Implementation of a Posttraumatic Stress Disorder Mentoring Program to Improve Treatment Services

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Three years ago the Department of Veterans Affairs (VA) charged the National Center for PTSD (NCPTSD) to develop a mentoring program to train directors of specialized PTSD clinical programs in effective management skills. There were three reasons for this. First, the number of veterans from the Afghanistan and Iraq conflicts coming to the VA for PTSD treatment was rapidly increasing. Second, a major augmentation in mental health staffing had brought many new clinicians to the VA who were unfamiliar with war-zone–related PTSD and with the VA system of care at a time of changing administrative requirements. Third, the clinical complexity of these veterans required additional mentoring because their PTSD was often associated with depression, mild traumatic brain injury, substance use, chronic pain, aggressive behavior, and/or insomnia. The resulting PTSD Mentoring Program created a national network of program directors to disseminate and implement best management practices by supporting local experts in their mentoring of other VA PTSD program directors. This article describes the implementation of the PTSD Mentoring Program and examines methods of how other programs can successfully use and adapt the mentoring model. A description of what is working and where obstacles still exist for the program is provided. Our experience with the program supports the use of peer mentoring as a method to offer educational training on trauma in different settings and using different modalities.

Keywords: posttraumatic stress disorder, mentoring, implementation, best management practice

Mental health services in the Department of Veterans Health Administration (VHA) have gone through an unprecedented expansion in the past few years. Approximately 540,000 soldiers returning from the conflicts in Afghanistan and Iraq have obtained VHA health care, and rates of Vietnam-era veterans in mental health treatment have doubled in the last 10 years (Desai, Rosenberg, Spencer, & Gray, 2008). In addition, a comprehensive Mental Health Strategic Plan issued in 2004 changed the delivery of VHA mental health services. The Strategic Plan, a result of the President’s New Freedom Commission on Mental Health, outlined a bold transformation in the delivery of VHA mental health care that would ensure equal access and reduce the variability in care offered to the growing numbers of veterans from the Afghanistan and Iraq wars. The plan presents a recovery rather than pathology approach to mental health care and integrates mental health services into the overall health care for veterans (Edwards, 2008).

To respond to the growing need for mental health services, major increases in funding for VHA mental health programs has occurred with more than 6,000 new mental health providers hired nationally since 2004. More than 350 providers have been hired specifically for the PTSD Clinical Teams (PCTs) that offer PTSD specialty care, and the number of PTSD clinics has continued to grow, in spite of a general reorganization of clinics where PTSD specialty care is becoming increasingly a part of general ambulatory care. Mental health treatment program modifications have also been made to add new substance abuse specialists to PTSD specialty programs to treat the common co-occurring disorders, to have programs specifically aimed for veterans of Afghanistan and Iraq, to address sexual trauma that occurred in the military, and to add tracks designed to address women’s health issues to serve this growing group of returning veterans.

Specialized PTSD treatment programs have existed in VHA for almost 30 years. In 1984, the Chief Medical Director’s Special Committee on PTSD recommended that every one of the Department of Veterans Affairs’ 172 hospitals be funded for a special clinical program dedicated to address PTSD. Educational conferences were soon convened to provide training information on the
The latest developments in clinical issues including PTSD assessment, treatment, and models of care for this relatively new diagnostic program area. While most training centered on PTSD-related clinical issues, there was little guidance available for the new PTSD program directors on how to effectively manage and administer their programs.

After the release of the Strategic Plan, VHA leadership recognized that systemic changes needed to be made to PTSD Clinical Teams to meet the plan’s requirements and the increasing numbers of returning veterans. Based on recent clinical research, the VA Office of Mental Health Services (OMHS), a branch of VHA leadership, in a significant top-down approach, began to extensively invest in the training of PTSD clinicians in evidence-based cognitive–behavioral psychotherapies for PTSD. A rollout of training in cognitive processing therapy (CPT) began in 2006 followed by a rollout of training in prolonged exposure (PE) therapy initiated in 2007. Recognizing that implementation of evidence-based clinical practices and efficient clinic management to enable delivery of effective practices presents a challenge in a system as large and complex as the VHA mental health care system, the leadership invested considerable resources for training for both the CPT and PE dissemination initiatives. However, despite the training, implementation problems were brought by PTSD program directors to the attention of the rollout training leaders and to the National Center for PTSD (NCPTSD) staff. Administrative challenges prevented successful implementation of the evidence-based treatments in some PTSD clinics. With limited resources, clinicians were faced with determining which veterans should be offered individual CPT or PE and which should remain in traditional support groups. Another problem that the rollout training leaders noted arose with the shift from group to individual treatment; facility leadership did not initially understand why fewer veterans were being seen each week in the PTSD clinics. Clinicians were also unsure how to get workload credit for 90-min sessions (required for PE) in a system designed for 60-min treatment sessions. Changes in clinic policies and structures were necessary to accommodate the new treatment delivery system. Local innovations were needed to ensure implementation of the recommendations, to eliminate the gap between what needed to be done and what was currently being practiced in the clinics.

The limitations of traditional efforts to promote evidence-based PTSD treatment practices have been outlined elsewhere (Ruzek & Rosen, 2009). The authors noted that implementation initiatives are more likely to be sustained over time when systematic support is offered in conjunction with specific training efforts (Fixsen, Blasé, Timbers, & Wolf, 2001). The rollout trainings provided expertise in the dissemination of the evidence-based PTSD psychotherapies but little guidance on how to actually redesign clinic structures to be able to offer the treatments. Peer-based mentorship has been promoted as one way to build capacity for what is known as “knowledge translation” research and practice, the process for improving health care delivery and outcomes by promoting research utilization in decision making (Gagliardi et al., 2009).

**Program Development**

The PTSD Mentoring Program was launched in early 2008 within each of the 21 Veterans Integrated Service Networks (VISNs) or national geographic regions. The VISN mental health leader selected two mentors for each region (n = 42). The mentors were experienced program directors who were often recognized as leaders in the field. The PTSD mentors are not mentors in the classic sense of an experienced, senior-level person who provides individual consultation and professional development advice to a junior clinician. The PTSD mentors function more as regional champions or advocates of best management practices for the participant program directors and sometimes as facilitators for the VISN mental health leaders and VHA leadership. The mentors not only have to be willing to share their expertise with their peers, but they also have to be able to know how to effectively describe their management solutions and, most importantly, be willing to share their time. All other PTSD program directors, Iraq and Afghanistan veteran program directors (SeRVMH), military sexual trauma (MST) coordinators, and PTSD specialists were invited into the program as PTSD Mentoring participants (n = 330).

A Mentoring Steering Committee consisting of leadership from the VHA’s NCPTSD, mental health leaders from OMHS, and the VISN mental health leaders was developed (n = 17). The committee meets quarterly to monitor the overall direction of the program, reviews a quarterly progress report, suggests solutions as issues arise, and proposes timely topics for the monthly mentor conference calls led by the program manager. (For overall structure of the program, see Figure 1.)

A key piece of the program was the selection of a program manager to serve as an “external facilitator,” a component that has been shown to be critical to such an implementation effort (Sulli-
van, Blevins, & Kauth, 2008). The program manager regularly participates in the regional mentor/participant conference calls and through these calls often hears of concerns and developments about which regional and national leadership may be unaware. Through interaction with the Steering Committee, the mentoring program manager is able to bring these developments to the committee to rapidly address issues as well as being able to get information and subsequent action back to the larger program community. But more than that, the program manager is increasingly called upon to act as a mentor to the mentors themselves, advising on career options (the more traditional idea of mentoring), and adopting practice changes, as suggested by others examining best management practices of system redesign to improve the delivery of care, and sharing practical methods to increase access to programs.

The program is designed to provide information to its participants through the regional mentors and is done through formal educational presentations, ongoing monthly mentoring conference calls, and web-based information that can be accessed at any time. Thus the model of implementation of the PTSD Mentoring Program has used a comprehensive multilevel approach to training and adopting practice changes, as suggested by others examining educational interventions intended to develop new skills by clinicians (Sullivan et al., 2008).

Implementation

The PTSD Mentoring Program was kicked-off by a national face-to-face conference (n = 199; 39 mentors, 160 mentee participants) that offered formal training in core concepts as well as allowing time for break-out groups on specific topics. The first half day of training allowed mentors to meet to develop a common knowledge base, and to clarify an understanding of their responsibilities in the program in a face-to-face format that allowed them to establish new relationships. The kick-off conference featured topics that ranged from an overview of PTSD programs including treatment structures, models of care, and managing growing work-load panel sizes, to the clinical management of new and complex issues such as traumatic brain injury and chronic pain. The topics reflected the diverse administrative needs to be addressed through the program.

Importantly, time was allotted at the kick-off meeting to allow the two mentors in each region to meet separately with their program participants (range 5–10). For many, this was the first opportunity they had to meet each other even though they worked in the same jobs in the same region. While the names of the mentors may have been familiar, most participants reported that until this face-to-face meeting, they had never considered calling these local experts for advice. In a posttraining assessment, more than 80% of the conference attendees (n = 159) expressed high satisfaction with the training experience. The opportunity to meet face-to-face is so popular that the model has been passed down to local regions where face-to-face meetings are also now held and financially supported by the VISN Mental Health Leaders to build on the relationships from the original meeting. The face-to-face meetings are recognized as critical to the program’s initial success and its continued accomplishments. Although several regions encompass large geographical areas, the annual face-to-face meeting is seen as a component that holds the program together. Several mentors have visited every clinic in their region to consult, observe practices, and share their methods of meeting new requirements. Those visits have been particularly helpful in strengthening communication and the mentor–participant relationships.

Three months after the kick-off meeting of the PTSD Mentoring Program, the release of a unique product in health services took place. In July 2008 VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, detailed the range of mental health services that should be available to all veterans no matter what facility they use to receive their care. The underlying idea behind the handbook is that a veteran should be able to walk into any VA medical center throughout the country and have the opportunity to receive certain mental health services. Specific items in the handbook for PTSD specialty programs became the focus of the PTSD Mentoring Program, with clinic directors sharing best management practices in meeting the new requirements. For example, the requirements specified in the handbook that include access to evidence-based psychotherapy for PTSD required modifications to existing PTSD specialty programs that included system redesign such as the ability to offer telemental health treatments. Other requirements entail timely access to services, training of local police departments about PTSD, integrated SUD and PTSD care, and a focus on a recovery model.

A strong, continuous communication plan was recognized as central to the success of the program, and information is provided
to the field through a variety of mechanisms. Bimonthly calls with the 42 mentors are scheduled to learn about current issues in the field and to provide mentors with information from the VA executive leadership on new initiatives or changes that are coming. Examples of the topics for these calls include the implementation of “peer support” groups to help offer aftercare support to veterans who have completed an evidence-based treatment or what an appropriate workload panel size should be for a staff psychologist.

On alternating months, national “program” calls are offered to all mentoring participants \( n = 250 \). It is often at these calls that local solutions are presented or that outside faculty experts are brought in to speak on topics such as the ways that the new SUD clinicians have been successfully integrated in PTSD Clinical Teams or how telehealth has been used to provide specialty care to remote, rural Community Based Outpatient Clinics. More formal educational training is provided through a monthly webinar lecture series that affords opportunities for continuing educational credits. A national face-to-face meeting for the 42 PTSD mentors is held annually.

The core of the program consists of the conference calls held between the two mentors and their regional participants (range 4–14). The focus of the calls is to present information passed down from the mentor calls with the Mentoring Program manager, encourage sharing of innovative models of care, and getting group input on solving problems that may be specific to their region. Although the majority of the participant program directors are new hires, new to the VA system, and new to military/veteran culture (See Table 1), a number are long-standing VA employees who are now learning about many of the changes in mental health treatment delivery and management that are reflective of new practices within VHA.

The mentoring program is also supported by external facilitation from experts including NCPTSD staff, executive leadership, program faculty, and the steering committee and is reinforced through the continuing conference calls, didactic lectures, face-to-face meetings, and web-based trainings. It is a constant source of back-and-forth communication from the field to leadership and back again, and it is difficult to see how it would all be maintained without the work of a central contact, the program manager, responsible for keeping the process in movement.

Results

From the original 199 clinicians who attended the kick-off meeting, the PTSD Mentoring Program has steadily grown and now has more than 250 participants. Participation is voluntary, and we still struggle to identify and invite all of the participants who have administrative duties and could benefit from the program. The program is now recognized by OMHS leadership as a model for training and support for other programs within the VA and is used to organize other groups of managers such as those working in mental health residential rehabilitation treatment programs. The program is built on internal facilitation by local change agents within the regions such as the local PTSD mentors and the VISN mental health leaders. The role of the mentors has evolved from one of advising other PTSD program directors about how to manage a strong PTSD specialty program to one of advising facility and regional leadership about how to structure PTSD care at local and regional levels. VISN mentors have been promoted to national leadership positions as well as appointed to regional mental health councils. VISN mentors are increasingly used to troubleshoot problems within facilities and assist in clinic redesign issues because of their increased expertise in these areas and to present at national meetings because of their involvement in the mentoring program. We see these facts alone as signs of the mentoring program’s success.

The program design includes a formal evaluation. The Dissemination and Training Division of the NCPTSD recently conducted the evaluation to determine whether the original aims of the program have been met. The goals of the evaluation are to describe not only the structure and outcomes of the program but also the process, to measure involvement in the mentoring program and clinician attitudes about their benefit from participation. We recognize that it is important to show VA leadership that because of this program there has been an improvement in the ability of veterans to have access to evidence-based PTSD treatments, in consistency of management practices by the program directors, in clinic administration practices, and in referral patterns. The results of the evaluation will also serve as a management tool that will be reviewed by the steering committee and will guide modifications to the program in the coming year. Specific administrative and clinical topics suggested will assist us in planning for the coming year. Indeed, as the program has developed, the evolving cultural and structural changes in the VHA (e.g., shifts in clinical demands, new models of treatment, and modifications to models of care) have made apparent the potential of the PTSD Mentoring Program to address the changes.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Participants ( n = 59 )</th>
<th>Mentors ( n = 26 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profession</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>48 (80%)</td>
<td>22 (85%)</td>
</tr>
<tr>
<td>Social worker</td>
<td>8 (14%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>3 (5%)</td>
<td>3 (12%)</td>
</tr>
<tr>
<td>Role (may have more than one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCT program director</td>
<td>18 (31%)</td>
<td>14 (54%)</td>
</tr>
<tr>
<td>PCT staff member</td>
<td>8 (14%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>SeRVMH leader</td>
<td>7 (12%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>PTSD specialist</td>
<td>7 (12%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>MST coordinator</td>
<td>5 (8%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other MH programs</td>
<td>19 (32%)</td>
<td>6 (23%)</td>
</tr>
<tr>
<td>Time with VHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–1 year</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>2–5 years</td>
<td>37 (63%)</td>
<td>9 (35%)</td>
</tr>
<tr>
<td>6–10 years</td>
<td>6 (10%)</td>
<td>5 (19%)</td>
</tr>
<tr>
<td>11–15 years</td>
<td>4 (7%)</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>16–20 years</td>
<td>4 (7%)</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>&gt;21 years</td>
<td>8 (14%)</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>Time specializing in PTSD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–1 year</td>
<td>5 (8%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>2–5 years</td>
<td>43 (73%)</td>
<td>12 (46%)</td>
</tr>
<tr>
<td>6–10 years</td>
<td>2 (3%)</td>
<td>8 (31%)</td>
</tr>
<tr>
<td>11–15 years</td>
<td>5 (8%)</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>16–20 years</td>
<td>2 (3%)</td>
<td>4 (15%)</td>
</tr>
<tr>
<td>&gt;21 years</td>
<td>2 (4%)</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Supervise other staff</td>
<td>27 (45%)</td>
<td>19 (74%)</td>
</tr>
<tr>
<td>OMHS trained in CPT</td>
<td>45 (77%)</td>
<td>18 (70%)</td>
</tr>
<tr>
<td>OMHS trained in PE</td>
<td>36 (61%)</td>
<td>10 (37%)</td>
</tr>
</tbody>
</table>
To determine the levels of satisfaction and engagement of the PTSD mentors and participants with the program in a more informal and rapid manner, an anonymous online survey was compiled and responses were shared at the annual mentor meeting last summer. For an overall description of the program participants, see Table 1. The survey \((n = 85; 40\% \text{ of PTSD program directors})\) revealed that the majority of participants are relatively new to the VA (60%) and to their positions as program directors (70%). Most have been able to attend at least one face-to-face VISN meeting (79%) and have participated in the VISN conference calls (91%). When asked about specific training issues that have been addressed through the program, a large majority (80%) stated that their participation in the program has helped them rethink their clinic design, has offered solutions to clinic problems, has been worthwhile, and has aided them in their work (see Figure 2).

**Discussion**

We hope to be able to create a community network through the mentoring program at a time of large cultural shifts in VHA. PTSD clinical directors face not only increasing numbers of patients and requirements but treat more complex patients with common co-occurring disorders and symptoms, such as mild traumatic brain injury (mTBI), substance use, chronic pain, insomnia, anger issues, and polytrauma. Because of new VHA recommendations, the old idea that different symptoms and disorders are handled in different departments of the facilities is rapidly changing. The “silos” of substance abuse treatment being treated on the eighth floor, PTSD on the ninth floor, depression on the second floor, and diabetes and smoking cessation on the first floor are breaking down. With these changes, there is an obvious need to train PTSD program directors not only in effective ways to address all of these complex clinical issues but to also help them to understand how they can efficiently manage their clinics while taking on ever-increasing responsibilities.

The Steering Committee decided early in the process that it is important that the PTSD Mentoring Program not be limited to a “top down” approach to system change, although it served that function with a coordinated and rapid means of getting policy changes out to the field. Importantly, the program also explicitly fosters a “bottom-up” approach to communication. Mentors pass information gleaned from their regional calls and meetings on topics covered, problems addressed, and important new concerns up to organizers of the mentoring program and leadership.

In some cases we have had to try different solutions to discover what would work best with the mentoring program. We thought that online Internet education and communication resources were critical to the program’s success. Listserv discussion forums offered through a VA intranet site were established to allow participants to share a library of relevant items, access important information such as conference call schedules, and query one another for advice in handling specific problems. What we have learned, however, is that the participants do not have extra time to read or participate in the discussion forums and instead prefer to send e-mails to the Program Manager and get assistance from the field through that method. This allows the Program Manager to filter the messages so that only relevant material is passed on to the entire group, whereas specific responses that do not need to be shared with the group as a whole can be sent to the inquiring clinician. The greatest success of the intranet site has been its use as a library where VHA documents are maintained and training manuals and materials are stored and can be easily accessed.

An example of how the PTSD Mentoring Program has expanded to address other training needs is in the development of a monthly lecture series and web-based courses on various subtopics of psychopharmacological treatments for PTSD. Mentors who are expert psychiatrists formed a workgroup to present a series of lectures, design a PTSD Psychopharmacology “Factsheet,” and facilitate a discussion forum to encourage and support best practices for prescribing medications to treat PTSD. Continuing education credits are offered to attendees of webinars that include psychiatrists, psychologists, social workers, nurses, and clinical pharmacists. The program was rapidly developed in response to a need to address concerns about the possible overmedicating of PTSD patients in VA. With its network of providers in place, the PTSD Mentoring Program was able to quickly react and pool its resources to address and design trainings to meet this clinical need. The resulting PTSD psychopharmacology lecture program is popular with large attendance on the monthly calls and is renewed for another year of lectures to now address various aspects of recommendation changes in the new VA/DoD Clinical Practice Guideline for the Management of PTSD using a case presentation format.

In several ways, the PTSD Mentoring Program has also driven the development of educational products produced by the NCPTSD. For example, after recognizing that a large majority of PTSD clinicians were new to the VA, we developed an online course that offers continuing educational credits on “Understanding Military Culture” to teach clinicians about the different branches of the military, roles, and how the military addresses traumatic stress. We also developed online courses on co-occurring disorders to help them learn how to integrate comorbid treatments in their clinics. Thus we use information from the field to help us creatively address training and education about combat-related trauma.

Soon after the program’s development the Mentoring Program manager was included in site visits to PTSD Residential Rehabilitation Programs throughout the country. The site visit project was developed to describe the environments of PTSD residential treatment settings and current treatments/practices offered in those

![Figure 2. Participation in the Mentoring Program.](image-url)
environments. The visits are intentionally friendly and involve interviews with staff members and veterans enrolled in the program to get their thoughts on what is most effective about the treatment program. Recommendations are suggested to help improve care. The inclusion of the PTSD Mentoring Program mentors on the site visits strengthens relationships between the regional mentors and the residential program staff and allows for another opportunity to share effective management practices in a face-to-face format. More than 40 site visits have now been conducted.

We provide an example to illustrate how effective the site visits can be. A residential program struggled with large numbers of veterans on a waiting list, a program design that required participants to remain in the program for 90 days, and few licensed staff members to provide the required PTSD evidence-based treatments. The residential program director had shared his issues on the regional mentoring call and requested assistance through his facility leadership. One of his VISN mentors accompanied the program manager on a site visit to his program. Although the mentors and program manager have no official authority, they can use the handbook requirements as authority to make suggestions and recommendations to facility leadership and to programs. The mentor shared how he had used PTSD program administrative data in his own clinic to support the hiring of new clinicians to offer effective treatments, move unlicensed staff to other supportive clinic roles, and design the flexibility of his own program which allowed for a flexible length of stay based on the improvement of the individual veteran. Recommendations were made to leadership in a letter, and changes to the residential program were soon implemented. New staff members have been hired, access to treatment is now readily available without long waits, and the program offers individual unique patient-centered treatment plans. The mentor and residential program director stay in monthly contact through their conference calls to follow the program’s progress, and the facility leadership is pleased with the results of the visit. This visit also helped to give recognition to the mentoring program as a facilitator of solutions to clinic administrative problems.

The site visits have now enabled us to provide materials obtained at the site visits to other programs. PTSD program directors can download application forms for PTSD residential programs and obtain information about admission practices from the mentoring website. Information on unique practices such as mindfulness classes or insomnia treatment is compiled, posted on the website, and shared with other program directors. Leadership in OMHS is also informed of results of the visits and at their conclusion; a report is generated and shared with facilities. In part because of the success of the residential site visits, there is now a system in place to allow for site visits by the mentoring program manager, VISN mentors, and, if needed, outside experts to visit and consult with struggling outpatient facilities on unique problems. Recent visits have resulted in clinic redesign to increase patient flow in and out of the clinic to meet increased demands, to use data to increase staffing, and to improve coordination of aftercare between a residential program and the local outpatient clinic. PTSD mentors are able to influence change by providing concrete examples of effective management practices in their own clinics that have improved delivery of care. They also often share their clinic outcomes data to support their recommendations. Additional issues such as the development of increased clinic capacity through the use of peer support groups and telehealth delivery of care have been addressed and shared through the outpatient site visits.

As we think of ways to share the successes and difficulties of the program and explore how other institutions could adopt the design, we again looked to lessons learned within the VA from other clinical training initiatives. It has been suggested that simply providing training and ongoing supervision, even when identified as a priority by the local facility, is not enough to actually ensure transfer of new practices into everyday care. Sullivan and colleagues (2009) have confirmed that training must be tailored to the trainees, and both trainees and administrators must be actively engaged in adoption of new practices (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004).

What Is Working Well

Our mentors in the PTSD Mentoring Program are not just acting as supervisors or consultants but are also peers who have to find their own new solutions to a rapidly changing clinical landscape. They are recognized as individuals with advanced experience and knowledge who are committed to providing not only support for best management practices by the participants but also offering support to their participants’ careers, long a function of a traditional mentoring role (Ragins & Cotton, 1999). The conference calls between the mentors and participants are important, but it appears that the face-to-face interaction between the participants, the continued coordination by the NCPTSD program manager, and continued external monitoring of the program are critical to the program’s success. Because neither mentors nor participants are given protected work time to be in the program, the PTSD Mentoring Program had to be extremely relevant to the lives of the program directors. The development of agendas that address specific needs of the program directors for the conference calls, practical solutions to the problems they face daily, and the easy access to resources on the program website have helped to overcome the greatest threat to the establishment of a good mentoring relationship, which is a lack of time.

Research on mentoring has shown that the most effective mentors add structure of their own to those of the formal program (such as region-specific agendas for their monthly calls or the individual face-to-face site visits that have taken place within a region), are not pessimistic even with ever-growing demands, and are open and generous in sharing early experiences with the participant such as a willingness to share best practices of solutions to problems (Boyle & Boice, 1998). We continue to work to ensure that the PTSD Mentoring Program mentors meet these criteria, to discuss what it means to be a strong mentor, and think that all of these factors help to make this program a success in the VA and would be critical considerations for programs outside the VA to adopt this model.

How This Program Could Be Modeled

We think that there are implications of the success of this program for not only other large bureaucratic agencies but for small programs as well that are working to implement change. We started the Mentoring Program with clearly defined problems that needed to be addressed. It is important that agencies considering a
mentoring program be clear on the issues that they will be dealing with. Mentoring programs are as varied as the organizations that support them. One-on-one matching programs are popular with professions where there is a specific achievement level for the members of the profession and career guidance is critical such as university programs. Group mentoring, which we have used in this model, has the advantage of enabling organizations to provide mentoring to more participants than can be accommodated in one-on-one matching programs. In group mentoring, one or two mentors normally work with a group of participants that have something in common or wish to pursue a common need. This design worked well with our program and fit naturally with the overall VHA regional network design.

Our mentoring program design would work well, for instance, for the Department of Defense mental health or substance abuse clinics as they increasingly move from programs primarily staffed by active-duty military clinicians to those that are supported primarily by civilian providers who do not have a background in military culture. A mentoring program with one or two mentors in a geographical area that would facilitate learning clinic administrative procedures through pairing of new civilian clinicians with an experienced clinician would be a great resource and would be a way to ensure standardization of best clinical services.

The model could also be used by organizations to train and develop skills in a specific area of trauma education. For instance, we have realized that the PTSD clinic directors are not all proficient in how to measure outcomes in their clinics and need information on where to obtain clinical data, how to use the data to look at outcomes, and finally how to implement changes based on those outcomes. Specific mentors who are knowledgeable in this area can serve as mentors to the program directors in this area of expertise, even if they are not part of their regional group. If clinicians are using a psycho-education group to prepare veterans for one of the evidence-based treatments or are adding mindfulness classes as an adjunctive treatment to PTSD treatment, they need to know how to assess those treatments to see whether they are indeed improving outcomes or assisting the veteran in his or her recovery. We now plan to use the mentoring program platform to offer training in program evaluation and outcomes methodology for the program directors. What is important for a mentoring program is to have a clear, defined scope, a common manageable theme, and a clear timeline with a system to measure progress.

We similarly think that smaller state government agencies or community-based mental health clinics could benefit from the model. Too often, because of dwindling funds, there is no overlap when an individual is hired into a position with the person who has previously held the job. By teaming new employees with a more experienced member, even remotely, best management practices and administrative skills can be shared, built, and maintained. Organizations only need to ensure before start-up that the program is affordable by considering costs associated with mailings and communication, travel expenses, and so forth.

Where it becomes more difficult to figure out how to implement this model is when an organization builds a new program where there are not many experienced people in place to serve as mentors. An example of this has been seen in the new VHA Veterans Justice Outreach Program where a new program has been designed from the ground up to assist veterans with legal issues to direct them to treatment and all employee participants are relatively new to the program. In this case, the mentoring program model does not really fit. However, the few senior officials in charge of the program may need to act as overall mentors and adopt some aspects of the PTSD Mentoring Program, such as the conference calls and website, that can allow the clinicians to share best management practices and training while the program is developed. Then more experienced employees could begin to offer a mentoring program to newer employees.

Program Obstacles

It is important to understand and address potential barriers to mentoring before designing and initiating a mentoring program. Support from key stakeholders is critical, and we were fortunate that we had that support. There are still issues that we face. For example, we continue to address the need for protected work time for the program directors that have no designated time to handle their administrative duties and are not compensated for their participation time in the mentoring program. In facilities that must maintain a steady flow of new patients, the need to reserve every hour for clinical care often pushes administrative responsibilities and consultation into the evening hours. We are working with the executive leadership to try to find an appropriate balance.

We also know that we have not yet reached everyone who could benefit from the mentoring program. Because of the very nature of their jobs, the PTSD specialists can be hard to identify. When we started the mentoring program, it was difficult to recognize all of the PTSD program directors in the field. There are still clinicians in remote locations that we have not yet reached or been able to sufficiently engage in the program because of the heavy demands on their time to make it beneficial for them. We struggle to offer them positive solutions to their workloads and to make the program worth their time.

Next Steps

The design of the PTSD Mentoring Program offers continuity through its sharing of effective management solutions, which is crucial at a time when the VA is working to standardize its mental health offerings so that a veteran knows he or she will receive the best available treatments. The program provides a system that offers education and training but also effectively answers questions, provides support, and makes recommendations for busy clinicians. It is a mechanism for addressing many of the challenges that the VA now faces, including how to deliver quality mental health care to increasing numbers of veterans including those in remote rural areas, how to modify short-term inpatient acute care facilities for young veterans with unique challenges, and how to build relationships with mental health leadership and colleagues. The PTSD Mentoring Program has advanced PTSD treatment within the VA and has become a model for other specialty care areas within the VA.

The PTSD Mentoring Program has rapidly created a national network to disseminate and implement best management practices through a process of sharing of practices and local solutions by supporting local experts in their mentoring of other VA PTSD program administrators. This model can help programs that have a similar focus to identify potential problems, plan solutions, and create innovative or effective training and educational practices.
based on our experience. Through clear goals and measurable objectives, mentoring program planners can tell early on if the program’s practices should be changed to achieve success. The flexibility in the structure of the program allows for change, so as needs in the field evolve, we can also adapt and expand the program as necessary.

In many respects, the mentoring program now provides a “collective voice” for the participants that had not existed before. The program affords isolated program directors with a larger view and understanding of other effective programs in the field. This new field of vision helps them consider local changes to their programs and also provides them with support to take to their local management when changes are necessary.

References


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