create a culture of peer support among their organization, but also to motivate change that might influence the greater culture of the United States. As an organization, GV hopes that such an

approach might empower all of us to embrace a culture of peer support. To learn more about the development of the training, please visit http://growingveterans.org/peer-support.

Conversely, the federal VA's regional healthcare system in the CAI's same geographical region only has two paid Peer Specialists on staff, although there are enough slots for three. (Merritt, 2016) By training a higher number of peer supporters, GV fosters a culture of peer support that extends beyond the furrows of their fields of the organization and into the broader community. As members of this CAI engage in external work and volunteer activities with veterans who are often not using VA services, their "peer support perspective" has encouraged others to communicate openly about their experiences and to seek healthcare services and achieve wellness.

Discussion

There are three mechanisms of action by which peer support is thought to be effective for veterans and service-members with mental illness, including PTSD. (Jain et al., 2013) The first is *promotion of social bonds*, which increases available social support, thus facilitating increased social activity and subsequent community integration. Promotion of social bonds influences the peer recipient to seek treatment for mental health issues. Thus, the second mechanism of action associated with peer support is the *promotion of wellness and/or recovery*. Peer providers act as a positive role model, promoting feelings of hope and empowerment for recovery. These actions can lead to increased self-efficacy, autonomy, and subsequently the ability to cope with stress, seek one's potential, and live a self-directed life. The third mechanism for action is *enhancing understanding of the healthcare system.* Peer support providers can enhance the individual's level of engagement in mental health treatments by de-stigmatizing decisions to seek treatment, acting as a "cultural broker" to help recipients understand available treatment and resources, and acting as a navigator to the healthcare system.

To promote social bonds and wellness and enhance understanding of the healthcare system, GV's peer support model incorporates characteristics that established a *culture of peer support*, setting it

apart from other, more formalized peer support programs. For example, GV peer-supporters do not take chart notes for a medical team or have paid positions, as they do in medical and mental health institutions. (Chinman, Henze, & Sweeney, 2013; Chinman, Salzer, & O'Brien-Mazza, 2012) GV acknowledges the limitations of paid, professional peer-support roles, such as role confusion, resistance among staff, unequal treatment, hiring challenges, and lack of consistent funding. (Chinman et al., 2013, 2012) Instead, peer-supporters trained by GV are volunteers, who look for opportunities to use their own stories of healing and recovery to encourage veterans who have not sought health services to do so to improve their level of wellness. The GV peer support training emphasizes communication skills and strategies, and helps peer-supporters use their own stories of healing and wellness-seeking to motivate change in others. This approach sets a precedent, which normalizes and encourages participants to share personal stories of overcoming trauma, if it is helpful and therapeutic to others within the group. Finally, GV is a mission oriented organization, which – as evaluation data has suggested – supports participants' meaningful socialization around a shared cause: being of service to their community. This orientation has facilitated the informal nature of GV's peer support program. Unlike other formalized peer-support or mental health programs, which focus primarily on treatment or condition, GV provides space for participants to simultaneously serve their communities and receive the support that they need. This program builds on the idea that veteran engagement in volunteer civic service to communities has been found to improve health, connections with veterans and community, and provide a renewed sense of purpose. (Gould, Scheinberg, & Matthieu, 2014) This approach is especially relevant for veterans transitioning to civilian life in that they provide a setting that builds on their individual strengths, allows veterans to apply specialized skills, instills a feeling of connectedness and contribution to their communities, and re-creates a familiar culture of camaraderie and inclusiveness among veterans. (Kranke, Gin, Saia, Heslin, & Dobalian, 2016)

The VA requires peer support specialists to *be in recovery*, which is defined under their application qualifications as someone who is:

> … able to talk about their condition candidly, and offer descriptions of helpful tools and resources they have used to manage their lives every day… able to live in the community of their choice, independently and have a meaningful life that they are satisfied with. It often means that they haven't been hospitalized or had legal problems as a result of their mental health condition for more than a year. It doesn't mean that they no longer have any symptoms or don't need to take medication to manage their symptoms, but those symptoms no longer interfere with major functioning in most life activities in a significant way. (Peer Support FAQs - VA Careers, 2015, n.p.)

Comparatively, for those GV peer supporters who have experienced trauma, the expectation is that peer-supporters who attend the organization's peer support training must have made a *commitment to recovery* and have begun taking steps toward wellness. As a result, parts of the training helps peer supporters learn what they can do individually to seek their own wellness and enhance their recovery. GV's culture of peer-support allows individuals to participate, at any stage of wellbeing that they are experiencing. Another cultural expectation, then, is that everyone is seeking to improve their own level of wellbeing and to support each other as peers in the process. This approach recognizes that peer supporters may still be struggling, but it encourages them to share those struggles with other peers to create a culture, or social network, of people looking out for and encouraging each other to seek greater supports. To assure these peer supporters continuously progress in their healing or recovery, the organization uses staff and volunteer supervisors who are mental health professionals and maintains collaborative arrangements with their local VA health and mental health clinics.

As the formal evaluation demonstrates, GV's innovative approach meets the outcomes expected from an effective peer-support program by matching evidence-based practices with

population preferences. As the qualitative statements above suggest, the outdoor, agricultural setting, coupled with the emphasis on volunteerism alongside civilian community members, allows GV to reduce negative stigma and invite veterans to show up without fear of judgment or bureaucratic challenges. On many occasions, GV has welcomed new veterans who report they have not left their homes in weeks or months; the farm was their first step in re-engaging with their community again. The informal nature of the farm is what made it easy for those veterans to take that step. While it is evident that GV has developed an innovative approach to preventing veteran isolation and enhancing veteran reintegration through their peer support model, further evaluation is needed. As they continue developing their peer support training, on-going evaluation of the implementation of their model will help the field of peer support, particularly in promoting healthy veteran reintegration, and allow other organizations doing work in peer support to consider new and innovative approaches to their work.

Despite the substantial efforts made by the VA to address veterans' mental health issues, including exceeding the hiring goal of Peer Specialists set by the Executive Order (Office of Public and Intergovernmental Affairs, 2013), approximately half of veterans with mental health problems do not receive mental health services. (Institute of Medicine, 2010; Seal et al., 2007) Low utilization has been found to be related to stigma (e.g., belief of being seen as weak, incompetent), organizational barriers (e.g., difficulty with scheduling a doctor appointment), and negative perceptions of mental health care (e.g., lack of trust in mental health professionals, thinking less of others who seek care, or considering treatment ineffective or unhealthy). (Kim, Thomas, Wilk, Castro, & Hoge, 2010) Recognizing this reality, there has been a call for innovative approaches to enhance mental health treatment outreach and to "meet the veterans where they are," including matching evidence-based practices with patient preferences. (Hoge, 2011) Peer support improves self-empowerment, social support, social functioning, and decreases social isolation in civilians as well as in veterans with

mental health issues, by offering these benefits not only to the recipient, but also to the provider of those services (Chinman et al., 2006; Repper & Carter, 2011). Veterans with PTSD reported social support, purpose and meaning, normalization of symptoms, hope and therapeutic benefits to peer support. (Hundt, Robinson, Arney, Stanley, & Cully, 2015)

The GV model of peer support aligns with the call to "meet the veterans where they are" by implementing innovative, evidence-based approaches that improve the social functioning and support of veterans. Furthermore, 154 people (90 veterans and 64 civilians) have received peer support, based on a three month follow-up from the 12 initial (of 30 total) participants thus far, indicating the applicability of this program across geographic and demographic boundaries. Given that the program is based on evidence and best practices, the program is expected to expand across communities as the trainings continue, which is the goal: to develop a culture of peer support. One key to why GV's peer support program is so accessible may lie in its flexibility. GV has developed a culture of peer-support, which allows individuals to participate at any stage of wellbeing that they are experiencing. Moreover, given that GV maintains an informal environment and that they are a mission-centered organization where peer support is not their sole focus, they do not require a particular, organizational infrastructure or agenda in order for their program to be successfully implemented. Additionally, since GV's peer-support approach is inclusive of both those who have and have not experienced trauma, it is adaptable for the participants of many organizations.

Conclusion

The GV model has been a work of continuous refinement to improve the peer support program. Among the biggest barriers GV found to providing peer support to veteran members was allowing for adequate financial support and time for staff to train and outreach to other veterans. Although these are common barriers to interventions in traditional mental health systems (Hoge et al., 2004; Pagoto et al., 2007; McFall, Malte, Fontana, & Rosenheck, 2000), this CAI has employed

innovative strategies to overcome these issues, such as leveraging community partnerships to bring veterans into the fold. For example, GV has built relationships with regional entities of national agencies that engage the veteran population in service projects, disaster relief, and physical fitness activities. To strengthen the network, develop a culture of peer support across agencies, and spread awareness for GV's mission to veterans within those agencies, GV is training leadership from these external agencies in their peer support model. Additionally, this CAI facilitates regular, consistent community activity where anyone could show up and learn more about peer support and the organization's operations in general. Examples of these include a weekly farmer's market at a nearby Veterans Affairs Medical Center, and a number of weekly volunteer events held at a variety of locations. Furthermore, GV is expanding its online and social media presence to extend resources, opportunities, and outreach to veterans in a non-resource intensive way. Given the high rates of both mental health issues in veterans and veterans who prefer to either not seek treatment in the VA or at all, as well as the strong evidence behind peer support being effective in military and veteran populations, the need for innovative, community-based, informal evidence-based approaches like the peer support program at GV is critical. With its peer mentoring model and its mission "to grow food, communities, and each other," Growing Veterans moves reintegration one step farther from isolation and one step closer to social solidarity—a concept that cultural critic Sebastian Junger wrote, "is at the core of what it means to be human" (2016, p. 133).

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References

Amdur, D., Batres, A., Belisle, J., Brown Jr, J.H., Cornis-Pop, M., Mathewson-Chapman, M., Harms, G., Hunt, S.C., Kennedy, P., Mahoney-Gleason, H. and Perez, J. (2011). VA integrated post-combat care: A systemic approach to caring for returning combat veterans. *Social Work in Health Care*, *50*(7), 564–575.

Atkinson, J. (2009). An evaluation of the gardening leave project for ex-military personnel with PTSD and other combat related mental health problems (p. 6). *The Pears Foundation.* Retrieved from http://www.gardeningleave.org/wp-content/uploads/2009/06/completeglsummary.pdf

Besterman-Dahan, K., Chavez, M., Bendixsen, C., & Dillahunt-Aspillaga, C. (2016). Community reintegration of transitioning veterans: An overview of agricultural initiatives. In M. Townsend (Ed.) *Veterans: Political, Social and Health Issues* (pp.27-50). Nova Science Publishers, Inc.

Broadhead, R. S., Heckathorn, D. D., Altice, F. L., Van Hulst, Y., Carbone, M., Friedland, G. H., Selwyn, P. A. (2002). Increasing drug users' adherence to HIV treatment: results of a peer-driven intervention feasibility study. *Social Science & Medicine*, *55*(2), 235–246.

Brown, S. P., Worden, E. C., Frohne, T. M., & Sullivan, J. (2011). Horticultural therapy. Florida Cooperative Extension Service, Institute of Food and Agricultural Sciences, University of Florida. Retrieved from http://edis.ifas.ufl.edu/ep145

Burns, G. W. (2012). Nature-guided therapy. In *Encyclopedia of the Sciences of Learning* (pp. 2436–2437). Springer. Retrieved from http://link.springer.com/10.1007/978-1-4419-1428-6_930

Capra, G. (2014, May). *VHA - ORH update*. Presented at the National Coalition for Homeless Veterans Annual Conference, Washington D.C. Retrieved from http://www.nchv.org/images/uploads/Capra%20Rural%20Health%20Update%20May%202014%281%29.pdf

Carter, M. L. (2000). Social support systems as factors of academic persistence for African American, lower-income, first-year college students and high school graduates not attending college. Doctoral Dissertation. University of Buffalo

Chalquist, C. (2009). A look at the ecotherapy research evidence. *Ecopsychology*, *1*(2), 64–74.

Chinman, M., Henze, K., & Sweeney, P. (2013). Peer specialist toolkit: Implementing peer support services in VHA. VISN 1 and VISN 4 publishers, VHA.

Chinman, M., Salzer, M., & O'Brien-Mazza, D. (2012). National survey on implementation of peer specialists in the VA: implications for training and facilitation. *Psychiatric Rehabilitation Journal*, *35*(6), 470-473.

Chinman, M., Young, A. S., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, *33*(2), 176–195.

Creamer, M.C., Varker, T., Bisson, J., Darte, K., Greenberg, N., Lau, W., Moreton, G., O'Donnell, M., Richardson, D., Ruzek, J. and Watson, P. (2012). Guidelines for peer support in high-

risk organizations: An international consensus study using the delphi method. *Journal of Traumatic Stress*, *25*(2), 134–141.

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry*, *11*(2), 123–128.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, *6*(2), 165–187.

Everly Jr, G. S., & Flynn, B. W. (2005). Principles and practical procedures for acute psychological first aid training for personnel without mental health experience. *International Journal of Emergency Mental Health*, *8*(2), 93–100.

Fetherman, D. (2005). An exploration of the meaning and effects of horticultural therapy on human health and well-being. Unpublished Doctoral Dissertation, Marywood University, Scranton, PA.

Fried, G. G., & Wichrowski, M. J. (2008). Horticultural therapy: A psychosocial treatment option at the Stephen D. Hassenfeld children's center for cancer and blood disorders. *Primary Psychiatry*, *15*(7) n.p.

Friese, S. (2013). ATLAS. ti 7 user guide and reference. *Berlin: ATLAS. Ti Scientific Software Development GmbH*. Scientific Software, Berlin.

Fusaro, J. M. (2010). *Exploring the potential benefits and challenges to collaboration between small farmers and veterans*. Doctoral Dissertation, Humboldt State University. Retrieved from http://humboldt-dspace.calstate.edu/handle/2148/673

Goldberg Looney, L. (2014). Military service members' and veterans' preferred approach to mental health services. Master of Science in Psychology Thesis, Virginia Commonwealth University. Retrieved from http://scholarscompass.vcu.edu/etd/3608/

Goldstrom, I. D., Campbell, J., Rogers, J. A., Lambert, D. B., Blacklow, B., Henderson, M. J., & Manderscheid, R. W. (2006). National estimates for mental health mutual support groups, self-help organizations, and consumer-operated services. *Administration and Policy in Mental Health and Mental Health Services Research*, *33*(1), 92–103.

Gould, O., Scheinberg, A., & Matthieu, M. (2014). The mission continues: A case study of the well after service model. *Center for a New American Security.* Retrieved from http://www.cnas.org/sites/default/files/publications-pdf/CNAS_WellAfterServiceCaseStudy_VoicesFromTheField_updated.pdf

Greden, J. F., Valenstein, M., Spinner, J., Blow, A., Gorman, L. A., Dalack, G. W., … Kees, M. (2010). Buddy-to-buddy, a citizen soldier peer support program to counteract stigma, PTSD, depression, and suicide. *Annals of the New York Academy of Sciences*, *1208*(1), 90–97.

Heisler, M. (2006). Building peer support programs to manage chronic disease: seven models for success. *Oakland, CA, California Health Care Foundation*.

Herzog, T. R., Maguire, P., & Nebel, M. B. (2003). Assessing the restorative components of environments. *Journal of Environmental Psychology*, *23*(2), 159–170.

Hoerster, K. D., Lehavot, K., Simpson, T., McFall, M., Reiber, G., & Nelson, K. M. (2012). Health and health behavior differences: US military, veteran, and civilian men. *American Journal of Preventive Medicine*, *43*(5), 483–489.

Hoge, C. W. (2011). Interventions for war-related posttraumatic stress disorder: Meeting veterans where they are. *JAMA*, *306*(5), 549–551.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*(1), 13–22.

Hundt, N. E., Robinson, A., Arney, J., Stanley, M. A., & Cully, J. A. (2015). Veterans' perspectives on benefits and drawbacks of peer support for posttraumatic stress disorder. *Military Medicine*, *180*(8), 851–856.

Institute of Medicine. (2010). *Returning home from Iraq and Afghanistan: Preliminary assessment of readjustment needs of veterans, service members, and their families.* The National Academies Press Washington, DC.

---. (2014). Returning home from Iraq and Afghanistan: Assessment of readjustment needs of veterans, service members, and their families. *Military Medicine*, *179*(10), 1053–1055.

International Association of Peer Supporters. (2012, September 22). *National Practice Guidelines (U.S.)*. Retrieved from http://inaops.org/national-standards/

Iqbal, S. U., Rogers, W., Selim, A., Qian, S., Lee, A., Ren, X. S., … Kazis, L. (2009). *The Veterans RAND 12 Item Health Survey (VR-12): what it is and how it is used.* Washington, DC: Veterans Health Administration.

Jain, S., McLean, C., Adler, E., Lindley, S. E., Ruzek, J., & Rosen, C. S. (2013). Does the integration of peers into the treatment of adults with posttraumatic stress disorder improve access to mental health care? A literature review and conceptual model. *Journal of Traumatic Stress Disorders & Treatment*, *2*(3) n.p. Retrieved from http://www.scitechnol.com/2324-8947/2324-8947-2-109.pdf

Junger, S. (2016). *Tribe: On homecoming and belonging*. Twelve, New York.

Kaplan, S., & Talbot, J. F. (1983). Psychological benefits of a wilderness experience. In I. Altman & J.Wohlwill (Eds) *Behavior and the natural environment* (pp. 163–203). Springer, U.S. Retrieved from http://link.springer.com/chapter/10.1007/978-1-4613-3539-9_6

Kim, P. Y., Thomas, J. L., Wilk, J. E., Castro, C. A., & Hoge, C. W. (2010). Stigma, barriers to care, and use of mental health services among active duty and National Guard soldiers after

combat. *Psychiatric Services 61(6) pp* 582-588. Retrieved from http://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2010.61.6.582

Kranke, D., Gin, J., Saia, R., Heslin, K., & Dobalian, A. (2016). A qualitative investigation that applies an ecological strengths-based perspective to veterans' experience of reintegration into civilian life. *Military Behavioral Health*, *4* (1) 75-81.

Krasny, M. E., Pace, K. H., Tidball, K. G., & Helphand, K. (2014). Nature engagement to foster resilience in military communities. In K. Tidball & M. Krasney (Eds) *Greening in the Red Zone* (pp. 163–180). Springer Netherlands.

Kudler, H., & Straits-Tröster, K. (2009). Partnering in support of war zone veterans and their families. *Psychiatric Annals 39* (2). Retrieved from http://doi.apa.org/?uid=2009-02781-006

Maher, N. (2014). *VHA - ORH FY 15-19 strategic plan development*.

Marek, L., Hollingsworth, W., D'Aniello, C., O'Rourke, K., Brock, D., Moore, L., Butler, J., Zhang, J. and Wiles, B. (2012). Returning home: What we know about the reintegration of deployed service members into their families and communities. *NCFR Report Magazine, Spring; n.p.*

McFall, M., Malte, C., Fontana, A., & Rosenheck, R. A. (2000). Effects of an outreach intervention on use of mental health services by veterans with posttraumatic stress disorder. *Psychiatric Services* 51(13); pp369-74. Retrieved from http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.51.3.369

Mead, S., & MacNeil, C. (2006). Peer support: What makes it unique. *International Journal of Psychosocial Rehabilitation*, *10*(2), 29–37.

Mental Health America. (2016, February 15). Nationally certified peer-specialist draft core competencies. Retrieved from http://flcertificationboard.org/assets/uploads/MHA-Nationaly-Certified-Peer-Specialist-Draft-Core-Competencies-for-Public-Comment.pdf

Merritt, L. (2016, April 15). Puget Sound VA Peer Support. Personal email.

Money, N., Moore, M., Brown, D., Kasper, K., Roeder, J., Bartone, P., & Bates, M. (2011). *Best practices identified for peer support programs*. Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury. Retrieved from http://www.dcoe.mil/content/Navigation/Documents/Best_Practices_Identified_for_Peer_Support_Programs_Jan_2011.pdf

Morin, R. (2011). The difficult transition from military to civilian life. *Pew Research Center*. Retrieved from http://www.pewsocialtrends.org/2011/12/08/the-difficult-transition-from-military-to-civilian-life/

National Association of Social Workers Practice Snapshot: The Transformation of the Mental Health System. (2006). Retrieved June 8, 2016, from https://www.socialworkers.org/practice/behavioral_health/0206snapshot.asp

National Wildlife Federation. (2012). Developing healthy kids through outdoor play: The whole child report - National Wildlife Federation. Retrieved from http://www.nwf.org/Be-Out-There/Why-Be-Out-There/Whole-Child.aspx

Nesta & National Voices. (2015). Peer Support: What is it and does it work? Retrieved from https://www.nesta.org.uk/sites/default/files/peer_support_-_what_is_it_and_does_it_work.pdf

Office of the First Lady, The White House. (2015, April 17). Fact Sheet: VA Vet Centers and Administration Progress on Mental Health. Retrieved from https://www.whitehouse.gov/the-press-office/2015/04/17/fact-sheet-va-vet-centers-and-administration-progress-mental-health

Office of Public and Intergovernmental Affairs. (2013, Nov. 5). News releases - VA meets president's mental health executive order hiring goal. Retrieved from http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2487

Office of the Press Secretary. (2012, Aug. 31). Fact sheet: President Obama signs executive order to improve access to mental health services for veterans, service members, and military families.

Retrieved from https://www.whitehouse.gov/the-press-office/2012/08/31/fact-sheet-president-obama-signs-executive-order-improve-access-mental-h

Office of Rural Health (n.d.). Rural veterans coordination pilot. Retrieved June 16, 2014, from http://www.ruralhealth.va.gov/coordination-pilot/

Pagoto, S. L., Spring, B., Coups, E. J., Mulvaney, S., Coutu, M.-F., & Ozakinci, G. (2007). Barriers and facilitators of evidence-based practice perceived by behavioral science health professionals. *Journal of Clinical Psychology*, *63*(7), 695–705.

Peer Support FAQs - VA Careers. (2015, June 3). [General Information]. Retrieved from http://www.vacareers.va.gov/peer-to-peer/faqs.asp

Peers for Progress. (2016). Science behind peer support. Retrieved from http://peersforprogress.org/learn-about-peer-support/science-behind-peer-support/

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, *20*(4), 392–411.

Sandel, M. H. (2004). Therapeutic gardening in a long-term detention setting. *Journal for Juvenile Justice Services*, *19* (1-2) 123-131.

Sayer, N. A., Carlson, K. F., & Frazier, P. A. (2014). Reintegration challenges in U.S. service members and veterans following combat deployment. *Social Issues and Policy Review*, *8*(1), 33–73. http://doi.org/10.1111/sipr.12001

Sayer, N.A., Frazier, P., Orazem, R.J., Murdoch, M., Gravely, A., Carlson, K.F., Hintz, S. and Noorbaloochi, S (2011). Military to civilian questionnaire: a measure of postdeployment community reintegration difficulty among veterans using Department of Veterans Affairs medical care. *Journal of Traumatic Stress*, *24*(6), 660–670.

Sayer, N., Noorbaloochi, S., Frazier, P., Carlson, K., Gravely, A., & Murdoch, M. (2010). Reintegration problems and treatment interests among Iraq and Afghanistan combat veterans receiving VA medical care. *Psychiatric Services*, *61*(6), 589–597.

Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103, 788 confirm title US veterans returning from Iraq and Afghanistan seen at department of veterans affairs facilities. *Archives of Internal Medicine*, *167*(5), 476–482.

Sherman, P. S., & Porter, R. (1991). Mental health consumers as case management aides. *Psychiatric Services*, *42*(5), 494–498.

Solomon, Z., Waysman, M., Levy, G., Fried, B., Mikulincer, M., Benbenishty, R., … Bleich, A. (1992). From front line to home front: A study of secondary traumatization. *Family Process*, *31*(3), 289–302.

Substance Abuse & Mental Health Services Administration. (2012). SAMHSA's working definition of recovery: 10 guiding principles of recovery. PEP12-RECDEF. SAMSHA. Retrieved from http://store.samhsa.gov/shin/content//PEP12-RECDEF/PEP12-RECDEF.pdf

Szofran, J., & Meyer, S. (2004). Horticultural therapy in a mental health day program. *Journal of Therapeutic Horticulture*, *15*, 32.

Tang, P. (2013, June 7). A brief history of peer support: Origins | Peers For Progress. Retrieved from http://peersforprogress.org/pfp_blog/a-brief-history-of-peer-support-origins/

Thomas, V. J. (2014). *Assessing the effect of sense of community on military veteran community reintegration difficulties*. Unpublished Doctoral Dissertation. University of Tennessee, Knoxville. Retrieved from http://trace.tennessee.edu/cgi/viewcontent.cgi?article=4125&context=utk_graddiss

Turley, B., Pullen, L., Thomas, A., & Rolfe, A. (2000). *LivingWorks applied suicide intervention skills training (ASIST): A competency-based evaluation*. Melbourne, Australia: LivingWorks.

Twill, S. E., Norris, M., & Purvis, T. (2011). Weeds and seeds: Reflections from a gardening project for juvenile offenders. *Journal of Therapeutic Horticulture*, *21*(1), 6-17.

Vet Centers and the Social Contract. (2015, Jan. 9). Retrieved from http://www.vietnam.ttu.edu/events/1996_Symposium/96papers/healing.php

Westlund, S. (2012). Bringing nature to consciousness in peace and conflict studies through a phenomenological analysis of veterans' narratives of nature and recovery. Doctoral Dissertation. University of Manitoba. Retrieved from http://mspace.lib.umanitoba.ca/jspui/handle/1993/13235

Wilson, W., & Pratt, C. (1987). The impact of diabetes education and peer support upon weight and glycemic control of elderly persons with noninsulin dependent diabetes mellitus (NIDDM). *American Journal of Public Health*, *77*(5), 634–635.

Appendix A

Table 3: Quality of life measures: Military to civilian questionnaire (M2C-Q)

*Variables	Veteran n= 40 Mean ± SD
M2C-Q Total	1.7 ± 1.1
Dealing with people you do not know well	1.7 ± 1.4
Making new friends	1.9 ± 1.5
Keeping up friendships with people who have no military experience	1.9 ± 1.4
Keeping up friendships with people who have military experience	1.3 ± 1.3
Getting along with relatives	1.6 ± 1.4
Getting along with your spouse or partner	1.5 ± 1.2
Getting along with your child or children	1.1 ± 1.2
Finding or keeping a job	1.5 ± 1.7
Doing what you need to do for work or school	1.7 ± 1.5
Taking care of your chores at home	1.6 ± 1.3
Taking care of your health	1.6 ± 1.3
Enjoying or making good use of free time	1.7 ± 1.4
Taking part in community events or celebrations	1.9 ± 1.5
Feeling like you belong in a civilian society	1.6 ± 1.3
Confiding or sharing person thoughts and feelings	2.0 ± 1.3
Finding meaning in life	1.8 ± 1.5

Appendix B

Table 4: Veteran participant military background

Variables	Veteran n= 43 n(%) or Mean ± SD
Military Branch	
Army	26 (60.5)
Navy	8 (18.6)
Air Force	3 (7.0)
Marine Corps	4 (9.3)
Coast Guard	2 (4.7)
Other	0(0.0)
Deployed (yes)	33 (76.7)
Combat Zone Deployment (yes)	29 (87.9)
OIF	19 (65.5)
OEF	10 (34.4)
August 1990-August 2001	4 (13.8)
May 1975-July 1990	1 (3.4)
Vietnam Era	2 (6.9)
February 1955 to July 1964	0 (0.0)
Korean War	1 (3.4)
Total Deployments	1.9 ± 2.2

Appendix C

Table 5: Veterans Rand 12-physical & mental component scores

Variable	CAI	2006 VHA Urban Users	2006 VHA Rural Users	PTSD Veterans*
PCS Score	44.4	39.4	38.7	30.8
MCS Score	39.4	47.6	47.9	39.5

*The PCS and MCS scores are taken from the VR-36

Appendix D

Table 6: Demographics

Variable	Veteran n= 43 n (%) or Mean ± SD
Gender	
Male	32 (74.4)
Female	11 (25.6)
Age	41.9 ± 13.4
Ethnicity	
Caucasian	38 (88.4)
African-American	0 (0)
Asian	0 (0)
Other/Unknown	2 (7.0)
Highest Level of Education	
<High School	0 (0.0)
High School/GED	0 (0.0)
<Associates Degree	15 (34.9)
Associates Degree	5 (11.6)
≥College	23 (53.5)
Household Income	
≤$10,000	11 (25.6)
≥$10,0001-≤$25,000	9 (20.9)
≥$25,001-≤$45,000	9 (20.9)
≥$45,0001	11 (25.6)
Employment Status*	
Part-Time	8 (18.6)
Full-Time	17 (39.5)

Self-Employed	2 (4.7)
Homemaker	0 (0)
Unemployed and looking	6 (14.0)
Unemployed and *not* looking	1 (2.3)
Retired	6 (14.0)
Medically Retired	3 (7.0)
Volunteering	6 (14.0)
Service-Connected Disability Rating	
<30%	14 (32.6)
≥30%-≤90%	22 (51.2)
100%	3 (7.0)
Student Status	
Part-Time	6 (14.0)
Full-Time	5 (11.6)
Not a student	22 (51.2)
Plan to go back to school	8 (18.6)
Current Marital Status	
Married	13 (30.2)
Separated	3 (7.0)
Divorced	9 (20.9)
Single/Never Married	11 (25.6)
Widower/Widow	1 (2.3)
Partner, not married	4 (9.3)
Number of people in household	
1-3	33 (76.7)
4-6	8 (18.6)
7-8	1 (2.3)

>8	1 (2.3)
Current Residence	
Rural	25 (58.1)
Urban	16 (37.2)

*Items not mutually exclusive

Appendix E

Table 7: Veteran participants' satisfaction with CAI

Parameter n (%)	**Agree**	**Neutral**	**Disagree**	***Not applicable**
I get more exercise, *n=27*	21 (77.6)	5 (18.5)	1 (3.7)	9
My diet has improved, *n=26*	11 (2.3)	13 (50.0)	2 (7.7)	10
I feel less depressed or discouraged, *n=26*	19 (73.1)	5 (19.2)	2 (7.7)	10
I have been sick less often, *n=26*	11 (42.3)	13 (50.0)	2 (7.7)	10
My pain level has improved, *n=23*	8 (34.7)	10 (43.4)	5 (21.7)	13
I need fewer medications, *n=22*	11 (50.0)	9 (40.9)	2 (9.1)	14
I have made new friends with military experience, *n=28*	23 (82.2)	1 (3.6)	4 (14.2)	8
I have made new friends with no military experience, *n=28*	18 (64.3)	7 (25.0)	3 (10.7)	8
My relationships with old friends have improved, *n=28*	14 (40.0)	13 (46.4)	1 (3.6)	8
My relationships with my family members have improved, *n=27*	15 (55.5)	10 (37.0)	2 (7.4)	9
My ability to communicate with people I know has improved, *n=27*	17 (62.9)	8 (29.6)	2 (7.4)	9
My ability to communicate with strangers has improved, *n=28*	20 (71.4)	6 (21.4)	2 (7.1)	8
I am more involved in community events, *n=28*	19 (67.9)	6 (21.4)	3 (10.7)	6
I feel a sense of purpose, *n=27*	24 (88.9)	0 (0.0)	3 (11.1)	7

I feel a sense of belonging, *n=27*	24 (88.9)	0 (0.0)	3 (11.1)	*7*
I have learned new skills, *n=27*	24 (88.9)	2 (7.4)	1 (3.7)	*7*
I have developed goals for the future, *n=26*	20 (76.9)	5 (19.2)	1 (3.8)	8
I have developed new interests, *n=27*	24 (88.9)	2 (7.4)	1 (3.7)	*7*
I enjoy my free time more, *n=27*	17 (62.9)	9 (33.3)	1 (3.7)	*7*

*Not included in sample size.