Peer Specialist Learning Community

Summary Report: October 2010

CENTER FOR SOCIAL WORK RESEARCH

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Executive Summary

Background Information

In October 2005, Texas was one of seven states to be awarded a Mental Health Transformation State Incentive Grant (MHT-SIG) from the Substance Abuse and Mental Health Services Administration SAMHSA). The MHT-SIG originated from the President's 2003 New Freedom Commission Report on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. Through this grant, Texas was charged with transforming mental health services in the state by "building a solid foundation for delivering evidence-based mental health and related services, fostering recovery, improving quality of life, and meeting the multiple needs of mental health consumers across the lifespan" (Texas Department of State Health Servces, n.d. www.mhtransformation.org). Via Hope, Texas Mental Health Resource was created through the Texas MHT Project, in collaboration with the Department of State Health Services (DSHS), Mental Health America of Texas (MHAT), and the National Alliance on Mental Illness Texas (NAMI). Via Hope promotes mental health wellness to Texans by providing training and technical assistance resources to consumers, youth and family members. In addition to providing classroom and on-line training courses in a wide variety of mental health subject areas, Via Hope also provides training and certification for peer specialists and facilitates a learning community in order to help mental health agencies integrate peer specialists into their Centers (Via Hope, n.d. www.viahope.org).

To increase the number of consumers trained to be peer specialists in Texas, in FY 2010, Via Hope developed a new training and certification program for peer specialists (please see the *Peer Specialist Training and Certification Program: Evaluation Report* for more details about the program) and also offered Local Mental Health Authorities (LMHAs), Community Mental Health Centers (CMHCs), and Consumer-Operated Service Providers (COSPs) an opportunity to participate in a Peer Specialist Learning Community (PSLC). The main goal of the PSLC was to ensure employment opportunities for peer specialists by helping providers understand the benefits of hiring and utilizing CPSs, identify changes in recovery orientation necessary to successfully incorporate CPSs into the workplace, and acquire additional supports in order for both CPSs and providers to be successful.

Core Components of the PSLC

On November 13, 2009, Via Hope and DSHS distributed an announcement requesting applications for the PSLC. Via Hope and DSHS received applications from 10 LMHAs, one CMHC, and one COSP and all were invited to participate. Each organization was required to put together a team of *at least* two members: an Executive Director or key staff person with delegated authority and one consumer. Additional departments within the organization could be represented on the team, but were not required. Teams were also required to attend two PSLC conferences (one at the beginning of the learning community process and one at the end), complete an implementation plan, administer an online recovery orientation survey to staff members at two time points, participate in 8 monthly conference phone calls and 2 individual phone calls. In addition, 7 centers received a site visit and presentation from Chris Martin and Lori Ashcraft of Recovery Innovations intended to enhance the recovery orientation and/or develop recovery culture at the Center level.

Conclusions, Recommendations and Future Directions

The intent of the PSLC was for participating organizations to hire peer specialists and improve the recovery orientation of the organization. Through this process, Via Hope provided mental health agencies across the state of Texas an opportunity to share resources and information with one another in order to establish peer support programs and integrate peer specialists into their respective workforces. Regarding that intent, the overall outcomes of the PSLC are considered positive.

- Of the 12 organizations participating in the PSLC, 1 created, 5 enhanced, and 6 expanded peer specialist positions in their organizations.
- Comments disclosed during the individual and group calls and from the PSLC Wrap-Up Conference indicate a high level of satisfaction and enthusiasm for the learning community process.
- Of the 9 teams that put together a PowerPoint presentation, 8 explicitly stated they would recommend the PSLC to other Centers who are considering participating in the future.

Throughout the PSLC, staff from the University of Texas at Austin Center for Social Work Research (UT-CSWR) collected data and shared data from the application, RSA staff surveys, individual and conference calls, and final presentations at the Wrap-Up Conference.

- *Recommendation: In future learning communities, data collected and reported back to Centers could be used by Centers to identify strengths and areas for improvement as well as track progress on goals.*

The PSLC was the first of its kind in Texas and received highly positive feedback from the participating Centers. There were also lessons learned from this PSLC that can be used to improve future learning communities.

- Only 10 of the 38 LMHAs (a little over 25%) across the state of Texas turned in applications to participate in the PSLC. This modest application rate indicates either a lack of knowledge or a lack of interest in the learning community.
  - *Recommendation: Enhance future learning community marketing and/or visibility strategies.*
- The PSLC was only advertised to the LMHAs and COSPs and not the State Psychiatric Hospitals, which have similar needs.
  - *Recommendation: Market the PSLC to state hospitals in addition to the LMHAs as these organizations have shown an interest in integrating peer specialists into their organizations by sending individuals to Via Hope's Peer Specialist Training and Certification program.*
  - *Recommendation: Due to the very different nature of the organizations, consider facilitating a separate learning community specific to the needs of COSPs.*

Executive-level participation is vital to the success of a Peer Specialist Learning Community and to the integration of peer specialists within an organization.

- The Executive Director (or key staff person with authority to implement the necessary changes) was required to complete the application but not required to fully participate in the PSLC.
  - *Recommendation: The Executive Director or an individual in a leadership position should attend the Learning Community Kick-Off Conference and participate more fully in the PSLC to demonstrate organizational buy-in.*

To gain the benefits associated with collaborative learning, it is important for participants to be present and engaged in learning community activities.

- Participation rates on the monthly group conference calls were relatively low, with an average participation rate of just over 50%. Conversely, participation rates on individual calls were higher, with 83% of centers participating.
    - *Recommendation: Prior to calls, send a reminder of the date and time of the call and an agenda to help teams prepare for discussion topics.*
    - *Recommendation: Future learning communities should attempt to accommodate schedules for higher participation on group calls.*
    - *Recommendation: Build rapport and tailor the provision of training and technical assistance to the needs of individual Centers by increasing the frequency of individual calls.*

Texas is unique in its geographic, ethnic, and cultural diversity.

- Some Centers expressed interest in collaborating with Centers that are closer geographically.
    - *Recommendation: Facilitate regionalized phone calls among Centers so that the teams could assist one another in addressing certain issues that may be particular to the region, for example, issues specific to South Texas or veterans issues in regions with military facilities.*
- As another method to enhance support for both providers and peer specialists, Via Hope and the Texas Department of State Health Services created an on-line forum (MHTonline.org) where team members can exchange and share information relating to the learning community or other topics..
    - *Recommendation: Enhance marketing strategies for the on-line forum (MHTonline.org) to increase the number of communication channels available to teams.*

Chris Martin and Lori Ashcraft of Recovery Innovations provided recovery orientation training to 7 of the 12 participating Centers.

- All Centers expressed a high degree of appreciation for the training provided by Recovery Innovations and several indicated that they would have liked to see the training offered earlier in the learning community process.
    - *Recommendation: Offer site visits within the first few months of the learning community to serve as the basis for increasing recovery culture throughout the Center.*
    - *Recommendation: Clarify details of site visit (i.e., which staff members to invite to attend) before the site visit.*
    - *Recommendation: Work in conjunction with Recovery Innovations (or another training organization) to provide training tailored to the needs of each Center.*

The majority of the PSLC activities revolved around integrating peer specialists into the Center workforce. During the PSLC, the importance of a recovery orientation/culture at the organizational level was acknowledged by Centers as important to the successful integration of peer specialists.

- *Recommendation: Change the emphasis of next year's learning to be recovery focused with the integration of peer specialists included as part of that change rather than the focus of the change.*

Note: Via Hope has already taken this recommendation into consideration and is currently planning a "Recovery-Focused Learning Community" for FY 2011 with the integration of peer specialists as one component.

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Background Information

Via Hope, Texas Mental Health Resource

In October 2005, Texas was one of seven states to be awarded a Mental Health Transformation State Incentive Grant (MHT-SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA). The MHT-SIG originated from the President's 2003 New Freedom Commission Report on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. This report instructed states to identify any problems with or gaps in the mental health care system and, furthermore, to make recommendations to improve upon the current system. Through this grant, Texas was charged with transforming mental health services in the state by "building a solid foundation for delivering evidence-based mental health and related services, fostering recovery, improving quality of life, and meeting the multiple needs of mental health consumers across the lifespan" (Texas Department of State Health Servces, n.d., www.mhtransformation.org). A transformed system will provide consumers with the knowledge and resources that will facilitate active participation with service providers in designing and developing the systems of care in which they are involved.

Via Hope, Texas Mental Health Resource was created through the Texas MHT Project, in collaboration with the Department of State Health Services (DSHS), Mental Health America of Texas (MHAT), and the National Alliance on Mental Illness Texas (NAMI). Via Hope promotes mental health wellness to Texans by providing training and technical assistance resources to consumers, youth and family members. In addition to providing classroom and on-line training courses in a wide variety of mental health subject areas, Via Hope also provides training and certification for peer specialists and facilitates a learning community in order to help mental health agencies integrate peer specialists into their Centers (Via Hope, n.d., www.viahope.org).

Peer Specialists and the Peer Specialist Learning Community

Individuals often report feeling socially isolated, powerless, and demoralized when receiving services from the mental health system (Chinman, Young, Hassell, & Davidson, 2006). However, as the mental health system transforms to become more recovery-oriented, a new workforce is gaining momentum. Employed in a wide variety of settings, peer specialists are individuals with lived experience of mental illness, who are in recovery and willing to use their life experiences to assist others in earlier stages of recovery (Davidson, Chinman, Sells, & Rowe, 2006; Hebert, Drebing, Rosenheck, Young, and Armstrong, 2008). Because peer specialists can relate to the consumer experience, they are often thought of as the "bridge" that connects the consumer to the mental health system (Independent Living Research Utilization [ILRU] Community Living Partnership, 2008). Peer support services provided by a Certified Peer Specialist (CPS) are related to the consumer's individualized treatment plan (i.e., helping consumers develop skills for coping and managing psychiatric symptoms or providing consumers an opportunity to support each) and are often based on the concept of mutuality (Via Hope, n.d., www.viahope.org). For instance, supporting another consumer not only helps that individual, but also helps to strengthen one's personal recovery. CPSs can be

employed by mental health care agencies to offer peer support services and can be reimbursed for these services through Medicaid, an established funding program within the federal government.

To increase the number of peer specialists in Texas, in FY 2010, Via Hope provided training and certification for peer specialists and also offered Local Mental Health Authorities (LMHAs), Community Mental Health Centers (CMHCs), and Consumer-Operated Service Providers (COSPs) an opportunity to participate in a Peer Specialist Learning Community (PSLC). The intent of the PSLC was to assist Centers in adopting, enhancing, or expanding the use of peer specialists in the organization. The PSLC consisted of teams of professionals and consumers that worked together to develop implementation plans for the successful creation and integration of CPS positions in the day-to-day operations of the provider. The main goal of the PSLC was to ensure employment opportunities for peer specialists by helping providers understand the benefits of hiring and utilizing CPSs, identify changes in recovery orientation necessary to successfully incorporate CPSs into the workplace, and acquire additional supports in order for both CPSs and providers to be successful.

******See the companion report, Peer Specialist Training and Certification Program: Evaluation Report, for further details regarding this initiative.******

A formal evaluation of the PSLC was not conducted; however, The University of Texas Center for Social Work Research (UT-CSWR) assisted with collecting data, documenting and reporting on the PSLC activities. The aim of this report is to provide a broad descriptive framework regarding how a learning community may facilitate the implementation of certified peer specialists into LMHAs, CMHCs or COSPs. Included in this report is a description of the core components of the PSLC activities and all associated data that was collected throughout this process, as well as a summary of the findings, possible directions for the future and final recommendations.

Core Components of the PSLC

The Application

On November 13, 2009, Via Hope and DSHS distributed an announcement requesting applications for the PSLC (See Appendix A for a copy of the announcement). Each team was expected to "understand the process of hiring and sustaining a peer specialist" and "demonstrate substantial progress of the LMHA peer specialist implementation plan" at the end of the nine month PSLC. The Executive Director, or a key staff member with delegated authority, was required to complete the application and return it via email. (See Appendix B for a copy of the application). Applications were accepted through November 24, 2009.

Via Hope and DSHS received applications from 10 LMHAs, one CMHC (Metrocare Services), and one COSP (Austin Area Mental Health Consumers). All 12 applicant agencies, as listed below, were invited to participate:

1. Andrews Center
2. Austin Area Mental Health Consumers
3. Bluebonnet Trails Community MHMR Center

4. Burke Center
5. Center for Life Resources
6. Central Counties Center for MHMR Services
7. Heart of Texas Region MHMR Center
8. Hill Country Community MHMR Center
9. MHMR of Tarrant County
10. Metrocare Services
11. Tri-County MHMR Services
12. Tropical Texas Center for MHMR

Of the 12 Centers participating, 6 of the Centers reported using peer specialists at the time of the application (e.g., Austin Area Mental Health Consumers, Heart of Texas Region MHMR Center, Hill Country Community MHMR Center, Metrocare Services, Tri-County MHMR Services, Tropical Texas Center for MHMR). At these 6 Centers, there was variation in the number of peer specialist positions (ranging from 1 to 25), the number of hours a week each peer specialist works (ranging from 10 to 60), the peer specialists' type of employment (e.g. employee, independent contractor, or volunteer), the length of time the Center had each position (ranging from 1 to 14 years), and the number of consumers each peer specialist works with (ranging from 1 to 40). In addition, open-ended responses on the application varied in the level of formal training of the peer specialists (i.e., no formal training or Psychosocial Rehabilitation training) the source of funding for these positions (i.e., General Revenue, grants), the typical responsibilities of peer specialists (i.e., one-on-one peer support, support groups, working with ACT team), and the supervision of peer specialists (i.e. supervised daily/weekly/monthly by Program Supervisor, Executive Director, etc.).

In addition to basic information about the Center, the application also included an instrument to assess the agency's readiness to use peer specialists. The Readiness Self-Assessment consisted of 29 items, categorized into the following 6 subscales: Leadership, Culture Change, Planning and Preparation, Recruitment, Hiring and Supervision, and Follow Through. Using a 5 point scale, applicants were asked to mark an "X" over the number that best indicated the extent to which they agreed or disagreed with each item (1 = Strongly Disagree; 5 = Strongly Agree). The average responses from all Centers are displayed in Table 1 below for each item, subscale, and for the overall total.

Table 1. Average Responses on Readiness Self-Assessment

Readiness Self-Assessment Factors and Items	Average Response
Leadership	***4.23***
We communicate a clear commitment to the recovery model from the top of the organization.	4.50
The concept of recovery is included in our mission statement.	3.75
The leaders of this organization endorse recovery consistently in active, involved, and visible roles.	4.42
We view peer support as an essential part of the recovery model.	4.50
We have secure funding for the use of peer specialists.	4.00
Culture Change	***3.76***
We endorse the concept of recovery in new employee orientation.	4.17
We describe the role of peer specialists in new employee orientation.	3.17
We provide recovery-based educational trainings to staff.	3.92
We use people-first language throughout the agency.	3.92
We develop recovery-based individual care plans with consumers.	4.08
We create recovery-based materials including newsletters, consumer satisfaction surveys, and documentation audits.	3.75
We provide sufficient administrative support to staff to implement change.	4.17
We have a volunteer consumer advisory council of people served by us to partner with staff in policy making and hiring.	2.92
Planning and Preparation	***3.83***
Our peer specialists are permanent staff positions with the same benefits as other employees in similar classifications.	3.67
We use standard job titles and job descriptions for peer specialists.	4.08
The responsibilities of peer specialists include service provision, ongoing educational efforts with staff, and providing a consumer voice in management decision making.	4.17
We train supervisors how to work specifically with peer specialists, including how to apply peer specialist ethics.	2.75
We follow an established, clear policy on dual relationships (consumer/peer specialist and other staff).	4.17
Recruitment	***3.28***
We have an ongoing process to identify and recruit potential candidates for peer specialist positions.	3.50
Our peer specialists complete a standardized training and certification program with a code of ethics and continuing education requirements.	3.00
We have a policy on whether or not to hire consumers who received services from this organization, based on a rational study of the overall situation.	3.33

Readiness Self-Assessment Factors and Items	Average Response
Hiring and Supervision	***4.00***
We hire peer specialists with substantive, meaningful lived experience with mental illness so their insights can be shared with providers and other consumers.	4.00
We hire peer specialists who demonstrate recovery success to effectively communicate that recovery is possible.	4.08
We have reviewed our agency personnel policies to ensure there are no unintended obstacles to hiring peer specialists.	4.08
We provide regular quality supervision of peer specialists.	3.83
We regularly evaluate job performance of peer specialists as we do other staff positions.	4.00
Follow Through	***3.56***
We evaluate the outcomes of programs and activities that include peer specialist participation.	3.67
We provide opportunities for career advancement, promotion, and meaningful salary increases to peer specialists.	3.42
We maximize peer specialist inclusion in ongoing staff support activities.	3.58
Summary Score	***3.81***

Overall ratings of readiness were high. This might be expected since these organizations volunteered to participate in the PSLC. The three readiness factors receiving the highest ratings from director responders were: Leadership, Hiring and Supervision, and Planning and Preparation. The three readiness factors with the lowest ratings were: Recruitment, Follow Through, and Culture Change.

The Team

In order to participate in the PSLC, each organization was required to put together a team of *at least* two members. Because executive sponsorship is considered a critical component of the program's success, one of the team members had to be either the Executive Director or a key staff person with delegated authority to implement the necessary changes. The team also had to include at least one consumer, who was either currently working as a peer specialist or had aspiration to become a peer specialist. In addition to these two required team members, additional departments within the organization could be represented on the team, but were not required. There was variation in the number of team members from each site, with teams ranging in size from the minimum requirement of two members up to seven members. Table 2 below describes the team members from each agency.

Table 2. Team Members by Participating Center

Name of Center	Job Titles of Team Members
Andrews Center	Division Director Mental Health Community Support
	Mental Health Routine Case Manager
Austin Area Mental Health Consumers	Executive Director
	Peer Support Coordinator
	Lead Peer Specialist
	Return to Work Program Coordinator
	Peer Group Facilitator
Bluebonnet Trails Community MHMR Center	Executive Director
	Director of Mental Health Special Projects
	A Williamson Co. client desiring to be employed as the Peer Specialist
	Director of Mental Health Services
	Client Rights Officer
Burke Center	A staff member functioning as a Peer Coordinator
	Clinical Director Burke Center Nacogdoches Adult Clinic
	Peer partner to be named at a later date
Center for Life Resources	Chief Executive Officer
	Administrative Assistant
Central Counties Center for MHMR Services	Mental Health Director
	Peer Specialist to be determined
	Program Specialist
Heart of Texas Region MHMH Center	Executive Director
	Crisis Services Program Director
	Program Manager, Case Management
	Peer Volunteer
Hill Country Community MHMR Center	Mental Health Director
	Peer Support Coordinator
	Rehabilitation Specialist
	Director of Children's Mental Health Services
	Training Specialist

Name of Center	Job Titles of Team Members
MHMR of Tarrant County	Assistant Director, Mental Health Adult Services
	Program Manager, Penn Square Mental Health Adult Clinic
	Coordinator, Peer Support Services (consumer)
Metrocare Services	MD Chief Executive Officer
	Program Manager
	Four Peer Facilitators
	Clinical Manager
Tri-County MHMR Services	Administrator of Rehabilitation Services
	Psychosocial Rehabilitation Specialist – Peer Provider
Tropical Texas Center for MHMR	Clinic Manager (Harlingen)
	Cameron ACT Team Leader
	Hidalgo ACT Team Leader

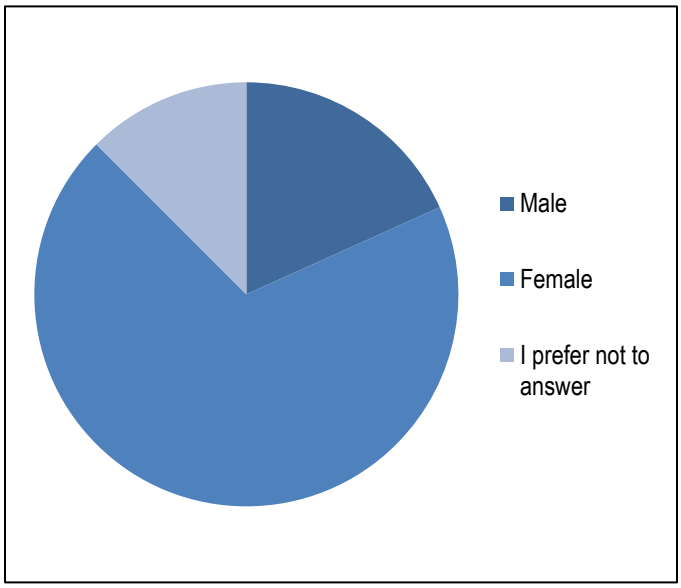
Recovery Orientation – Time 1

An organization's recovery orientation is an important part of the successful integration of peer support into the organizational structure of a mental health agency (Independent Living Research Utilization Community Living Partnership, 2008; Gates and Akabas, 2007; Chinman et al., 2006; Carlson, Rapp, & McDiarmid, 2001). In order to assess each Center's recovery orientation, staff members at each Center completed an online survey from December 2009 to January 2010 that included questions about: 1) employment and demographic information, 2) the Recovery Self-Assessment (RSA; O'Connell, Tondora, Croog, Evans, and Davidson, 2005) scale, and 3) four open-ended questions. A total of 433 staff members from the 12 Centers provided partial or complete responses to this survey.

Employment and Demographic Information – Time 1

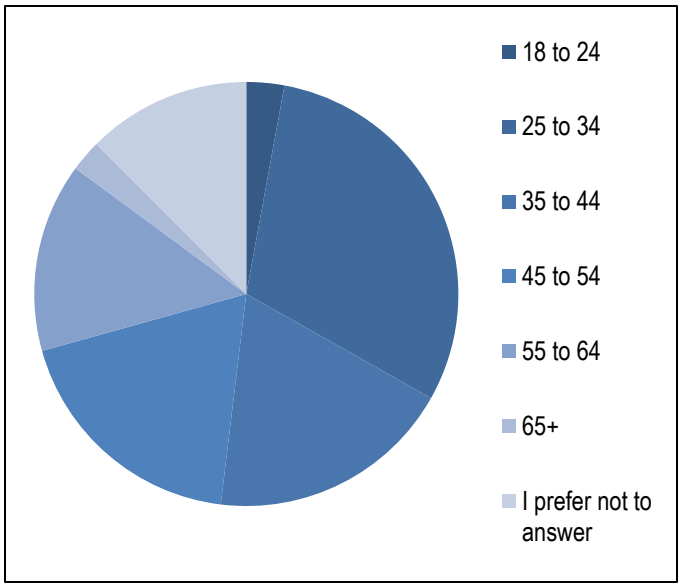
Of the 433 partial or complete responses received from staff, 416 (96.1%) provided demographic information, as summarized below.

Figure 1. Gender of RSA Respondents – Time 1



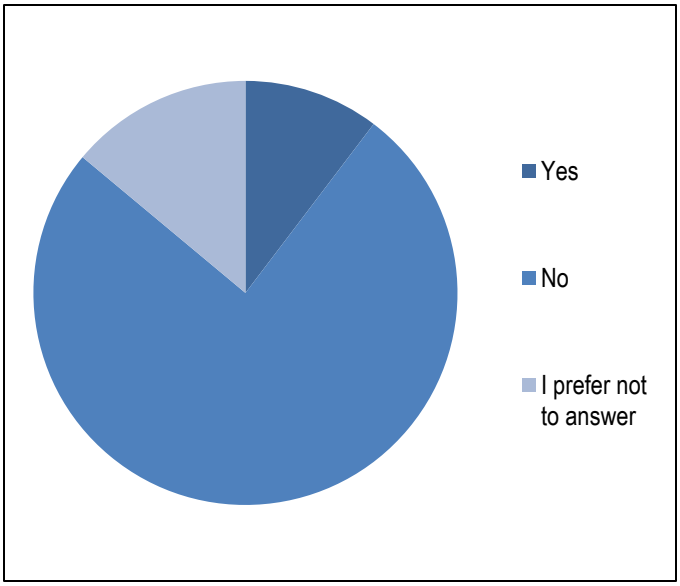
There was some degree of variation between respondents on all demographic and employment variables. In terms of gender, 18.3% (n=76) of the respondents identified themselves as male, 69.2% (n=288) identified themselves as female, and 12.5% (n=52) selected "I prefer not to answer" (see Figure 1 to the left).

Figure 2. Age of RSA Respondents – Time 1



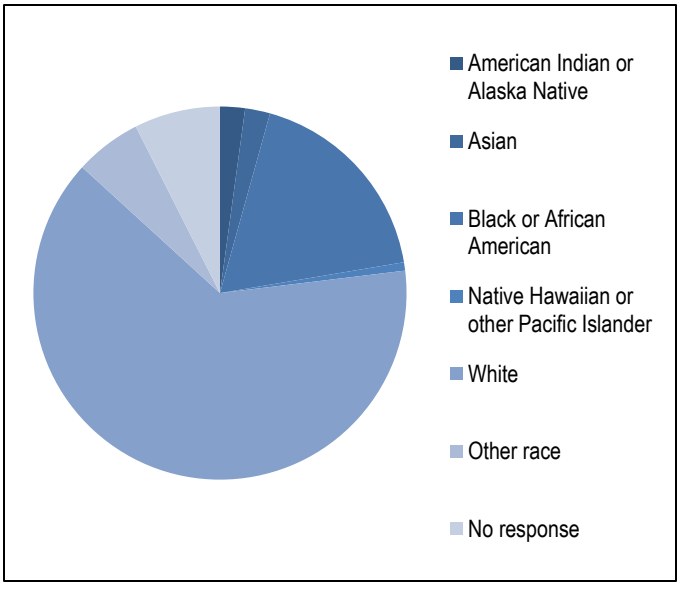
For age, 2.9% (n=12) of respondents were between the ages of 18 to 24, 30.3% (n=126) were between the ages of 25 to 34, 18.8% (n=78) were between the ages of 35 to 44, 18.8% (n=78) were between the ages of 45 to 54, 14.4% (n=60) were between the ages of 55 to 64, 2.4% (n=10) were 65 years of age or older, and 12.5% (n=52) selected "I prefer not to answer" (see Figure 2 to the left).

Figure 3. Hispanic or Latino Origin of RSA Respondents – Time 1



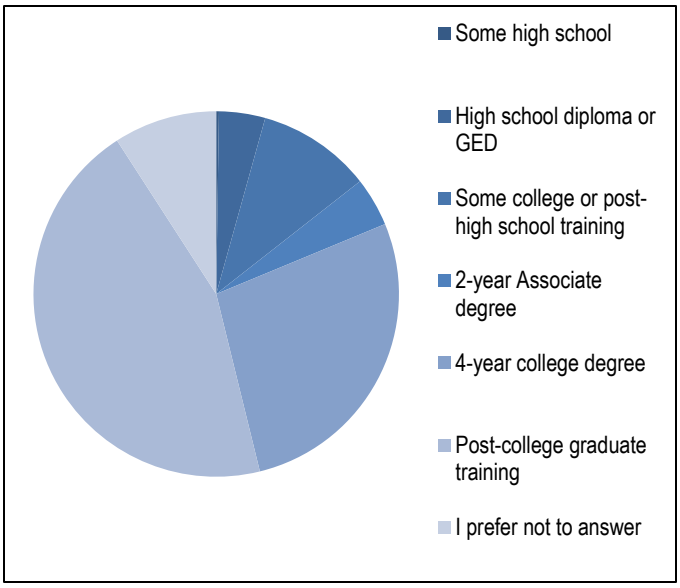
When asked "Are you of Hispanic or Latino origin?", 10.3% (n=43) responded "Yes", 75.7% (n=315) responded "No", and 13.9% (n=58) selected "I prefer not to answer (see Figure 3 to the left).

Figure 4. Race/Ethnicity of RSA Respondents – Time 1



In terms of race, 2.2% (n=9) of respondents were American Indian or Alaska Native, 2.2% (n=9) were Asian, 18.0% (n=75) were Black or African American, 0.7% (n=3) were Native Hawaiian or other Pacific Islander, 63.7% (n=265) were White, 5.8% (n=24) identified themselves as "Other race", and 7.5% (n=31) did not provide a response (see Figure 4 to the left).

Figure 5. Education Level of RSA Respondents – Time 1



For the highest level of education obtained, 0.2% (n=1) have completed some high school, 4.1% (n=17) have received their high school diploma or GED, 10.1% (n=42) have complete some college or post-high school training, 4.3% (n=18) have received a 2-year Associate degree, 27.4% (n=114) have received a 4-year college degree, 44.7% (n=186) have received post-college graduate training, and 9.1% (n=38) selected "I prefer not to answer" (see Figure 5 to the left).

In addition, approximately half of the respondents (49.0%; n=204) hold at least one professional certification or license. In terms of employment, a majority of respondents (82.0%; n=341) provide mental health services to consumers in their current positions. Responding staff members have worked in the mental health field from anywhere between 1 month and 35 years and have worked at their current organization from anywhere between 1 month and 33 years.

Recovery Self-Assessment (RSA) – Time 1

The RSA (O'Connell et al., 2005) is a widely used, validated assessment, consisting of 36 items that measure five domains related to recovery orientation: life goals, consumer involvement/recovery education, diversity of treatment options, choice, and individually-tailored services. The "Life Goals" domain was assessed with 11 items that reflect the extent to which consumers are assisted and supported in the development and pursuit of individually defined life goals, such as employment and education. "Consumer Involvement and Recovery Education" consisted of eight items, which reflect the extent to which consumers are involved in developing and providing programs/services, staff trainings, advisory board/management meetings, and community education activities. The "Diversity of Treatment Options" domain was assessed with six items which reflect the extent to which consumers are provided a variety of treatment options, including linkages to peer mentors and support. The fourth domain, "Choice – Rights and Respect", consisted of six items which reflect the extent to which consumers are treated with respect, provided access to treatment records, and assisted with outside referrals. Finally, "Individually-Tailored Services" was assessed with five items, which measure the extent to which services are tailored to individual needs, cultures, and interests, provided in a natural environment, and focus on building community connections.

Of the 433 partial or complete responses received from staff, 422 (97.5%) completed enough items on the RSA to be scored. Based on the responses of these 422 staff members, the following table summarizes the degree to which Centers reported providing recovery-oriented practices in a recovery-supportive

environment. Using a 5 point scale where 1 indicates "Strongly Disagree" and 5 indicates "Strongly Agree," staff members were asked to rate the extent to which they felt the following items reflect the activities, values, and practices of their agencies. The overall average responses across all Centers participating in the PSLC are listed below. *Note: Higher averages indicate stronger agreement.*

Table 3. Mean Responses on RSA – Time 1

Factors and Items on the Recovery Self-Assessment	Mean Response
Life Goals	***3.81***
Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization.	3.88
Staff routinely assist individuals in the pursuit of educational and/or employment goals.	3.90
The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations.	4.16
Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.05
Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs.	4.08
Staff play a primary role in helping people in recovery become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education.	3.72
Staff use a language of recovery (i.e. hope, high expectations, respect) in everyday conversations.	3.80
Agency staff believe that people can recover and make their own treatment and life choices.	4.04
The achievement of goals by people in recovery and staff are formally acknowledged and celebrated by the agency.	3.33
Staff and agency participants are encouraged to take risks and try new things.	3.22
Staff are knowledgeable about special interest groups and activities in the community.	3.71
Consumer Involvement and Recovery Education	***3.16***
People in recovery are regular members of agency advisory boards and management meetings.	2.98
People in recovery work along side agency staff on the development and provision of new programs and services.	2.95
Persons in recovery are involved with facilitating staff trainings and education programs at this agency.	2.88
This agency provides structured educational activities to the community about mental illness and addictions.	3.20
People in recovery are routinely involved in the evaluation of the agency's programs, services, and service providers.	3.18
Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup).	3.48
This agency provides formal opportunities for people in recovery, family members service providers, and administrators to learn about recovery.	3.44
The development of a person's leisure interests and hobbies is a primary focus of services.	3.15

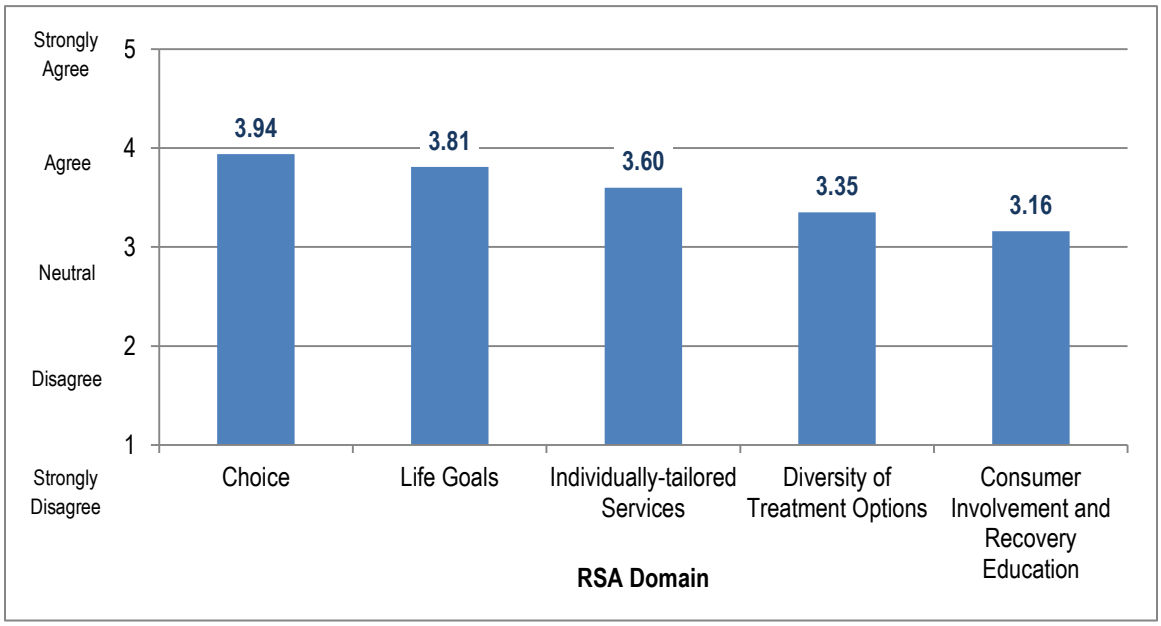
Factors and Items on the Recovery Self-Assessment	Mean Response
Diversity of Treatment Options	***3.35***
This agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs.	3.48
Criteria for exiting or completing the agency are clearly defined and discussed with participants upon entry to the agency.	3.52
People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests.	3.67
This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose.	3.17
Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	2.95
At this agency, participants who are doing well get as much attention as those who are having difficulties.	3.31
Choice -- Rights and Respect	***3.94***
Agency staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices.	4.55
People in recovery have access to all their treatment records.	3.65
Staff at this agency listen to and follow the choices and preferences of participants.	3.83
People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work.	3.76
Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis.	4.09
Most services are provided in a person's natural environment (i.e., home, community, workplace).	3.76
Individually-tailored Services	***3.60***
Helping people build connections with their neighborhoods and communities is one of the primary activities in which staff at this agency are involved.	3.85
This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs.	3.60
This agency provides education to community employers about employing people with mental illness and/or addictions.	3.27
All staff at this agency regularly attend trainings on cultural competency.	3.31
Every effort is made to involve significant others (spouses, friends, family members) and other natural supports (i.e., clergy, neighbors, landlords) in the planning of a person's services, if so desired.	3.95
Summary Score	***3.59***

Although individual Centers varied in the provision of recovery-oriented services, all means tended to be high. Therefore, in order to compare means across the Centers and across time, the relative values will be examined, as there was not a high degree of variation among the absolute values of the factors and items.

Center averages on the RSA (O'Connell et al., 2005) overall ranged from 3.27 to 4.43. As shown in Figure 6 (below), the "Choice – Rights and Respect" domain had the highest average across all Centers with an average score of 3.94. "Life Goals" was the second highest RSA domain with an average score of 3.81 at Time 1, followed by "Individually-Tailored Services" at 3.60, "Diversity of Treatment Options" at 3.35, and finally, "Consumer Involvement and Recovery Education" was ranked the lowest across all Centers at 3.16. All Centers, with the exception of the COSP, scored the highest on the "Choice – Rights and Respect" domain and the lowest on the "Consumer Involvement and Recovery Education" domain. The three

domains falling in the middle varied from Center to Center, but a majority of the Centers followed the same pattern as the overall (e.g., "Life Goals" ranking second, "Individually-Tailored Services" ranking third, and "Diversity of Treatment Options" ranking fourth).

Figure 6. Mean Responses on RSA by Domain – Time 1



In terms of individual items comprising the domains, the top five endorsed recovery-oriented practices across all Centers at Time 1 are as follows (in descending order): Agency staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices; The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations; Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis; Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs; and, Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests. The five least endorsed recovery-oriented practices at Time 1 are as follows (in ascending order): Persons in recovery are involved with facilitating staff trainings and education programs at this agency; People in recovery work along side agency staff on the development and provision of new programs and services; Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school; People in recovery are regular members of agency advisory boards and management meetings; and, The development of a person's leisure interests and hobbies is a primary focus of services. The five highest and five lowest items were based on the average response across all Centers.

Data from the RSA can help each agency identify strengths and areas for improvement, as well as provide context on how each individual agency compares to the other agencies. Therefore, after the data was collected, UT-CSWR provided each Center an "Agency Recovery Profile," which included the number of staff members who completed the survey at that individual Center, a table (similar to the one above) that

contained the average response for each item at the individual Center in comparison to the overall average response for each item for all participating Centers, the Center's five highest rated items, areas of strength (in comparison to other Centers), the Center's five lowest rated items, and areas of improvement (in comparison to other Centers). The strengths and weaknesses were based on the standard deviation of the entire response population. If item responses from an individual Center were more than three standard deviations from the average response across all Centers, that area was identified as a relative strength for that Center. If responses from an individual Center was less than three standard deviations from the average response across all Centers, that area was identified as a relative area for improvement for that Center. Please see Appendix C for an example of the "Agency Recovery Profile".

Open-Ended Items – Time 1

In addition to demographic, employment, and RSA data, respondents completed four open-ended questions. The responses to these questions were then qualitatively theme-coded in order to summarize responses. Each question is displayed below, along with the overarching themes of the responses to each question, and the percentage of total codes (*Note: some responses received multiple codes*) assigned that fall under each category. A total of 433 individuals responded to at least one of the questions.

1. Do you have any experience collaborating with peer specialists? Please describe.

   Of the 433 individuals responding to this question, responses comprised 433 codes, consisting of 7 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in Table 4 below.

Table 4. Experience Collaborating with Peer Specialists – Time 1

Theme	% of Total Codes	Typical Responses
No experience	58.0%	None; No
Yes, on a regular basis	19.6%	Yes; Years of experience; Frequently collaborate with / refer clients to peer specialist
A little/some experience	15.2%	We have peer specialists employed at our Center; I'm aware of their job responsibilities
Other	2.8%	I work with peer specialists outside of the mental health system (i.e., school, refuge program); I work with other mental health professionals
I am a peer specialist	2.1%	References working as a peer specialists or with clients in a peer specialist capacity
I do not know what a peer specialist is/more information needed	1.2%	Unsure; Unknown; What is a peer specialist
Not applicable	1.2%	n/a; Peer specialists are able to relate to the consumers

2. How do you think working with a peer specialist would affect the recovery of the consumers with whom you work? Please explain.

   Of the 411 individuals responding to this question, responses comprised 488 codes, consisting of 11 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in Table 5 below.

Table 5. Effect of Peer Specialists on Consumer Recovery – Time 1

Theme	% of Total Codes	Typical Responses
Empathy/shared experience	19.9%	Peer specialists are able to relate to the consumer experience; Consumers are more likely to open up with someone who has "been there"
Beneficial/positive effect (general)	16.8%	It will enhance the recovery of the consumers; It will be beneficial to clinicians, consumers, and the peer specialists, themselves;
Inspiration/sense of hope/encouragement	11.5%	Peer specialist are real life examples that recovery is possible; Gives consumers a chance to interact with individuals with diagnoses who are leading productive lives
Mentorship/moral support	9.8%	Peer specialists provide consumers with extra support that is critical to the recovery process;
Learning experience/insight	9.6%	Peer specialists can discuss the steps they took to move forward in their recovery; Consumers gain a better understanding of their illness
Other	8.0%	Working with peer specialists may make consumers feel more connected to the community; Consumers enjoy peer support groups
More information needed	7.2%	I don't know what a peer specialist is; What are typical job responsibilities of peer specialists?
No opinion	4.5%	I do not know; I have no idea
Not applicable	4.5%	I don't work with consumers or peer specialists; n/a
Concerns about peer specialist	4.1%	The peer specialist must be stable mentally and emotionally; It is important that the peer specialist receives training
No effect on recovery/negative effect	4.1%	Peer specialists have the potential to negatively impact one's recovery; Peer support services would no benefit or minimally benefit a consumer's recovery

3. Do you have any concerns about your organization creating permanent peer specialist staff positions? Please explain.

   Of the 414 individuals responding to this question, responses comprised 451 codes, consisting of 12 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in Table 6 below.

Table 6. Concerns with Creating Peer Specialist Positions – Time 1

Theme	% of Total Codes	Typical Responses
No concerns	58.1%	No; None; It would be wonderful
Training	5.5%	It is imperative that the peer specialists receive the appropriate training/education; Peer specialists should not act as clinicians or case managers
Other	5.3%	Commonly a stigma associated with mental illness; Fear that peer specialists will take other positions; Lack of physical (office) space at organization
Need more information	5.1%	I don't know what a peer specialist is; I need more information about the job responsibilities of a peer specialist
Boundaries	4.7%	I have concerns about the peer specialist-client, and the peer specialist-staff relationship; Peer specialist may have issues with role confusion or power conflict
Selection of appropriate individual	4.2%	It is difficult identifying the "right" individuals for the peer specialist position; Peer specialists should be stable in their recovery
Supervision	4.0%	Peer specialists need ongoing supervision; These positions need to be monitored regularly, just as all other positions at the agency are
Cost/funding	3.8%	We do not currently have the money in our budget to fund these positions; Lack of funding at federal, state, and/or Center level
Relapse potential	3.5%	Job-related stress may result in the peer specialist relapsing; Peer specialist might become overwhelmed by job responsibilities/stress
Confidentiality	2.2%	Concerns with confidentiality, privacy, access to medical records, etc.
Not applicable	2.2%	N/A; I do not work with peer specialists
Extra workload	1.3%	The creation of more peer specialist positions may increase the workload for other non-peer staff; Would need more management positions

4. Is there anything else that you would like to share with us regarding the recovery orientation of your organization?

   Of the 230 individuals responding to this question, responses comprised 244 codes, consisting of 9 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in Table 7 below.

Table 7. Recovery Orientation of Organization – Time 1

Theme	% of Total Codes	Typical Responses
Recovery-oriented organization	7.0%	Our organization focuses on promoting recovery-related concepts; The recovery model is used throughout our agency
Lack of funding	5.3%	The lack of funding prevents us from enhancing the recovery of consumers; Limited funding does not allow for us to use peer specialists to their full potential
Lack of personnel (peers and non-peers)	1.6%	The lack of staff members does not allow us to focus on the recovery of the individuals; Demand for peer support services is high, but we do not have enough staff
Lack of recovery-orientation/focus on medical model	9.0%	The focus of our services is on stabilization and medication management; We do not discuss recovery or recovery concepts
Internal struggle/discordance within the agency	1.6%	Decisions are made by people who do not work with peer specialists on a day-to-day basis; Struggle/conflict between different levels/departments within the agency
Emphasis on cost-savings	2.0%	The goal of the organization is to make money; Focus is on numbers, money, or cost
Not applicable	7.0%	N/A; I do not know what peer specialists do
No	56.6%	No; Nothing; Not at this time
Other	9.8%	Stigma associated with mental illness; More groups needed

Overall responses to the open-ended questions appear to indicate that although not many respondents had experience collaborating with peer specialists, they did believe it would be beneficial for consumers to work with peer specialists, they had few concerns about creating peer specialist positions in their organizations, and recognized that including peer specialists in the workforce would require organizational changes to accommodate the new positions.

The Learning Community Kick-Off Conference

Each team participated in the Learning Community track at the United State Psychiatric Rehabilitation Association (USPRA) "Windows to Wellness" conference in Austin on January 7-9, 2010. At this 3-day conference, nationally recognized leaders in the Consumer Wellness Movement and Texas leaders shared their insights and knowledge about the use of peer support within the mental health system. The goal of the Kick-Off Conference was to provide participants with an opportunity to use what they learned and to begin developing a comprehensive peer specialist implementation plan. Each team also received an individualized "Agency Recovery Profile" based on RSA responses (see description of profile above). The conference was divided into 11 workshops, which included exercises for the teams to develop portions of their peer specialist implementation plans, as well as homework assignments to work on during the conference. Please see Appendix D for copy of the 2010 Conference Schedule and Appendix E for a description of the Conference Toolkit provided to each participating agency. Via Hope provided a travel / lodging stipend to offset most of the costs for the teams to attend both the Kick-Off and Wrap-Up conferences in Austin.

Each Center selected to participate in the PSLC was asked to complete an implementation plan, which was given to them in the toolkit and discussed at the Kick-Off Conference. The implementation plan was intended to help each Center document a plan on how to implement certified peer specialists into the organization's workforce. Via Hope encouraged each Center to provide all members of the team an opportunity to participate in the development of each section of their plan. Only 4 of the 12 agencies (e.g. Tri-County MHMR Services, MHMR of Tarrant County, Tropical Texas Center for MHMR and Metrocare Services) turned in implementation plans to Via Hope, however, most Centers discussed working on some area of the implementation plan on the monthly calls.

Conference Calls

Over the course of PSLC, Via Hope facilitated eight monthly conference calls between the participating teams. These conference calls took place from January to August. Participation rates across all Centers varied for each call, ranging anywhere from three Centers (January) to nine Centers (May and June). By individual Center, participation rates ranged from one conference call (Andrews Center and Bluebonnet Trails Community MHMR Center) to all eight conference calls (Tropical Texas Center for MHMR). Qualitative data collected from the monthly conference calls is summarized by Center in a later section of this document (see "Summary of Findings by Center" beginning on page 31).

Individual Calls

In addition to monthly conference calls, a staff member from Via Hope completed two individual calls to the teams at each of the Centers in April and again in August. For both calls, Via Hope was able to contact 10 Centers. Andrews Center and Tropical Texas Center for MHMR did not participate in the April individual call. Andrews Center and Central Counties Center for MHMR Services did not participate in the August individual call. Please see Appendix F for the call script from April and Appendix G for the call script from August. Qualitative data collected from the monthly conference calls is summarized by Center in a later section of this document (see "Summary of Findings by Center" beginning on page 31).

Site Visits

In the months of May and June in 2010, seven of the 12 participating Centers received site visits from Chris Martin or Lori Ashcraft of Recovery Innovations. The Centers that received site visits are as follows: Bluebonnet Trails Community MHMR Center, Burke Center, Center for Life Resources, Hill Country Community MHMR Center, MHMR of Tarrant County, Tri-County MHMR Services, and Tropical Texas Center for MHMR. Each organization was encouraged to invite staff members to attend the 8-hour training (*Note: Due to time constraints, Burke Center received an abbreviated 2-hour visit).* The training presented ways to enhance the recovery orientation and/or develop a recovery culture at the Center. Overall, Centers were extremely pleased with the site visit and the presenters and expressed a desire for the entire organization to be exposed to recovery orientation training. A copy of the site visit agenda can be found in Appendix H.

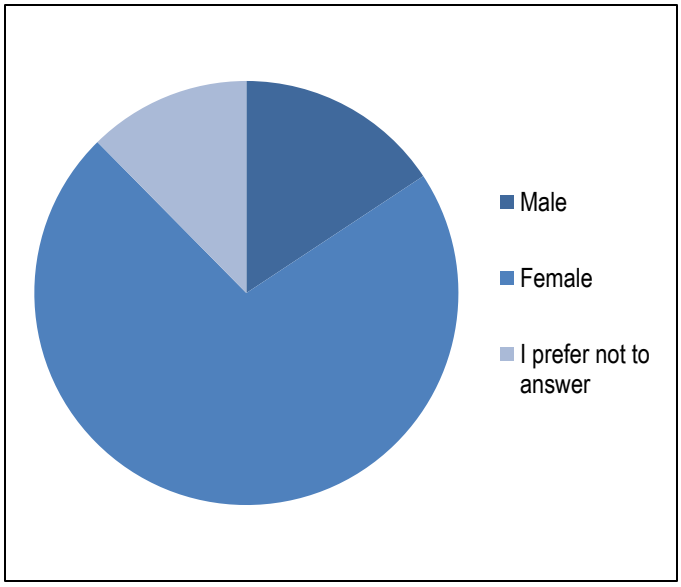
Recovery Orientation – Time 2

To determine if changes occurred over the course of the Learning Community, staff members at each of the organizations were asked to complete the same online survey from Time 1 for a second time during the period of August to September 2010 (Time 2). Response rates were much more modest at Time 2 compared to Time 1, with 132 partial or complete responses received from staff members at 6 of the 12 Centers participating in the PSLC (compared to 422 at Time 1). An anonymous linking code and demographic data was used to determine that 53 staff members responded at both Time 1 and Time 2.

Employment and Demographic Information – Time 2

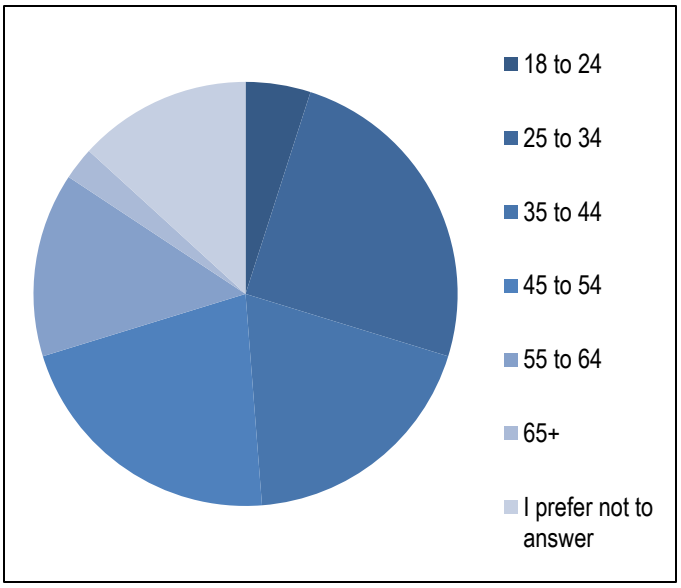
Of the 132 partial or complete responses received from staff, 121 (91.7%) provided demographic information, as summarized below.

Figure 7. Gender of RSA Respondents – Time 2



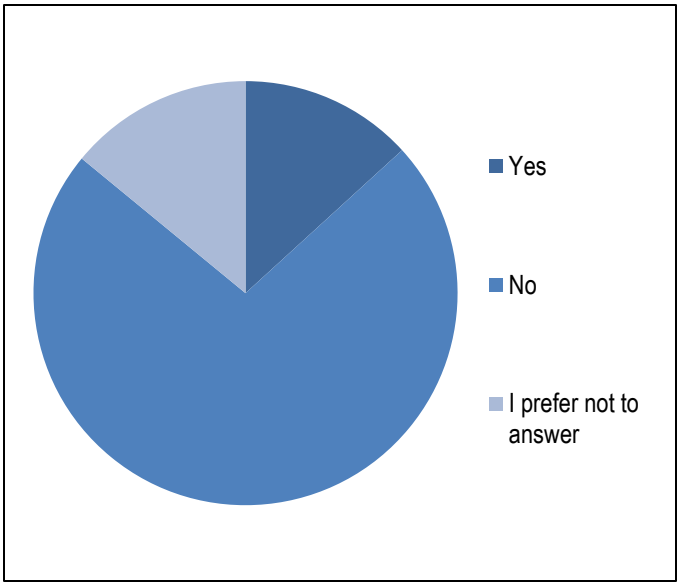
There was a slight degree of variation between the employment and demographic variables at Time 1 compared to Time 2, but these differences were not significant. In terms of gender, 15.7% (n=19 of the respondents identified themselves as male, 71.9% (n=87) identified themselves as female, and 12.4% (n=15) selected "I prefer not to answer" (see Figure 7 to the left).

Figure 8. Age of RSA Respondents – Time 2



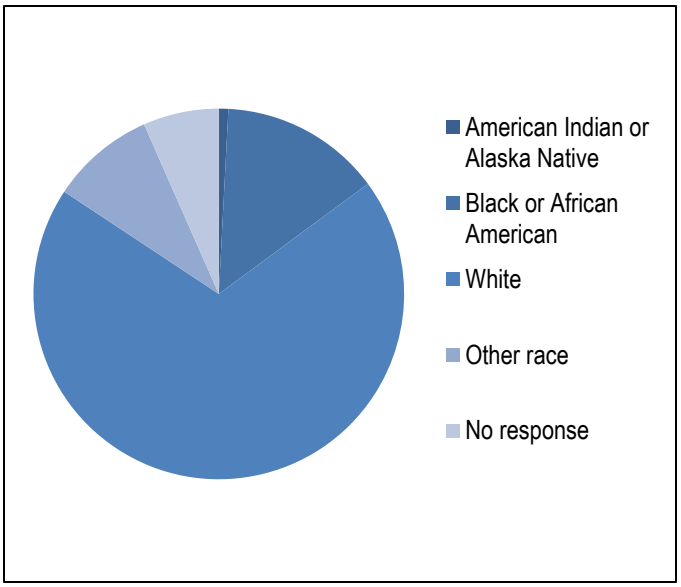
For age, 5.0% (n=6) of respondents were between the ages of 18 to 24, 24.8% (n=30) were between the ages of 25 to 34, 19.0% (n=23) were between the ages of 35 to 44, 21.5% (n=26) were between the ages of 45 to 54, 14.0% (n=17) were between the ages of 55 to 64, 2.5% (n=3) were 65 years of age or older, and 13.2% (n=16) selected "I prefer not to answer" (see Figure 8 to the left).

Figure 9. Hispanic or Latino Origin of RSA Respondents – Time 2



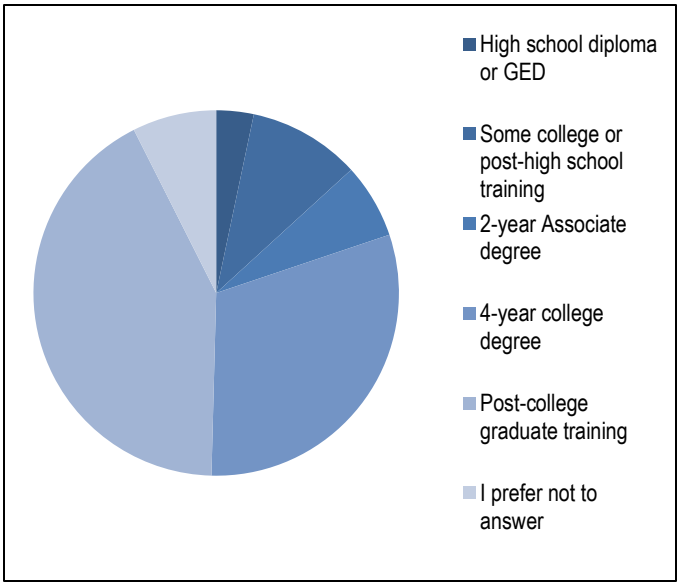
When asked "Are you of Hispanic or Latino origin?", 13.2% (n=16) responded "Yes", 72.7% (n=88) responded "No", and 14.0% (n=17) selected "I prefer not to answer (see Figure 9 to the left).

Figure 10. Race/Ethnicity of RSA Respondents – Time 2



In terms of race, 0.8% (n=1) of respondents were American Indian or Alaska Native, 14.0% (n=17) were Black or African American, 69.4% (n=84) were White, 9.1% (n=11) identified themselves as "Other race", and 6.6% (n=8) did not provide a response (see Figure 10 to the left).

Figure 11. Education Level of RSA Respondents – Time 2



For the highest level of education obtained, 3.3% (n=4) have received their high school diploma or GED, 9.9% (n=12) have complete some college or post-high school training, 6.6% (n=8) have received a 2-year Associate degree, 30.6% (n=37) have received a 4-year college degree, 42.1% (n=51) have received post-college graduate training, and 7.4% (n=9) selected "I prefer not to answer" (see Figure 11 to the left).

A little less than half of the 121 respondents providing demographic data (44.6%; n=54) hold at least one professional certification or license. In terms of employment, a majority of respondents (75.2%; n=91) provide mental health services to consumers in their current positions. Responding staff members have worked in the mental health field from anywhere from a few months to 40 years and have worked at their current organization from anywhere between 1 month and 32 years.

Recovery Self-Assessment (RSA) – Time 2

Of the 132 partial or complete responses received from staff, 127 (96.2%) completed enough items on the RSA to be scored. Based on the responses of these 127 staff members, the following table summarizes the degree to which Centers reported providing recovery-oriented practices in a recovery-supportive environment. Using a 5-point scale where 1 indicates "Strongly Disagree" and 5 indicates "Strongly Agree," staff members were asked to rate the extent to which they felt the following items reflect the activities, values, and practices of their agencies. The overall average responses across all Centers participating in the PSLC are listed in Table 8 below. *Note: Higher averages indicate stronger agreement.*

Table 8. Mean Responses on RSA – Time 2

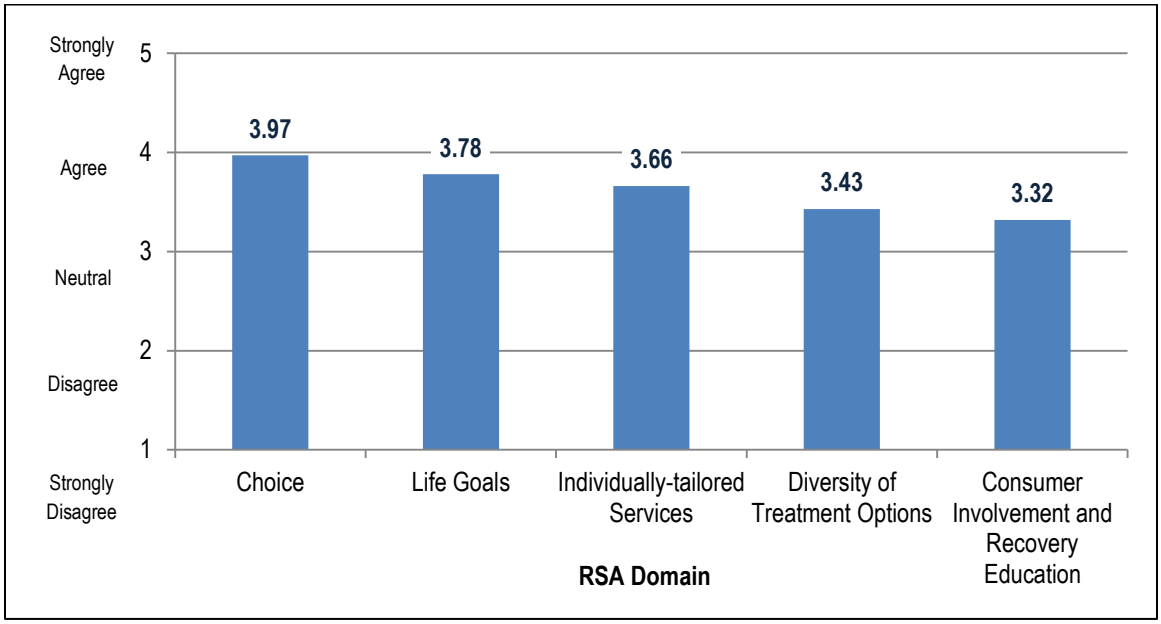
Factors and Items on the Recovery Self-Assessment	Mean Response
Life Goals	***3.78***
Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization.	3.82
Staff routinely assist individuals in the pursuit of educational and/or employment goals.	3.86
The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations.	4.02
Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.02
Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs.	4.11
Staff play a primary role in helping people in recovery become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education.	3.74
Staff use a language of recovery (i.e. hope, high expectations, respect) in everyday conversations.	3.76
Agency staff believe that people can recover and make their own treatment and life choices.	4.08
The achievement of goals by people in recovery and staff are formally acknowledged and celebrated by the agency.	3.38
Staff and agency participants are encouraged to take risks and try new things.	3.10
Staff are knowledgeable about special interest groups and activities in the community.	3.69

Factors and Items on the Recovery Self-Assessment	Mean Response
Consumer Involvement and Recovery Education	***3.32***
People in recovery are regular members of agency advisory boards and management meetings.	3.30
People in recovery work along side agency staff on the development and provision of new programs and services.	3.27
Persons in recovery are involved with facilitating staff trainings and education programs at this agency.	3.14
This agency provides structured educational activities to the community about mental illness and addictions.	3.38
People in recovery are routinely involved in the evaluation of the agency's programs, services, and service providers.	3.36
Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup).	3.51
This agency provides formal opportunities for people in recovery, family members service providers, and administrators to learn about recovery.	3.59
The development of a person's leisure interests and hobbies is a primary focus of services.	3.09
Diversity of Treatment Options	***3.43***
This agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs.	3.67
Criteria for exiting or completing the agency are clearly defined and discussed with participants upon entry to the agency.	3.32
People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests.	3.62
This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose.	3.36
Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	3.10
At this agency, participants who are doing well get as much attention as those who are having difficulties.	3.48
Choice -- Rights and Respect	***3.97***
Agency staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices.	4.56
People in recovery have access to all their treatment records.	3.59
Staff at this agency listen to and follow the choices and preferences of participants.	3.82
People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work.	3.91
Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis.	4.13
Most services are provided in a person's natural environment (i.e., home, community, workplace).	3.81

Factors and Items on the Recovery Self-Assessment	Mean Response
Individually-tailored Services	***3.66***
Helping people build connections with their neighborhoods and communities is one of the primary activities in which staff at this agency are involved.	3.88
This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs.	3.57
This agency provides education to community employers about employing people with mental illness and/or addictions.	3.22
All staff at this agency regularly attend trainings on cultural competency.	3.75
Every effort is made to involve significant others (spouses, friends, family members) and other natural supports (i.e., clergy, neighbors, landlords) in the planning of a person's services, if so desired.	3.88
Summary Score	***3.64***

Similar to Time 1, individual Centers varied in the provision of recovery-oriented services at Time 2; Center averages on the RSA overall ranged from 3.51 to 3.93. As shown in Figure 12 below, the "Choice – Rights and Respect" domain had the highest average across all Centers with an average score of 3.97. "Life Goals" was the second highest RSA domain with an average score of 3.78 at Time 1, followed by "Individually-Tailored Services" at 3.66, "Diversity of Treatment Options" at 3.43, and finally, "Consumer Involvement and Recovery Education" was ranked the lowest across all Centers at 3.32. The ranking of the domains followed an identical pattern as Time 1. When examining responses across time, four of the five domain averages increased (marginally). The only domain that decreased from Time 1 to Time 2 was "Life Goals." Furthermore, the overall RSA average increased from Time 1 to Time 2, indicating a potentially positive impact of the PSLC on recovery orientation.

Figure 12. Mean Responses on RSA by Domain – Time 2



In terms of individual items within domains at Time 2, the top four most endorsed practices were: Agency staff do not use threats, bribes, or other forms of coercion to influence a person; Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis, Staff routinely assist individuals in the pursuit of educational and / or employment goals; and Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs. The four least endorsed recovery-oriented practices across Centers were: Staff and agency participants are encouraged to take risks and try new things; Persons in recovery are involved with facilitating staff trainings and education programs at this agency; Groups, meetings, and other activities can be scheduled in the evening and on weekends so as not to conflict with other recovery-oriented activities such as employment or school; and, This agency provides education to community employers about employing people with mental illness and / or addictions.

At the Wrap-Up Conference in September 2010 (described in more detail in the section "The Learning Community Wrap-Up Conference"), the six Centers with staff members responding at Time 2 received a second "Agency Recovery Profile." Due to the low response rate at Time 2, the overall averages across Centers were not included in these profiles. Instead, the CSWR evaluators determined that change across time for the individual Center was a more useful measure to report. Thus, the profile included the average responses at Times 1 and 2 for that particular Center, in addition to the highest and lowest rated items for Centers who responded at both time points.

Open-Ended Items – Time 2

The same four open-ended questions were included in the questionnaire to assess recovery orientation at Time 2. The responses to these questions were then qualitatively theme-coded using the same codes as Time 1 in order to summarize responses. Because the typical responses for each theme were discussed above, they will not be discussed in this section. Instead each question is displayed below, along with the overarching themes of the responses to each question, and the percentage of total codes that fell under that category at Time 2. At Time 2, 132 individuals responded to at least one of these questions.

1. Do you have any experience collaborating with peer specialists? Please describe.

   Of the 132 individuals responding to this question, responses comprised 132 codes, consisting of 7 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in Table 9 below. From Time 1 to Time 2, there was a decrease in the percentage of total codes that indicated having no experience collaborating with peer specialists and an increase in the percentage of total codes that reported having a little or some experience collaborating with peer specialists. All other themes remained relatively stable from Time 1 to Time 2.

Table 9. Experience Collaborating with Peer Specialists – Time 2

Theme	% of Total Codes
No experience	45.5%
Yes, on a regular basis	18.9%
A little/some experience	25.0%
Other	2.3%
I am a peer specialist	5.3%
I do not know what a peer specialist is/more information needed	0.8%
Not applicable	2.3%

2. How do you think working with a peer specialist would affect the recovery of the consumers with whom you work? Please explain.

   Of the 124 individuals responding to this question, responses comprised 163 codes, consisting of 11 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in Table 10 below. Across time, there was little variation in the percentage of total codes for each theme of the second open-ended question.

Table 10. Effect of Peer Specialists on Consumer Recovery –Time 2

Theme	% of Total Codes
Empathy/shared experience	23.9%
Beneficial/positive effect (general)	16.0%
Inspiration/sense of hope/encouragement	12.9%
Mentorship/moral support	9.8%
Learning experience/insight	8.0%
Other	11.7%
More information needed	3.7%
No opinion	1.8%
Not applicable	5.5%
Concerns about peer specialist	2.5%
No effect on recovery/negative effect	4.3%

3. Do you have any concerns about your organization creating permanent peer specialist staff positions? Please explain.

   Of the 128 individuals responding to this question, responses comprised 141 codes, consisting of 12 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in Table 11 below. Similar to the previous question, there was little variation in the percentage of total codes for each theme of the third open-ended question across time.

Table 11. Concerns with Creating Peer Specialist Positions –Time 2

Theme	% of Total Codes
No concerns	61.7%
Training	2.8%
Other	5.0%
Need more information	3.5%
Boundaries	6.4%
Selection of appropriate individual	7.1%
Supervision	0.7%
Cost/funding	3.5%
Relapse potential	1.4%
Confidentiality	2.1%
Not applicable	5.0%
Extra workload	0.7%

4. Is there anything else that you would like to share with us regarding the recovery orientation of your organization?

   Of the 55 individuals responding to this question, responses comprised 55 codes, consisting of 9 major themes. These themes, the percentage of the total number of codes that fall under each theme and typical responses for each theme are displayed in the Table 12 below. For the fourth open-ended question, the only theme to change drastically from Time 1 to Time 2 was the "Not applicable", with a greater percentage of total codes falling into this category at Time 2 compared to Time 1.

Table 12. Recovery Orientation of Organization – Time 2

Theme	% of Total Codes
No	54.5%
Other	12.7%
Lack of recovery-orientation/focus on medical model	1.8%
Not applicable	16.4%
Recovery-oriented organization	3.6%
Lack of funding	5.5%
Emphasis on cost-savings	0.0%
Internal struggle/discordance within the agency	5.5%
Lack of personnel (peers and non-peers)	0.0%

Throughout the course of the PSLC, staff members at the participating Centers have gained a better understanding of the role of peer specialists, as indicated by the decrease in responses expressing a lack of awareness as to what a peer specialist is from Time 1 to Time 2. Furthermore, an increase in the number of peer specialists responding to the survey was displayed across time as well as an increase in the number of respondents who have had at least some experience collaborating with a peer specialist. Although these results potentially indicate growth within the peer specialist workforce, the response rates declined considerably from Time 1 (N=454) to Time 2 (N=132) which may have impacted the findings.

The Learning Community Wrap-Up Conference

On September 23-24, 2010, all Centers were invited to participate in the PSLC Wrap-Up Conference as a way to close the 9-month learning community process. Of the 12 Centers in the Learning Community, 9 Centers attended the conference. Andrews Center, Heart of Texas Region MHMR Center, and Tri-County MHMR Services did not attend. At the conference, teams heard from the following individuals:

- Dennis Bach, *Director, Via Hope Program*
    - Introductions and Objectives of the Conference.
- Michelle Steinley-Bumgarner, *Research Associate, Center for Social Work Research, University of Texas at Austin*
    - Review of the Readiness Self-Assessment (RSA) results and changes from Time 1 to Time 2.
    - Updated "Agency Recovery Profiles" were given to the teams at this time.
- Sam Shore, *Transformation Working Group (TWG) Co-Chair, MHT Project Director, Department of State Health Services*
    - Presentation of the state budget, funding options for CPSs, and the plan status and billing options for Medicaid
- Chris Martin, *Director of Training and Consultation at the Recovery Opportunity Center (ROC) at Recovery Innovations*
    - Developing a Recovery Orientation
    - Looking to the Future
- Anna Jackson, *Resource Coordinator, Via Hope Program* and Michele Murphy-Smith, *Research Associate, Center for Social Work Research, University of Texas at Austin*
    - The Recovery-Focused Learning Community for FY 2011

In addition to hearing from the speakers listed above, team members from each Center provided a PowerPoint presentation to the group on their progress and experience with the PSLC throughout the nine-month process. Teams were requested to present on the agency's objective during the PSLC, the number of peer specialist positions at the beginning of the process (and how many of those positions were filled), what they expected from peer services at the beginning, the status of their organization at the beginning (as determined by the results of the RSA at Time 1), how many peer specialist positions they currently have (and how many of those positions are filled), the typical responsibilities of peer specialists, the current status of the organization (as determined by the results of the RSA at Time 2), the most challenging parts of participating in the PSLC, the benefits of the learning community process, the impact of the process on services provided to clients, what they would say to other Centers who are thinking about participating next year, any testimonials regarding the PSLC, and finally any contact information they were willing to share. The teams were also asked to update their application information, which would help inform the group about the activities that had occurred at their Center from the time of the application to right before the Wrap-Up Conference. Five of the 12 teams completed the information updates. Summaries of each Center's findings are presented in the section immediately following.

Summary of Findings by Center

Based on the data from applications, application updates, survey data, group and individual phone calls, and presentations at the Wrap-Up Conference, a summary of each team's success in achieving the two major aims of the PSLC and progress on activities throughout the Learning Community process is presented below.

Andrews Center

Andrews Center is a local mental health authority (LMHA) located in northeast Texas and serves the counties of Henderson, Rains, Smith, Van Zandt, and Wood. At the time of the application Andrews Center did not use peer specialists in their workforce. Andrews Center was interested in "developing a peer support system that would help consumers, families, and our community understand the significant of recovery and dissolve stigmas related to Mental Illness." When asked if the goal was to create, enhance, or expand the number of peer specialist positions in the agency, Andrews Center responded that they hoped to expand. Unfortunately, only 2 staff members responded to the RSA at Time 1 and no staff members responded at Time 2, therefore making it difficult to report on changes in this organization's recovery orientation across time. Andrews Center participated in one conference call and expressed some concern about the lack of resources to help with a recovery paradigm shift at their Center. Although Andrews Center did not attend the September Wrap-Up Conference, they did provide a PowerPoint presentation to Via Hope which was shared at the conference. Based on the information provided in this presentation, Andrews Center has added some peer partner positions to their agency since the beginning of the Learning Community. This organization also reported that they achieved some of their original objectives, which were to gain insight on developing a peer support program and to expand existing veteran and military family programs.

Overall Andrews Center achievements on aims of the PSLC:

- Added peer partner positions
- Gained insight on developing a peer support program
- One peer specialist trained through the Via Hope-sponsored CPS training

Austin Area Mental Health Consumers

Austin Area Mental Health Consumers (AAMHC) is unique in that it is the only consumer-operated service provider (COSP) participating in the PSLC. It falls under the LMHA service area of Austin Travis County Integral Care and is one of the largest COSPs in Texas, serving approximately 1,000 members. At the beginning of the PSLC, AAMHC reported approximately 25 peer specialist positions. These peer positions worked between 10 and 40 hours a week, worked with between five and 40 consumers at a time and worked as employees, contractors, and volunteers. Typical responsibilities of peer mentors include one-on-one counseling, hands-on technical training, staff development training, and program meetings. Peer specialists also worked as Return to Work Program Coordinators and provided individuals with assistance in creating resumes, job search training, and peer group work. Similar to Andrews Center, AAMHC had only eight staff members complete the RSA at Time 1 and no staff members at Time 2. Nevertheless, these eight respondents ranked the "Life Goals" domain the highest, followed by "Individually-tailored Services",

"Consumer Involvement and Recovery Education", "Choice – Rights and Respect", and finally "Diversity of Treatment Options." Because AAMHC is a unique organization compared to the other 11 agencies participating in the Learning Community, their rankings on the RSA domains are vastly different than the overall RSA domain pattern described in the sections above. AAMHC has expressed a concern with resources (i.e. loss of funding) and the lack of staff development training. They are strategically planning for sustainability by seeking new sources of funding. In addition to achieving their original goal of reviewing and developing "needs-specific" job descriptions, AAMHC has also been working on developing a job description for a recently created Program Manager position. On the monthly conference calls, AAMHC frequently commented on the fact that while the interaction with the Centers was helpful, most of the topics discussed were not particularly relevant to their Center or their needs.

Overall Austin Area Mental Health Mental Health Consumers Achievements on PSLC Aims:

- Developing a Program Manager job description
- At least 2 peer specialists trained through the Via Hope-sponsored CPS training

Bluebonnet Trails Community MHMR Center

Located in central Texas, Bluebonnet Trails Community MHMR Center serves the counties of Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson. At the beginning of the PSLC, Bluebonnet did not use peer specialists at their organization. This agency was 1 of the 6 Centers in which staff members completed the RSA at both time points (68 staff members at Time 1 and 16 staff members at Time 2). Bluebonnet's overall RSA score increased marginally from Time 1 to Time 2 from 3.50 to 3.52, respectively. Although the subscales "Consumer Involvement and Recovery Education" and "Diversity of Treatment Options" increased over time, the remaining 3 subscales (e.g., "Life Goals", "Choice – Rights and Respect", and "Individually-Tailored Services") declined from Time 1 to Time 2. However, decreases could be attributed factors such as a better understanding of what recovery orientation is or lower response rates at Time 2. The highest ranking subscale for Bluebonnet was "Life Goals" and the lowest "Consumer Involvement and Recovery Education" at both time points. On the one conference call that Bluebonnet Trails participated in, concerns with the funding and recruitment of peer specialist positions were expressed, in addition to the acceptance of peer specialists by the entire organizations. Bluebonnet received a site visit from Chris Martin at Recovery Innovations, with which they were extremely pleased. They would have liked to see the training offered earlier on in the PSLC process and would have liked to have had more staff members attend. At the end of the PSLC, Bluebonnet had at least 2 individuals working in a peer specialist position. In the areas where peer specialists have been implemented, the team has noticed a huge increase in consumer trust levels and consumer participation.

Overall Bluebonnet Trails Community MHMR Center Achievements on PSLC Aims:

- Addition of peer specialist positions
- Increase in consumer trust and participation
- At least 4 peer specialists trained through the Via Hope-sponsored CPS training

Burke Center

Burke Center is located in northeast Texas and serves the counties of Angelina, Houston, Jasper, Nacogdoches, Newton, Polk, Sabine, San Augustine, San Jacinto, Shelby, Trinity, and Tyler. Although

Burke Center did not use peer specialists at their organization at the time of the PSLC application, their objectives of the learning community for this agency were to implement peer provider services and create peer specialist positions within the local clinic (Nacogdoches). Staff members completed the RSA at both Time 1 (n=11) and Time 2 (n=5). While the overall RSA score and the "Consumer Involvement and Recovery Education" domain increased across time, the four remaining domains either decreased or remained the same. This organization participated in a majority of the monthly conference calls (6 out of 8) on which they discussed agency-wide changes in recovery culture and also concerns about identifying appropriate individuals to fill the peer specialist positions. In addition, Burke Center received an abbreviated (2 hours) site visit from Chris Martin at Recovery Innovations in May 2010. At the Wrap-up Conference, they stated that they have filled both peer specialist positions, therefore accomplishing the goals stated at the beginning of the PSLC process. Burke Center updated their application information and reported that one of their two peer specialists attended the CPS training sponsored by Via Hope.

Overall Burke Center Achievements on PSLC Aims:

- Filled two peer specialist positions
- One peer specialist trained through the Via Hope-sponsored CPS training

Center for Life Resources

Located in north central Texas Center for Life Resources provides mental health services to the counties of Brown, Coleman, Comanche, Eastland, McCulloch, Mills, and San Saba. This agency's statement of interest at the beginning of the PSLC was, "We do believe peer support is one of the greatest contributions to recovery because of peer ability to relate and connect to other consumers." Over the 9-month period of the learning community, Center for Life Resources went from using no peer specialists at their organization to creating two peer specialist positions, one of which is filled. Staff members completed the RSA at both time points (Time 1: n=37; Time 2: n=8) and saw an increase over time in the domains "Choice – Rights and Respect" and "Diversity of Treatment Options" and, unfortunately, a decrease in the other 3 domains and in the overall RSA score. Like most of the other LMHAs, Center for Life Resources ranked the "Choice – Rights and Respect" domain the highest and the "Consumer Involvement and Recovery Education" domain the lowest at both Time 1 and Time 2. This agency participated in 6 of the 8 monthly conference calls and displayed enthusiasm and excitement for the increased use of peer specialists. Center for Life Resources received a site visit from both Lori Ashcraft and Chris Martin of Recovery Innovations in May 2010. They described this training session as "outstanding" and "inspirational". On the individual call that took place in the month of August, Center for Life Resources reported purchasing the "Keeping Recovery Skills Alive" toolkit from Recovery Innovations at the site visit in order to spread recovery culture throughout the entire organization. At the Wrap-Up Conference in September they stated, "The response from the staff has been very positive and supportive." According to the application update, they currently have two peer specialist positions who provide both individual and group peer support services as well as providing recovery education to non-peer staff members.

Overall Center for Life Resources Achievements on PSLC Aims:

- Creation of two peer specialist positions, one of which is filled
- One peer specialist trained through the Via Hope-sponsored CPS training

Central Counties Center for MHMR Services

Central Counties Center for MHMR Services is located in north central Texas, just east of the Center for Life Resources service area. Counties served by this organization are Bell, Coryell, Hamilton, Lampasas, and Milam. On the application, this agency "recognized the value of peer support activities and has attempted to better develop peer provider positions". However, they did not use peer specialists in their Center at the beginning of the PSLC. Staff members did not complete the RSA survey at Time 2. However, the ranking of RSA domains followed the same pattern as the overall rankings, with "Choice – Rights and Respect" being ranked the highest, followed by "Life Goals", "Individually-Tailored Services", "Diversity of Treatment Options", and finally, "Consumer Involvement and Recovery Education." On one of the 3 conference calls Central Counties participated in, they stated encountering some difficulty in recruiting individuals to fill the peer specialist positions. At the end of the PSLC, this agency had employed one peer specialist. According to their updated application, this peer specialist was trained by Via Hope and is responsible for maintaining the consumer clothes closet, providing community presentations, and assisting the Mobile Crisis Outreach Team.

Overall Central Counties Center for MHMR Services Achievements on PSLC Aims:

- Addition of one peer specialist, who is actively involved within the community
- One peer specialist trained through the Via Hope-sponsored CPS training

Heart of Texas Region MHMR Center

Located in north east Texas, just south of Dallas, Heart of Texas Region MHMR Center provides mental health care services to Bosque, Falls, Freestone, Hill, Limestone, and McLennan counties. At the time of the PSLC application, Heart of Texas reported having 4 available peer specialist positions (both employee and volunteer positions). They noted that they were extremely impressed with the outcomes of the peer specialist services. Based on the responses of 11 staff members on the RSA at Time 1, Heart of Texas ranked the RSA domains in the same manner as most of the other Centers (e.g., "Choice – Rights and Respect" being ranked the highest, followed by "Life Goals", "Individually-Tailored Services", "Diversity of Treatment Options", and finally, "Consumer Involvement and Recovery Education.") Although they did not attend the Wrap-Up Conference in September, they reported on the individual call in August that they lost the funding needed to hire peer specialists as originally intended. As a result, they used only one volunteer peer specialist as of August.

Overall Heart of Texas Region MHMR Center Achievements on PSLC Aims:

- Due to a loss of funding, the 4 peer specialist positions available at the beginning of the PSLC have been reduced to one volunteer peer specialist upon the close of the PSLC
- One peer specialist trained through the Via Hope-sponsored CPS training

Hill Country Community MHMR Center

Hill Country Community MHMR Center is located in east central Texas and serves the counties of Bandera, Blanco, Comal, Edward, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real. Schleicher, Sutton, Uvalde, and Val Verde. This LMHA has a history of using peer specialists funded by state general revenue and used the most peer specialists within their organization compared to all other LMHAs. Therefore, their objectives were to develop the workforce into a recovery-focused service delivery model and to secure training for the individuals holding peer specialist positions. Staff members completed the RSA at both Time 1 (n=40) and Time 2 (n=14). Not only did the total RSA score increase across time, but so did all five RSA domains. The domain that increased the most was the "Consumer Involvement and Recovery Education" which speaks to the impact peer specialists can have within an organization. Hill Country participated on 5 of the 8 monthly phone calls and discussed the ways in which peer support and recovery have been incorporated into their organization (i.e., hanging up "hope murals" and including peer support services into the new employee orientation training). Hill Country received a site visit from Chris Martin of Recovery Innovations in June 2010. They reported that people who were not formerly knowledgeable about the role of peer specialists responded very well to the training. On the August conference call they said they had enhanced the peer specialist positions they already had and were looking at the possibility of adding 3 more peer specialist positions.

Overall Hill Country Community MHMR Center on PSLC Aims:

- Organizational paradigm shift in recovery orientation
- Creation of 3 additional peer specialist positions
- At least 2 peer specialists trained through the Via Hope-sponsored CPS training

MHMR of Tarrant County

MHMR of Tarrant County is located in the Dallas area and provides mental health services to just Tarrant County. At the time of the application, this organization employed 2 peer specialists at their Center. These individuals had received peer specialist training from the Depression and Bipolar Support Alliance (DBSA). The objectives of participating in the PSLC were to "create increased awareness and knowledge of the recovery process and the role peer support plays in partnership with traditional treatment models in the pursuit of wellness in persons with mental health diagnoses" and "to identify current strengths and impediments to this process and to develop a plan for maximizing the successful integration of recovery and peer support into agency services". Staff members completed the survey at both Time 1 (n=62) and Time 2 (n=57) and results were similar to those of Hill Country Community MHMR Center. All RSA domains increased with time, as the total RSA score. Additionally, the domain "Consumer Involvement and Recovery Education" increased the most compared to all other RSA domains. Tarrant County participated in 7 of the 8 conference calls. On the conference calls, Tarrant County requested information regarding how to incorporate the recovery paradigm into other ancillary departments within the organization. This agency received a site visit from Lori Ashcraft and Chris Martin of Recovery Innovations in May 2010. Although they found that this training gave more legitimacy to what they were doing in terms of implementing peer support services, they felt some of the concepts presented were not particularly relevant to their Center. At the Wrap-Up Conference, it was reported that the organization now has 5 peer specialist positions, 4 of which are filled. They also reported that peer support has been accepted by both the direct care and non-direct care staff.

Overall MHMR of Tarrant County Achievements on PSLC Aims:

- Increased support of peer specialist services throughout the organization
- Creation of 3 additional peer specialist positions, 2 of which are filled

Metrocare Services

Metrocare Services is the only community mental health Center (CMHC) participating in the PSLC and provides services to just Dallas county. At the beginning of the PSLC, Metrocare employed 4 peer specialists at their organization. Their objectives over the 9-month period were to certify their peer specialists, increasing their tools in order to facilitate recovery, and increase peer inclusion. At Time 1, 136 staff members from Metrocare completed the RSA and 27 completed it at Time 2. They were one of three Centers to increase in all five RSA domains, as well as the total RSA score, across time. Metrocare participated in 5 of the 8 monthly conference calls and discussed how they have included peers into more Center activities over time. In addition, they have noticed changes in the way people look at individuals with mental illnesses and have even had consumers inquire about becoming peer specialists. At the end of the PSLC, Metrocare had 10 peer specialist positions, 5 of which are filled. This organization completed the application update and reported that 3 of these peer specialists work full-time and 2 work part-time and are funded through Managed Care/Medicaid.

Overall Metrocare Services Achievements on PSLC Aims:

- Addition of 6 peer specialist positions, 1 of which is filled
- At least 4 peer specialists trained through the Via Hope-sponsored CPS training

Tri-County MHMR Services

Located in east Texas, Tri-County MHMR Services provides mental health care services to Liberty, Montgomery, and Walker counties. One peer specialist was employed by Tri-County MHMR services at the time of application. This agency was interested in expanding their peer services program by certifying their peer specialists and learning how to utilize peer specialists to provide maximum benefits to the consumers. Although no staff members at Tri-County completed the RSA at Time 2, all RSA domains and the total RSA score were either above or the same compared to the overall Center averages. They participated in 5 monthly conference calls and expressed a concern that some of their CPSs were not sure how to apply the training to their work with consumers. Although Tri-County MHMR services had not added or expanded the amount of time their peer specialist works (as of August), they changed to role to include more one-on-one sessions and adjusted the way that she conducts groups. Tri-County received a site visit from Chris Martin of Recovery Innovations in June 2010 and was very happy with it, stating that it should be a standard component of the PSLC. This organization was one of three Centers that did not participate in the Wrap-Up Conference in September.

Overall Tri-County MHMR Services Achievements on PSLC Aims:

- Enhancement of peer services through an increase in one-on-one peer support sessions and a modification in the way peer support groups are conducted
- One peer specialist trained through the Via Hope-sponsored CPS training

Tropical Texas Center for MHMR

Tropical Texas Center for MHMR is located in south Texas and serves the counties of Cameron, Hidalgo, and Willacy. Although Tropical employed 3 peer specialists at the time of the application, they stated that they have had some difficulty hiring and retaining peer support specialists. No staff members completed the RSA at Time 2, however based on the responses of 7 staff members at Time 1, Tropical ranked higher than the overall Center average on all RSA domains, including the total RSA score. The "Choice – Rights and Respect" domain was ranked the highest and the "Consumer Involvement and Recovery Education" domain ranked the lowest. Tropical was highly participatory in the monthly conference calls and did not miss a single conference call. On the calls, Tropical discussed the inclusion of the peer specialists in staff meetings and on treatment teams has been relatively well received by other staff members, but still think there is room for improvement in changing the recovery culture. Tropical was pleased with the site visit received from Chris Martin at Recovery Innovations. On the August individual call, it was noted that staff members who had not previously had contact with peer specialists began implementing things that they learned at the training immediately. At the Wrap-Up Conference, this agency reported that they have 2 peer specialist positions within their organization, both of which are filled. These positions are funded similarly to other employees, such as through state funds and Medicaid reimbursement, according to their team application update.

Overall Tropical Texas Center for MHMR Achievements on PSLC Aims:

- Building awareness around recovery culture
- Funding of two peer specialist positions through state funds and Medicaid reimbursement
- One peer specialist trained through the Via Hope-sponsored CPS training

Conclusions, Recommendations and Future Directions

PSLC Intent and Outcomes

The intent of the PSLC was for participating organizations to hire peer specialists and improve the recovery orientation of the organization. Through this process, Via Hope provided mental health agencies across the state of Texas an opportunity to share resources and information with one another in order to establish peer support programs and integrate peer specialists into their respective workforces. Regarding that intent, the overall outcomes of the PSLC are considered positive.

- Of the 12 organizations participating in the PSLC, 1 created, 5 enhanced, and 6 expanded peer specialist positions in their organizations.
- When examining RSA scores across time the overall RSA average increased marginally from Time 1 to Time 2, indicating a potentially positive impact of the PSLC on recovery orientation. Furthermore, 4 of the 5 domains increased across time, with the "Consumer Involvement and Recovery Education" domain increasing the most from Time 1 to Time 2, suggesting a possible increase in the extent to which consumers are involved in various agency activities.
- Comments disclosed during the individual and conference calls and from the PSLC Wrap-Up Conference indicate an overall high level of satisfaction with and enthusiasm for the learning community process.
- Of the 9 teams that put together a PowerPoint presentation following Via Hope's outline, 8 explicitly stated they would recommend the PSLC to other Centers who are considering participating in the future.

Visibility of Learning Community

The PSLC was the first of its kind in Texas and received highly positive feedback from the participating Centers. There were also lessons learned from this PSLC that can be used to improve future learning communities.

- Only 10 of the 38 LMHAs (a little over 25%) across the state of Texas turned in applications to participate in the PSLC. This modest application rate indicates either a lack of knowledge or a lack of interest in the learning community.
    - *Recommendation: Enhance future learning community marketing and/or visibility strategies.*
- The PSLC was only advertised to the LMHAs and COSPs and not the State Psychiatric Hospitals, which have similar needs.
    - *Recommendation: Market the PSLC to state hospitals in addition to the LMHAs as these organizations have shown an interest in integrating peer specialists into their organizations by sending individuals to Via Hope's Peer Specialist Training and Certification program.*
    - *Recommendation: Due to the very different nature of the organizations, consider facilitating a separate learning community specific to the needs of COSPs.*

Executive Sponsorship

Executive-level participation is vital to the success of a Peer Specialist Learning Community and to the integration of peer specialists within an organization.

- The Executive Director (or key staff person with authority to implement the necessary changes) was required to complete the application but not required to fully participate in the PSLC.
    - *Recommendation: The Executive Director or an individual in a leadership position should attend the Learning Community Kick-Off Conference and participate more fully at some level in the PSLC to demonstrate organizational buy-in.*

Participation of Centers

To gain the benefits associated with collaborative learning, it is important for participants to be present and engaged in learning community activities.

- Participation rates on the monthly group conference calls were relatively low, with an average participation rate of just over 50%. Conversely, participation rates on individual calls were higher, with 83% of centers participating.
    - *Recommendation: Prior to calls, send a reminder of the call date and time and an agenda to help teams prepare for discussion topics.*
- Participation rates on the two individual calls were high at 83% (10 out of the 12 Centers) because the individual calls were scheduled during convenient times for each team.
    - *Recommendation: Future learning communities should attempt to accommodate schedules for higher participation on group calls.*
    - *Recommendation: Build rapport and tailor the provision of training and technical assistance to the needs of individual Centers by increasing the frequency of individual calls.*
- Only 4 of the 12 participating Centers turned in an implementation plan to Via Hope.
    - *Recommendation: Require teams to turn in completed implementation plans or any other documents corresponding to learning community activities.*
- Throughout the PSLC, staff from the University of Texas Center for Social Work Research (UT-CSWR) collected data and shared data from the application, RSA staff surveys, individual and conference calls, and final presentations at the Wrap-Up Conference.
    - *Recommendation: In future learning communities, data collected and reported back to Centers could be used by Centers to identify strengths and areas for improvement as well as track progress on goals.*

Geographic, Ethnic, and Cultural Diversity of Texas

Texas is a unique state, in that it is not only geographically expansive, but also exceptionally diverse in terms of ethnicity and culture.

Texas is unique in its geographic, ethnic, and cultural diversity.

- Some Centers expressed interest in collaborating with Centers that are closer geographically.
    - *Recommendation: Facilitate regionalized phone calls among Centers so that the teams could assist one another in addressing certain issues that may be particular to the region, for example, Hispanic culture within South Texas or veterans issues in regions with military facilities.*

    - *Recommendation: Provide regionalized phone calls for peer specialists to build a peer support network and, hopefully, prevent burnout, as they are often working on their own as agents of change within their respective Centers.*
- As another method to enhance support for both providers and peer specialists, Via Hope and the Texas Department of State Health Services created an on-line forum (MHTonline.org) where team members can exchange and share information relating to the learning community or other topics..
    - *Recommendation: Enhance marketing strategies for the on-line forum (MHTonline.org) to increase the number of communication channels available to teams.*

Site Visits

Chris Martin and Lori Ashcraft of Recovery Innovations provided recovery orientation training to 7 of the 12 participating Centers.

- All Centers expressed a high degree of appreciation for the training provided by Recovery Innovations and several indicated that they would have liked to see the training offered earlier in the learning community process.
    - *Recommendation: Offer site visits within the first few months of the learning community to serve as the basis for increasing recovery culture throughout the Center.*
    - *Recommendation: Clarify details of site visit (i.e., which staff members to invite to attend) before the site visit.*
- Although the recovery training provided by Recovery Innovations was extremely well-received, it was nearly identical across the 7 Centers.
    - *Recommendation: Work in conjunction with Recovery Innovations (or another training organization) to provide training tailored to the needs of each Center.*

Focus on Recovery Orientation

According to Watzlawick and collegues (1974) organizational change can be categorized into first- and second-order change (as cited in Perkins et al., 2007). First-order change refers to change that occurs incrementally, such as altering a specific area of the agency while not addressing any underlying structural issues. On the other hand, second-order or transformative change is described as a "paradigm shift" within an organization, in which the entire agency transforms.

- The goal of this year's PSLC was to facilitate first-order change by helping the Centers integrate peer specialists into their workforce. The majority of the PSLC activities revolved around integrating peer specialists into the Center workforce. During the PSLC, Centers acknowledged the importance of a recovery orientation/culture at the organizational level as important to the successful integration of peer specialists. Unfortunately, it was revealed that the some CPSs were not always well-received by non-peer staff members for a variety of different reasons, such ethical/boundary and confidentiality issues, lack of resources (both personnel to supervise CPSs and funding to pay for these positions), relapse potential of these employees, etc.
    - *Recommendation: Change the emphasis of next year's learning to be recovery focused with the integration of peer specialists included as part of that change rather than the focus of the change.*
      Note: Via Hope took this recommendation into consideration and is currently planning a "Recovery-Focused Learning Community" for FY 2011 with the integration of peer specialists as a main component.

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Appendix A:
Announcement Requesting Applications for Via Hope's Peer Specialist Learning Community

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

P.O. Box 149347
Austin, Texas 78714-9347
1-888-963-7111
TTY: 1-800-735-2989
www.dshs.state.tx.us

DAVID L. LAKEY, M.D.
COMMISSIONER

To: Local Mental Health Authority (LMHA) Executive Directors

From: Sam Shore, Director, Mental Health Transformation and Behavioral Health Operations

Date: November 10th, 2009

Re: Peer specialist learning community

Dear Executive Director:

Background:
Last Thursday, at the Executive Director's consortium meeting, I had the opportunity to distribute materials and present information about an upcoming learning community to support the development of peer specialists in LMHAs. You may have recently heard about Via Hope Texas Mental Health Resource, but are unsure what this is. Via Hope is a new training and technical assistance Center designed for consumers, family members, youth consumers, and professionals. It was established as part of the Texas Mental Health Transformation initiative in partnership with the Mental Health and Substance Abuse Division here at DSHS as well as NAMI (National Alliance for Mental Illness)and MHAT (Mental Health America of Texas) .

At our direction, Via Hope is developing a training and certification process for peer providers. Peer providers, also known as peer specialists, are adults in recovery from mental illness who use their lived experience to help other consumers make progress in their own recovery. Certified peer specialists have gone through special training and have passed a certification exam to demonstrate their competence in several practical areas.

We strongly believe that peer providers will become an indispensible part of the mental health workforce over the next few years. Several of the LMHAs have begun using peer specialists, and others have expressed an interest in using them but are not sure how, or the best way, to go about it. In conjunction with the training and certification program being developed by Via Hope, we will provide technical assistance to LMHAs to facilitate successfully adding certified peer providers to your staff roster. As such we have developed a process we call the "learning community".

Process:
The learning community, which will kick off with the conference in January, is an opportunity to interact with expert speakers and to learn from each other. The learning community is an innovative process that will take the LMHA delegates, over a nine month period, through the process of how to hire peer specialists, how to consider the system options for the change in organizational structure, how to manage the culture change and so on.

The goals of the learning community are to demonstrate a better understanding of how peers can be integrated in the workplace to promote recovery and to show substantial progress of the LMHAs peer specialist implementation plan. LMHA team members will walk away from the kick-off conference with an executable implementation plan based on the needs of your Center. Beyond the conference, the learning community will be supported through monthly teleconference calls and webinars ending with a congress.

What are the benefits?

- Kick off conference with an amazing group of nationally recognized speakers
- An opportunity to think creatively about your operational system and its recovery orientation
- Time away from the office to plan, to be creative and develop implementation strategies
- Ongoing technical support and assistance, including monthly conference calls among learning community members and expert speakers
- Data collection and analysis to measure the impact of learning community delegation.

Timeline:

- **Informational conference call:**
  - **Tuesday, 11:30-12:30, November 17th**

- **Kick off conference January 7th - 9th!**

- **Application due date: NOVEMBER 24TH!!**

Call in number: (866) 258-0959, meeting room number: *7915082*, please note the star key must be entered before and after the room number.

Funding:
There is currently available funding (travel and lodging) to support a delegation of up to ten 4 member LMHA teams to participate in the initial conference which will be held in Austin, January 7th-9th.

For additional information please contact Wendy Latham at wendy.latham@dshs.state.ts.us or 512.206.5249.

Thank you.

CC: Mike Maples, Assistant Commissioner, Mental Health and Substance Abuse Services
Ross Robinson, Program Services Section, Community Mental Health and Substance Abuse

Appendix B:
Peer Specialist Learning Community Application

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HEALTH RESOURCE

Peer Specialist Learning Community Application

The Peer specialist Learning Community is a nine month program designed to guide a local mental health provider through the process of developing a peer specialist program and successfully incorporating it in your ongoing operations. At the end of the nine month process, the successful applicant will be expected to:

- Understand the process of hiring and sustaining a peer specialist
- Demonstrate substantial progress of the LMHA peer specialist implementation plan

Developing a program that enables you to use peer specialists effectively requires much more that simply creating one or more new positions on the organizational chart. The Learning Community will identify the issues that you need to be aware of and guide you through the necessary steps. You will be provided with resource materials to help in the process. More importantly, you will be part of a group of colleagues working on the same issue and providing support for each other.

Participation in the Learning Community also requires a level of commitment from each Center accepted to participate. This commitment begins with Executive sponsorship of the team. The enclosed application form must be signed by the Center's Executive Director. If the team lead is someone other than the executive director, that individual must be delegated authority to implement the changes that are identified during the process.

Via Hope Texas Mental Health Resource is a collaboration between the Department of State Health Services, Mental Health America of Texas, and the National Alliance for Mental Illness of Texas. Via Hope is a training and technical assistance center for consumers, family members, youth consumers, and professionals. It provides classroom and on-line training courses in a wide variety of mental health subject areas in addition to peer specialist training and certification.

Via Hope is a collaborative effort of Mental Health America of Texas and the National Alliance on Mental Illness of Texas

c/o Mental Health America of Texas, 1210 San Antonio Street, Suite 200, Austin, Texas 78701 512.454.3706
c/o National Alliance on Mental Illness of Texas, Fountain Park Plaza III, 2800 S. I-35, Ste 140, Austin, Texas 78701 512.963.2000

MHA Mental Health America of Texas

NAMI TEXAS

The application contains four parts. Part One is a description of the Learning Community and the activities you are committing to if your application is accepted. Part Two is a brief description of the resources that will be provided to Learning Community participants. Part Three is the information you must provide that will be used to evaluate your application. Part IV is an Agency Readiness Self Assessment for the Use of Peer Specialists. Both parts III and IV must be completed and returned by email. You can enter information directly into this PDF file and save it.

Section One: Components of the Peer Specialist Learning Community

1. A team will have a minimum of two members, and most will have four to six members, depending on the size of the Center. The team must include either the Executive Director, or a key staff person with delegated authority to implement the necessary changes. Executive sponsorship of this program is critical to its success. The team must also include a minimum of one consumer, either a current peer specialist or a consumer with aspirations to become a peer specialist. Active consumer involvement in the development of the implementation plan is critical to its' success.

   Other types of staff positions that may be represented include individuals from the financial office, human resources, and clinical operations.

2. Each Center will conduct an on-line staff survey, in December, 2009.

3. Teams will participate in a Learning Community track at the USPRA conference in Austin on January 7-9, 2010. The track will include an orientation to the program and workshops during which you will begin developing your implementation plan.

4. Each Center will conduct a consumer survey within 45 days following the January conference.

5. Peer specialists currently employed in the Centers, or consumers with job offers from the Center, will apply to attend the Via Hope peer specialist certification training in March, 2010. Attendance at the certification training is limited, and applications from Peer specialists currently employed by the Centers will have priority consideration for this training.

6. Teams will participate in monthly conference calls and Webinars with other teams to share their progress and experience.

7. Each Center will conduct a follow-up staff survey approximately six months from the January conference.

8. Teams will attend a second implementation conference in summer, 2010, to share their experiences with the other teams, and provide an example for other Centers that are interested in beginning a program. This conference may be held in conjunction with the Council's annual conference.

9. Each Center will conduct a follow-up consumer survey within 45 days after the summer 2010 conference.

Section Two: Resources to be Provided to Participating Teams

1. A stipend will be provided to offset all or most of the travel and lodging costs for the teams to travel to the conference in Austin.

2. Each team will be provided an implementation toolkit to help plan and develop their program. The readiness assessment and staff survey are components of the toolkit that are completed in advance of the conference. The rest of the toolkit will be used at the January conference.

3. Nationally recognized experts in the use of peer specialists as well as Texas Centers with experience using peer specialists will conduct the workshops at the January conference.

4. Via Hope will facilitate monthly conference calls. In addition, we will provide an on-line forum where team members can exchange information and ask each other questions whenever they want.

Section Three: Applicant Information

Enter all of the information requested. There are no correct or incorrect answers. The purpose of this information is for the Learning Community facilitators to better understand the organizations that apply.

1. Name of Center:

2. Name and title of team lead:

3. Names, positions, and job titles (if applicable) of all other team members:

4. Provide a statement of executive sponsorship of this program, including commitment to participate in all of the activities listed in Section One and an appropriate delegation of authority to the team lead:

5. Statement of Interest: Describe why your Center is interested in participating in this program, and how your participation will contribute to the overall expansion and use of peer supports in Texas:

Note: The Learning Community does not give preference to Centers that already use peer specialists. However, for those that do use them, we need to know some information about these positions. If you answer yes to item 6, answer items 7 through 11. If you answer no, skip to item 12. Everyone must complete item 13.

6. Do you currently use peer specialists in your Center?
   a. Yes _____ No: _____

7. If yes, describe:
   a. How many positions you have

   b. How many hours/week each one works

   c. Whether each one is an employee, independent contractor, or volunteer

   d. How long you have had each position, and

   e. Approximately how many consumers each specialist works with at a time.

8. If you use peer specialists, describe what formal training, if any, each of them has received.

9. If you use paid peer specialists, what is the source of funding for these positions?

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10. If you currently use peer specialists, describe their responsibilities.

11. If you currently use peer specialists, how are they supervised (i.e., by whom and with what frequency)?

12. If you do not currently use providers, describe how you think you would use them in your center.

13. Attached is a Readiness Self Assessment Form. This form must be completed and returned with your application.

_____ _____

Signature of Executive Director Date

For: _____

Name of Agency

Completed applications must be returned no later than November 20, 2009 to: info@viahope.org (Using the subject line CPS LC Application)

Please fax a copy of this page with the Executive Director's signature to 512-454-3725, Attention: Via Hope.

Please mark an "X" over the circled number that best indicates the extent to which you agree or disagree with each of the following statements.

Leadership	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We communicate a clear commitment to the recovery model from the top of the organization.	①	②	③	④	⑤
The concept of recovery is included in our mission statement.	①	②	③	④	⑤
The leaders of this organization endorse recovery consistently in active, involved, and visible roles.	①	②	③	④	⑤
We view peer support as an essential part of the recovery model.	①	②	③	④	⑤
We have secure funding for the use of peer specialists.	①	②	③	④	⑤
Culture Change	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We endorse the concept of recovery in new employee orientation.	①	②	③	④	⑤
We describe the role of peer specialists in new employee orientation.	①	②	③	④	⑤
We provide recovery-based educational trainings to staff.	①	②	③	④	⑤
We use people–first language throughout the agency.	①	②	③	④	⑤
We develop recovery-based individual care plans with consumers.	①	②	③	④	⑤
We create recovery-based materials including newsletters, consumer satisfaction surveys, and documentation audits.	①	②	③	④	⑤
We provide sufficient administrative support to staff to implement change.	①	②	③	④	⑤
We have a volunteer consumer advisory council of people served by us to partner with staff in policy making and hiring.	①	②	③	④	⑤
Planning and Preparation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Our peer specialists are permanent staff positions with the same benefits as other employees in similar classifications.	①	②	③	④	⑤
We use standard job titles and job descriptions for peer specialists.	①	②	③	④	⑤
The responsibilities of peer specialists include service provision, ongoing educational efforts with staff, and providing a consumer voice in management decision making.	①	②	③	④	⑤
We train supervisors how to work specifically with peer specialists, including how to apply peer specialist ethics.	①	②	③	④	⑤
We follow an established, clear policy on dual relationships (consumer/peer specialist and other staff).	①	②	③	④	⑤

Recruitment	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We have an ongoing process to identify and recruit potential candidates for peer specialist positions.	①	②	③	④	⑤
Our peer specialists complete a standardized training and certification program with a code of ethics and continuing education requirements.	①	②	③	④	⑤
We have a policy on whether or not to hire consumers who received services from this organization, based on a rational study of the overall situation.	①	②	③	④	⑤
Hiring and Supervision	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
We hire peer specialists with substantive, meaningful lived experience with mental illness so their insights can be shared with providers and other consumers.	①	②	③	④	⑤
We hire peer specialists who demonstrate recovery success to effectively communicate that recovery is possible.	①	②	③	④	⑤
We have reviewed our agency personnel policies to ensure there are no unintended obstacles to hiring peer specialists.	①	②	③	④	⑤
We provide regular quality supervision of peer specialists.	①	②	③	④	⑤
We regularly evaluate job performance of peer specialists as we do other staff positions.	①	②	③	④	⑤
Follow Through	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
We evaluate the outcomes of programs and activities that include peer specialist participation.	①	②	③	④	⑤
We provide opportunities for career advancement, promotion, and meaningful salary increases to peer specialists.	①	②	③	④	⑤
We maximize peer specialist inclusion in ongoing staff support activities.	①	②	③	④	⑤

Appendix C:
Peer Specialist Learning Community Agency Recovery Profile Example

Recovery Profile for
(NAME OF CENTER)

Based on the responses of **73**[*] staff members at your Center, the following profile summarizes the degree to which your Center provides recovery-oriented practices in a recovery-supportive environment. The specific items your staff rated were developed to assess staff attitudes towards recovery, as well as to reflect objective practices associated with the principles of recovery, such as fostering individually defined life goals for consumers, involving consumers in management meetings and staff education, providing consumers choice and self-determination, linking consumers to peer mentors and support, and assisting consumers to become involved in non-mental health activities.

This recovery profile identifies strengths and areas for improvement for your Center, and summarizes your staff's average responses as compared to the average responses for all Centers participating in the Peer Specialist Learning Community.

Strengths

5 Highest Rated Items by respondents at your Center

- Agency staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices.
- Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs.
- Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.
- Agency staff believe that people can recover and make their own treatment and life choices.
- The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations.

Other Strengths (in comparison to other Centers)

No specific items received substantially higher ratings at your Center as compared to responses from other Centers participating in Peer Specialist Learning Community.

Areas for Improvement

5 Lowest Rated Items by respondents at your Center

- Persons in recovery are involved with facilitating staff trainings and education programs at this agency.
- People in recovery are regular members of agency advisory boards and management meetings.
- This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose.
- People in recovery work along side agency staff on the development and provision of new programs and services.
- Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.

Other Areas for Improvement (in comparison to other Center)

No specific items received substantially lower ratings at your Center as compared to responses from other Centers participating in Peer Specialist Learning Community.

[*] Last completed survey received on January 25, 2010.

Summary of Average Responses

Using a 5 point scale where 1 indicates strongly disagree and 5 indicates strongly agree, your staff were asked to rate the extent to which they felt that the following items reflect the activities, values, and practices of your agency. Your staff's average responses are listed below, as are the overall average responses across all Centers participating in the Peer Specialist Learning Community. *Note: Higher averages indicate stronger agreement.*

Factors and Items	(NAME OF CENTER)	All Centers
Life Goals	*3.77*	*3.81*
Staff actively assist people in recovery with the development of career and life goals that go beyond symptom management and stabilization.	3.81	3.88
Staff routinely assist individuals in the pursuit of educational and/or employment goals.	3.82	3.90
The role of agency staff is to assist a person with fulfilling their individually-defined goals and aspirations.	3.97	4.16
Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	4.16	4.05
Procedures are in place to facilitate referrals to other programs and services if the agency cannot meet a person's needs.	4.16	4.08
Staff play a primary role in helping people in recovery become involved in non-mental health/addiction related activities, such as church groups, special interest groups, and adult education.	3.66	3.72
Staff use a language of recovery (i.e. hope, high expectations, respect) in everyday conversations.	3.81	3.80
Agency staff believe that people can recover and make their own treatment and life choices.	4.06	4.04
The achievement of goals by people in recovery and staff are formally acknowledged and celebrated by the agency.	3.21	3.33
Staff and agency participants are encouraged to take risks and try new things.	3.21	3.22
Staff are knowledgeable about special interest groups and activities in the community.	3.70	3.71
Consumer Involvement and Recovery Education	*2.94*	*3.16*
People in recovery are regular members of agency advisory boards and management meetings.	2.69	2.98
People in recovery work along side agency staff on the development and provision of new programs and services.	2.85	2.95
Persons in recovery are involved with facilitating staff trainings and education programs at this agency.	2.58	2.88
This agency provides structured educational activities to the community about mental illness and addictions.	3.00	3.20
People in recovery are routinely involved in the evaluation of the agency's programs, services, and service providers.	3.10	3.18
Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup).	3.24	3.48
This agency provides formal opportunities for people in recovery, family members service providers, and administrators to learn about recovery.	3.10	3.44
The development of a person's leisure interests and hobbies is a primary focus of services.	3.00	3.15

Factors and Items	(NAME OF CENTER)	All Centers
Diversity of Treatment Options	*3.27*	*3.35*
This agency actively attempts to link people in recovery with other persons in recovery who can serve as role models or mentors by making referrals to self-help, peer support, or consumer advocacy groups or programs.	3.09	3.48
Criteria for exiting or completing the agency are clearly defined and discussed with participants upon entry to the agency.	3.45	3.52
People in recovery are given the opportunity to discuss their sexual and spiritual needs and interests.	3.70	3.67
This agency provides a variety of treatment options (i.e., individual, group, peer support, holistic healing, alternative treatments, medical) from which agency participants may choose.	2.84	3.17
Groups, meetings, and other activities can be scheduled in the evenings or on weekends so as not to conflict with other recovery-oriented activities such as employment or school.	2.94	2.95
At this agency, participants who are doing well get as much attention as those who are having difficulties.	3.51	3.31
Choice -- Rights and Respect	*3.96*	*3.94*
Agency staff do not use threats, bribes, or other forms of coercion to influence a person's behavior or choices.	4.66	4.55
People in recovery have access to all their treatment records.	3.80	3.65
Staff at this agency listen to and follow the choices and preferences of participants.	3.87	3.83
People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work.	3.82	3.76
Progress made towards goals (as defined by the person in recovery) is monitored on a regular basis.	3.96	4.09
Most services are provided in a person's natural environment (i.e., home, community, workplace).	3.64	3.76
Individually-tailored Services	*3.47*	*3.60*
Helping people build connections with their neighborhoods and communities is one of the primary activities in which staff at this agency are involved.	3.85	3.85
This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs.	3.60	3.60
This agency provides education to community employers about employing people with mental illness and/or addictions.	3.00	3.27
All staff at this agency regularly attend trainings on cultural competency.	2.99	3.31
Every effort is made to involve significant others (spouses, friends, family members) and other natural supports (i.e., clergy, neighbors, landlords) in the planning of a person's services, if so desired.	3.91	3.95
Summary Score	*3.50*	*3.59*

Appendix D:
Windows to Wellness Conference Schedule

WINDOWS TO WELLNESS CONFERENCE SCHEDULE

Thursday, January 7, 2010

9:00 – 12:00	WINDOWS TO WELLNESS REGISTRATION
1:00 – 2:30 PM	Outreach and Engagement Theory and Practice: Greg Gibson, South Park A
	Connecting Patients with Dual Disorders; J. Scott Thornton and Michaelanne Hurst, South Park B
	Job Descriptions and Responsibilities: Pat Nemec and Lyn Legere, Conference Center
2:30 – 3:00 PM	Break
3:00 – 4:30 PM	Windows to Wellness Welcome from: USPRA's Marcie Granahan. Organizational Culture and Staff Attitudes on Recovery Keynote Address: Dan Fisher, OMNI A, B, C
4:30 – 6:00 PM	Reception with Exhibitors, The Oaks

Friday, January 8, 2010

6:30 – 7:30 AM	Morning Yoga, Room 102
7:00 – 8:00 AM	Continental Breakfast, The Oaks
7:00 – 5:00 PM	REGISTRATION
8:00 – 9:30 AM	Larry Frick Overview of Carter Summit, Omni A, B, C
9:30 – 10:00 AM	Break with Exhibitors, The Oaks
10:00 – 11:30 AM	Putting the 'Human' in Human Resources: Universal policies to support peer and non-peer staff: Peggy Swarbrick, Lyn Legere and Pat Nemec, Conference Center
	Teaching Recovery to Professionals: Gareth Fenley, Omni A, B
	Empowerment: Dan Fisher, Omni C
11:30 – 1:00 PM	Wellness Coaching: Peggy Swarbrick Keynote Luncheon Speaker, Omni D
1:00 – 2:30 PM	Financial Sustainability: Larry Frick, Conference Center
	Mindfulness Methods with Veterans Having Serious Mental Illnesses: Wayne Gregory and Ivy Ickes, Omni A, B
	Achieving Recovery through a Focus Theory Model: Janet Paleo, Omni C
3:00 – 4:30 PM	Mind Your Language: The Appropriate Use of Language in the Field of Mental Health: Sarah Wilkinson, Tammy Heinz, Stephanie Bryant, Conference Center
	Wellness and Recovery: Lori Ashcraft, Omni A,B

	Recovery Relationships: Creating and maintaining healthy relationships, Stephen Harrington, Omni C
4:30 – 5:30 PM	Reception with Exhibitors

Saturday, January 9, 2010

6:30 – 7:30 AM	Morning Yoga
8:00 – 9:00 AM	Continental Breakfast, Room 102-104
9:00 – 10:30 AM	Workforce Development for Certified Peer Providers: Lori Ashcraft, Omni C
	USPRA Multicultural Principles: Pat Nemic, Room 102
	Connecting the Dots: Peer-to-peer connections that pay off: Stephen Harrington, Room 104
10:00 – 10:45	BREAK
10:45 – 12:15 PM	Wrap Up Session- Gateway to the Future, Conference Center
	NAMI Texas: In Our Own Voice, Room 102
	Advance Directive's for Mental Health Treatment: An Empowering Legal Document: Rita Brooks, Room 104

Appendix E:
Peer Specialist Learning Community Implementation Toolkit

Certified Peer Specialist Learning Community

Implementation Toolkit

Volume 2

Kick Off Conference

January 7-9, 2010

Table of Contents

Results of Conference Pre-Work

Agency Readiness Assessment

As part of your application for the Learning Community, you completed an Agency Readiness Assessment for the use of peer specialists that identified things that may need to be changed or developed (personnel policies, job descriptions, organizational culture) in order to successfully incorporate peer specialist positions in the organization. Each Center in the Learning Community conducted this checklist. A copy of your completed checklist and a summary of the responses from all members of the Learning Community follow so that you can compare your responses with those of your colleagues and refer to it as you develop your implementation plan.

Please mark an "X" over the circled number that best indicates the extent to which you agree or disagree with each of the following statements.

Leadership	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We communicate a clear commitment to the recovery model from the top of the organization.	①	②	③	④	⑤
The concept of recovery is included in our mission statement.	①	②	③	④	⑤
The leaders of this organization endorse recovery consistently in active, involved, and visible roles.	①	②	③	④	⑤
We view peer support as an essential part of the recovery model.	①	②	③	④	⑤
We have secure funding for the use of peer specialists.	①	②	③	④	⑤
Culture Change	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We endorse the concept of recovery in new employee orientation.	①	②	③	④	⑤
We describe the role of peer specialists in new employee orientation.	①	②	③	④	⑤
We provide recovery-based educational trainings to staff.	①	②	③	④	⑤
We use people–first language throughout the agency.	①	②	③	④	⑤
We develop recovery-based individual care plans with consumers.	①	②	③	④	⑤
We create recovery-based materials including newsletters, consumer satisfaction surveys, and documentation audits.	①	②	③	④	⑤
We provide sufficient administrative support to staff to implement change.	①	②	③	④	⑤
We have a volunteer consumer advisory council of people served by us to partner with staff in policy making and hiring.	①	②	③	④	⑤
Planning and Preparation	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Our peer specialists are permanent staff positions with the same benefits as other employees in similar classifications.	①	②	③	④	⑤
We use standard job titles and job descriptions for peer specialists.	①	②	③	④	⑤
The responsibilities of peer specialists include service provision, ongoing educational efforts with staff, and providing a consumer voice in management decision making.	①	②	③	④	⑤
We train supervisors how to work specifically with peer specialists, including how to apply peer specialist ethics.	①	②	③	④	⑤
We follow an established, clear policy on dual relationships (consumer/peer specialist and other staff).	①	②	③	④	⑤

Recruitment	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
We have an ongoing process to identify and recruit potential candidates for peer specialist positions.	①	②	③	④	⑤
Our peer specialists complete a standardized training and certification program with a code of ethics and continuing education requirements.	①	②	③	④	⑤
We have a policy on whether or not to hire consumers who received services from this organization, based on a rational study of the overall situation.	①	②	③	④	⑤
Hiring and Supervision	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
We hire peer specialists with substantive, meaningful lived experience with mental illness so their insights can be shared with providers and other consumers.	①	②	③	④	⑤
We hire peer specialists who demonstrate recovery success to effectively communicate that recovery is possible.	①	②	③	④	⑤
We have reviewed our agency personnel policies to ensure there are no unintended obstacles to hiring peer specialists.	①	②	③	④	⑤
We provide regular quality supervision of peer specialists.	①	②	③	④	⑤
We regularly evaluate job performance of peer specialists as we do other staff positions.	①	②	③	④	⑤
Follow Through	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
We evaluate the outcomes of programs and activities that include peer specialist participation.	①	②	③	④	⑤
We provide opportunities for career advancement, promotion, and meaningful salary increases to peer specialists.	①	②	③	④	⑤
We maximize peer specialist inclusion in ongoing staff support activities.	①	②	③	④	⑤

Please insert your summary of the Agency Readiness Assessment results here.

Staff Recovery Self Assessment Survey

The second task was to survey your staff to determine the prevailing attitudes among staff about the concept of recovery, hiring consumers as staff (peer specialists), and the current organizational culture. The Recovery Self-Assessment (RSA) scale was used for this purpose.

The RSA was developed by Maria O'Connell, Janis Tondora, Gerald Croog, Arthur Evans and Larry Davidson at the Yale University School of Medicine in collaboration with the Connecticut Department of Mental Health and Addiction Services. Feedback from consumers, family and friends, providers, researchers, advocates, and administrators informed the final scale items. (For more information about the development and use of the RSA, see "From Rhetoric to Routine: Assessing Perceptions of Recovery-Oriented Practices in a State Mental Health and Addiction System" published in the Spring 2005 issue of the *Psychiatric Rehabilitation Journal*).

A copy of the survey follows.

A Recovery Profile for your agency has been prepared. It includes a summary of the results of the entire Learning Community for comparison. Your agency profile is organized according to the five domains of recovery orientation measured on the RSA:

- Life Goals -- 11 items reflect the extent to which consumers are assisted and supported in the development and pursuit of individually defined life goals such as employment and education
- Consumer Involvement and Recovery Education -- 8 items reflect the extent to which consumers are involved in developing and providing programs/services, staff trainings, advisory board/management meetings, and community education activities
- Diversity of Treatment Options -- 6 items reflect the extent to which consumers are provided a variety of treatment options, including linkages to peer mentors and support
- Choice -- 6 items reflect the extent to which consumers are treated with respect, provided access to treatment records, and assisted with outside referrals

Individually-tailored Services -- 5 items reflect the extent to which services are tailored to individual needs, cultures, and interests, provided in a natural environment, and focus on building community connections.

Please insert your Agency's Recovery Profile here.

Implementation Plan

The purpose of participating in the Learning Community is more than learning about Peer Support. The goal for each agency is to develop an implementation plan that results in establishing peer specialist positions in your agency and ensuring that you provide the appropriate structure and supports to make them successful. Some PSLC agencies already use peer specialists but not as effectively or widely as they could. Other agencies have not used peer specialists at all, but want to begin. Either way, it requires a plan to be successful.

During the conference described in the following section, each team is expected to work on their implementation plan. Some agencies already know how and where they plan to use peer specialists; others need the information provided at the conference to help make those decisions. Each team should plan to leave the conference with the basic outline of an implementation plan and an understanding of what they need to do to complete it.

An implementation plan does not need to be elaborate or formal to be effective; content and team participation are what is important. Following is a suggested outline for the components of your implementation plan. Simply address each item and sub-item in the outline. You can write the responses as one single document, or as separate pieces kept in a binder. It may be easiest to discuss some parts as a team first, and then assign someone to write up the discussion. Other parts may be easier to assign to someone to work on and then review as a group. Either way, it is critical that all members of your team have a copy of the plan as it is being developed and that they have an opportunity to contribute to each section of the plan. It truly needs to be a team effort to be successful!

Learning Community Implementation Plan

I. Identify Intended Role(s) for Peer Specialists
   a. List types of activities that could be performed in your Center
   b. Develop sample job descriptions

II. Determine Number of Peer Specialist Positions to be used/created
   a. Initial goal
   b. Long term goal

III. Identify Source of Funding for Position(s)
   a. General Revenue or Medicaid?
   b. List Pros and Cons of intended source of funds.
   c. Assess overall budget impact of adding peer specialist position(s).

IV. Determine Organizational Placement and Supervision
   a. Refer to Exercise #3.
   b. Does this plan require any change in the current structure?
   c. If yes, what needs to be done to implement these changes and how long will it take?
   d. If peer specialists will be hired in the meantime, how will they be supervised?

V. Review Organization's Personnel Policies
   a. Identify Changes Needed.
   b. Identify Internal Process for Making Changes to Personnel Policies.
   c. Implement Changes.

VI. Prepare Internal Marketing Plan (See Exercise #1).

VII. Develop response plan for difficult situations (See Exercise #2)
   a. Identify individuals responsible for resolving situations
   b. Identify potential "workplace hazards" and develop plan for avoiding/eliminating them.

VIII. Prepare Recruitment Plan
   a. Where will you find potential candidates for peer specialist positions?
   b. How will you advertise (if at all) for these positions?
   c. Who will interview/hire these positions? Does there need to be any change from normal interviewing/hiring procedures?

IX. Develop contingency/backup plan
   a. If you have a vacancy in your peer specialist position, how will you cover those responsibilities while you recruit and train someone for that position?

X. Develop Ongoing Support Plan
   a. Once these positions are filled, what do you need to do to ensure they are successful?
   b. If you have only one or two positions, how will you connect them to other positions as part of a support community?

Windows to Wellness Conference

The first major event of the Learning Community is a specialized track at this Windows to Wellness Conference. This conference brings together nationally recognized leaders in the consumer wellness movement and Texas leaders in the use of peer support to share their insights and knowledge with the Learning Community teams. The conference is designed to provide participants an opportunity to use what they learn and begin developing a comprehensive implementation plan while at the conference with access to these resources.

Each team should review the results of the survey prior to beginning the workshops and try to identify those areas that may need particular attention in your agency. If you don't hear the information you need in the workshops, ask the instructors!

The workshops are designed to be in part working sessions. Some of the workshops will include exercises for you to develop portions of your implementation plan. Other exercises will be homework assignments for your team to work on during the conference and present at the closing session.

Peer specialist Learning Community Faculty

The following individuals lead the workshops in the Learning Community Track at the Kick-off conference. They are assisted by staff of community mental health Centers in Texas who already have a well developed peer specialist program.

LARRY FRICKS, M.A.: Larry Fricks currently serves as the Director of the Appalachian Consulting Group and Vice President of Peer Services for the Depression and Bipolar Support Alliance. For 13 years Larry was Georgia's Director of the Office of Consumer Relations and Recovery in the Division of Mental Health, Developmental Disabilities and Addictive Diseases. He is a founder of the Georgia Mental Health Consumer Network, a founder of the Georgia Consumer Council, a founder of Georgia's Peer Specialist Training and Certification and a founder of the Georgia Peer Support Institute. He served on the Planning Board for the Surgeon General's Report on Mental Health, and currently serves on the Board of Directors of Mental Health America and on the Advisory Board for The Carter Center Mental Health Journalism Fellowships.

Larry has a journalism degree from the University of Georgia and has won journalism awards from the Associated Press, the Georgia Press Association and Gannett Newspapers. He is the 1995 recipient of the Clifford W. Beers Award given annually by Mental Health America and the 2001 recipient of the American Association for World Health Award for significant contributions to improving community mental health. In 2004 he received the Recovery Award from International Association of Psychosocial Rehabilitation Services and in 2008 the Lifetime Achievement Voice Award from the Substance Abuse and Mental Health Services Administration for the development and adoption of multiple innovative, recovery-oriented programs and services.

Larry's recovery story and life's work to support the recovery of others was published by HarperCollins in the New York Time's best-selling book *Strong at the Broken Places* by Richard M. Cohen and was featured on the Today Show in 2008.

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DR. DANIEL FISHER, M.D., PhD: Dr. Daniel Fisher is a staff psychiatrist at Riverside Community Mental Health Center in Wakefield,Massachusetts. He has worked as a board-certified psychiatrist for 25 years

in a variety of inpatient and community settings such as a state hospital, day treatment Center, outpatient clinics, and elderly housing. He was Medical Director for a community mental health Center for 12 years. He also is a Co-Director of the National Empowerment Center in Lawrence, Massachusetts, a consumer-run Research, Training, and Information Center, which he helped found in 1992. Dr. Fisher is the co-recipient of the National Mental Health Association's 2002 Clifford Beers Award for Advocacy. He also helped found the Ruby Rogers Center for Advocacy and Peer Support in Cambridge, Massachusetts. Dr. Fisher spent five years doing neurochemical research at the National Institute of Mental Health from 1968 to 1973. During this period, Dr. Fisher was labeled with schizophrenia and hospitalized several times. He is among the few psychiatrists in the country who openly discusses his recovery from mental illness. His involvement in advocacy and peer support have played a vital role in his recovery.

Dr. Fisher obtained an M.D. from George Washington University Medical School in 1976 and completed his Residency in Psychiatry at a Harvard teaching program at Cambridge Hospital. He earned a Ph.D. in biochemistry from the University of Wisconsin in 1968 and an A.B. in Biology from Princeton University in 1965. Dr. Fisher lives in Cambridge, Massachusetts with his wife and two college-age daughters.

STEVE HARRINGTON, J.D.: Steve Harrington is Executive Director, National Association of Peer Specialist (NAOPS) and Recovery Opportunities. Steve is an accomplished and nationally known speaker and recovery advocate who has worked with mental health organizations at local, regional and state levels to move them toward true recovery-based systems.

A former lawyer, Steve also has found his own path of recovery from schizophrenia and depression. Though Steve earned three university degrees, he says he learned the most about life and living through his struggles with two mental illnesses. He has defied the predictions of life-long disability by psychiatrists. He is founder of the National Association of Peer Specialists (a group of persons with mental illness helping others with mental illness recover and build a better quality of life). He is also the author of three books on mental health issues: The Depression Handbook: Advice From A Survivor, Trees of Hope, and You Can Recover. Steve is a popular speaker at mental health events as he uses humor, costumes, unusual visual aids and stories from his life experience to entertain, inform and inspire audiences.

DR. PEGGY SWARBRICK, PhD: Peggy is Director of the Collaborative Support Programs of -New Jersey Institute for Wellness and Recovery Initiatives, and is a part time assistant professor in the Psychiatric Rehabilitation and Counseling Professions Program at University of Medicine and Dentistry of New Jersey - School of Health Related Professions.

Peggy has been involved in the mental health field since 1977 personally and professionally since 1986. Peggy worked as an occupational therapist in a variety of settings providing wellness and recovery focused services. Peggy has lectured nationally and internationally on recovery and wellness and consumer-operated services and completed doctoral work at New York University, in the Occupational Therapy Program. Peggy has published on the wellness and recovery model, consumer operated services, a commentary on a cognitive behavioral treatment for persons diagnosed with mental illness who experience PTSD, and peer delivered wellness and recovery programs.

Dr. PATRICIA (PAT) NEMEC, PsyD, CRC, CPRP: Nemec Training & Consulting. Pat Nemec is an independent trainer and consultant in psychiatric rehabilitation, and holds Adjunct Associate Professor appointments at both Boston University and the University of Maryland (College Park).

She was on the faculty of the Rehabilitation Counseling program at Sargent College of Health and Rehabilitation Sciences at Boston University from 1984-2008. She is currently active in the US Psychiatric Rehabilitation Association, and serves as the Vice President of the Commission for Certification of Psychiatric Rehabilitation Practitioners. She has written a number of articles, book chapters, and training materials on psychiatric rehabilitation. Nemec received her BA from Syracuse University, and her Psy.D. from the Massachusetts School of Professional Psychology. She is the recipient of numerous awards, including the 2007 John Beard Award from the US Psychiatric Rehabilitation Association.

LYN LEGERE, CPRP: Ms. Legere is the Director of Education at the Transformation Center and a Training Associate at Boston University, Center for Psychiatric Rehabiliation. She is also President of Massachusetts USPRA and a Supported Education Specialist at Boston University. Her areas of expertise include Certified Peer Specialists, Dignity of Risk, Recovery Oriented Services, Partnering Skills, and Psychiatric Vocational Rehabilitation

Lori Aschcroft, PhD.: Lori is Executive Director, Recovery Opportunities, a part of Recovery Innovations. During her 35 year behavioral health career, Lori has had a strong interest in the therapeutic effects of self-determination, choice, and personal freedom.

After a full career in California that included the Deputy Director for Community Programs of state Department of Mental Health, she re-located to Arizona where she accepted the position as Director for Adult Services for the Regional Behavioral Health Authority and served as a professor for the University of Arizona teaching psycho-social rehabilitation and managing one of eight SAMHSA funded employment demonstration programs. It was during this time that Lori became involved in the recovery movement. Through training with Mary Ellen Copeland and help from colleagues at Boston University, her commitment to recovery principles became a passion. When META Services (now Recovery Innovations) opened the Recovery Education Center in the fall of 2000, Lori accepted the position as Executive Director of the Center.

Lori recently developed curriculum to help consumers move beyond recovery by finding their purpose, making their own unique contribution, and using their experiences to help others grow and recover. Her own passion for recovery stems from personal experience having struggled with severe depression most of her life.

Learning Community Track Summary

The following sessions are part of the Learning Community Track. Some of these are restricted to only PSLC team member while others are plenary sessions or optional sessions with other conference participants.

Thursday:

9:00	In support of the Unrealistic	Workshop, PSLC Members Only
10:30	LC Track Overview	Workshop, PSLC Members Only
1:00	In Sync: Experience, etc.	Workshop, PSLC Members Only
3:00	Organizational Culture	Plenary, Open

Friday:

8:00	Outcomes from Carter	Workshop, Open
10:00	Human in Human Resources	Workshop, PSLC Members Only
Lunch	Wellness Coaching	Plenary, Open
1:00	Financial Sustainability	Workshop, PSLC Members Only
3:00	Power of Wellness	Workshop; PSLC Members' Choice
	or	
	Recovery Relationships	Workshop; PSLC Members' Choice

Saturday:

9:00	Enhancing Workforce/Peers	Workshop; PSLC Members' Choice
	or	
	Connecting the Dots (Networking)	Workshop; PSLC Members' Choice
10:45	Wrap Up/Gateway to Future	Workshop, LC Members Only

Learning Community Track In Detail

Part I Workshop: Setting the Conference Stage

The opening workshop, In Support of the Unrealistic, describes the culture of recovery and how peer specialists contribute to it.

Part II Workshop: PSLC Overview

This session provides an overview of the PSLC conference track, a summary and discussion of the results of the Recovery Self Assessment, and a description of the Learning Community model.

Following are copies of the three Power Point presentations for the workshop.

Part III Workshop: Experience, Expertise, Education & Employment

Peer specialists may be used in a wide variety of ways. However, Peer Specialists bring the most value to the workforce when their unique experiences, education and expertise are utilized. This workshop describes the unique competencies of CPSs, describes meaningful job descriptions, and addresses the barriers that thwart efforts to integrate peer workers as an effective method of fostering recovery outcomes.

A list of required competencies based on a review of current practices around the country is provided that can be adapted to an agency's own job description format.

Objectives:

1. Participants can construct effective and meaningful job descriptions based on critical competencies for Certified Peer Specialist and other peer positions;
2. Participants can effectively address cultural and systems challenges to integrating peers in the workforce;
3. Participants can implement a plan for addressing cultural and system challenges within their own setting; and
4. Participants can enticipate supervision and support needs of peer workers to be able to maximize effectiveness of peer roles in the workforce.

Following is a copy of the handout for the workshop.

In Sync: CPS Training & Job Requirements

Ensuring that CPS training aligns with the work requirements lessens role confusion for the CPS as well as traditional service providers. The presenters will describe a competency-based curriculum evaluation designed to critically review training objectives, content, and assessment procedures of the Massachusetts CPS training and examination through comparison with CPS job requirements.

Learning Objectives: After this workshop, participants will be able to

1. Explain the value of competency-based training
2. Define "competency"
3. Describe the process used in this project to generate a competency list

Background on the Massachusetts Certified Peer Specialist Program

The Massachusetts Certified Peer Specialist (CPS) Training is a modified version of the "Georgia model" organized, taught and administered by people with lived experience of mental health issues. The training team has made modifications to the Georgia curriculum to create a more interactive learning environment, address specific practices and needs of Massachusetts, and better address the learning needs of the CPS trainees. The most significant change was to go from an 8-day intensive training held over 1 ½ weeks to an extended training over 9 weeks that combines a short retreat and 6 individual training days. We also added in a homework component with assignments geared toward reinforcing the learning objectives as well as giving students the opportunity to get feedback about how well they're learning the material as they go through the course.

The goal of the training is to prepare people with lived experience to effectively model recovery and inspire hope for both service users and service providers. The key competencies fall into several categories: knowledge and understanding of the recovery process; knowledge and understanding of the mental health system; specific tools and strategies that support recovery; and self-help and wellness tools that can be both taught to others and used for oneself.

In the last year, we created an oversight committee to ensure that the CPS course and exam is fair for all trainees, meaningful to the professional expectations of a CPS, and in line with accepted certification practices. This committee is still in its early stages, but is charged with hearing any grievances from trainees, examining the curriculum and test from multiple perspectives and with defining expectations for continuing education.

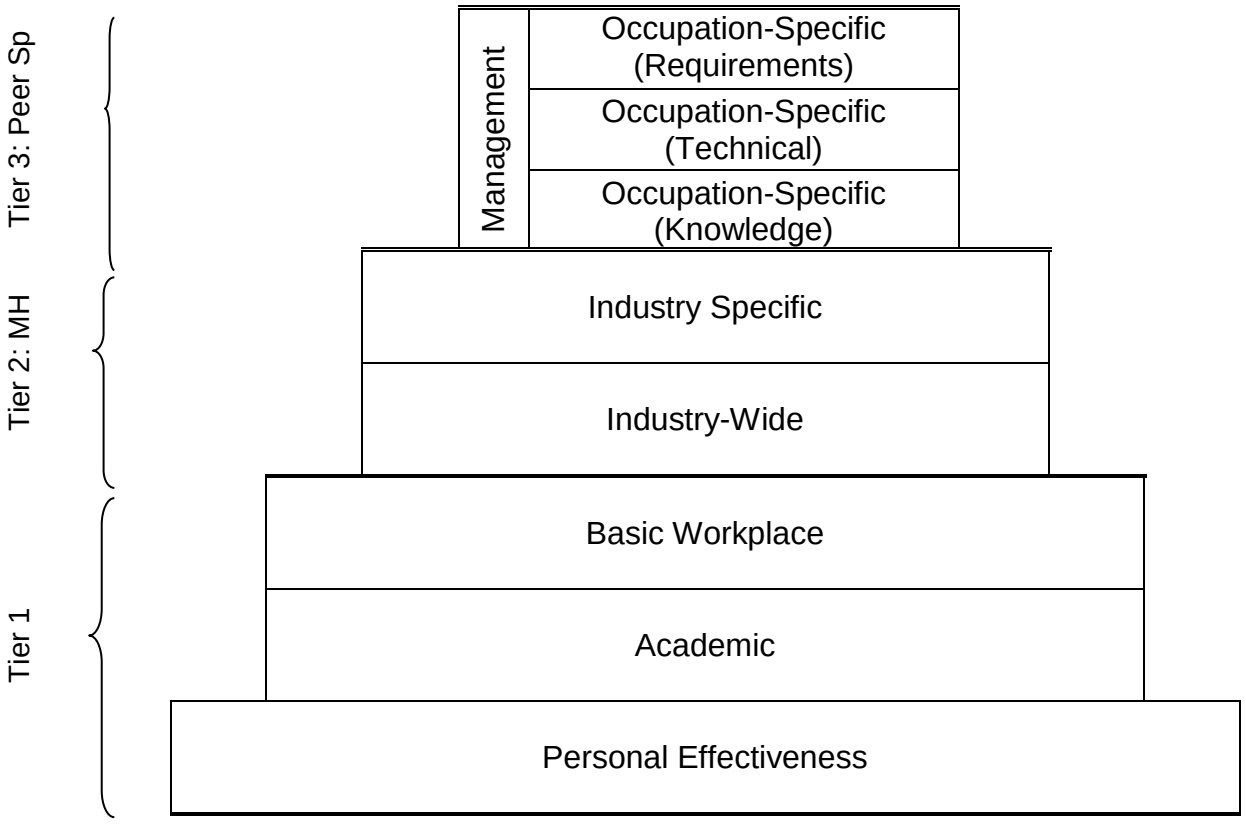
The Transformation Center is working with state agencies, including the Department of Mental Health (DMH), to broaden the impact of CPS and peer services within the mental health field in a number of ways. These include advocating for dedicated funding for CPS positions in all mental health agencies, advocating for Medicaid reimbursement for CPS services within and beyond mental health agencies, advocating for supervisory designation of the CPS/CPRP credential, and requesting funding and support for continuing education for advanced study in important topics such as supervision and trauma. *For more information, see http://www.transformation-Center.org*

Competencies

A competency is the ability to apply or using knowledge, skills, attitudes, and personal characteristics to successfully perform critical work tasks, specific functions, or operate in a given role or position (Ennis, 2008).

(Continued on next page)

The *Competency Model Clearinghouse* identifies nine tiers within a generic competency model:



For interactive graphic: http://www.careeronestop.org/competencymodel/pyramid.aspx

Massachusetts Certified Peer Specialist Training Competency Evaluation Project

- What knowledge, skills, and attitudes are needed by peer specialists (peer support providers)?
    - What is included in existing competency lists (KSA, values, task domains)?
    - What's missing from these lists that we think is important?
    - What do we think are the underlying competencies (KSA) for CPS?
    - Do working peer specialists agree with our list?
- What makes peer competencies different from competencies required by generic direct service providers operating within a truly recovery-oriented service system?
- Does the Massachusetts CPS Training teach the required competencies?

(a work in progress…)

What did we find so far?

- Most lists are global (focused on task domains), not specific (focused on KSA).
- Most lists mix generic (industry) competencies and peer (occupation) competencies.
- Some competencies seemed discriminatory or "stigmatizing" as written.
- The sources we used did not agree on much.
- We think the sources we used left out some competencies.
- Our final list of peer specialist competencies includes 170 items, with 143 of these being generic competencies for direct service providers in a truly recovery-oriented system. For now, we have left these generic competencies in our overall list, because we're not there yet.

Our competency list (in draft form), includes these task domains and competencies:

Administrative Responsibilities

- Skill in designing and/or evaluating training materials about peer support and recovery principles

Engagement (Partnership)

- Skill in acknowledging a power differential while maintaining a relationship of mutuality
- Skill in communicating respect in a relationship of equality and mutuality
- Skill in describing personal experience with a psychiatric condition in order to engage individuals and/or their families
- Skill in negotiating roles and relationship rules with a person using services within a peer support context
- Skill in using self-disclosure to create a relationship of mutuality and equality

Inspiring

- Knowledge of the history of the C/S/X movement and the role of local leaders
- Skill in articulating recovery principles through a personal story to a variety of audiences, including, service providers, academic audiences, and the general public
- Skill in describing personal experience with a psychiatric condition in order to inspire individuals and/or their families
- Skill in role modeling recovery

Person-Centered Assessment, Planning, and Interventions

- Skill in developing and maintaining peer networks
- Skill in negotiating one's role as a representative and/or support for someone when attending a treatment/service planning meeting
- Skill in supporting a person moving from one environment to another
- Skill in using one's personal story to advocate on behalf of a person using services

Professional Relationships

- Skill in addressing colleagues and programs who are personally demeaning through negative attitudes, prejudice, or discrimination

- Skill in defining and educating colleagues about peer job roles and responsibilities

Promoting Wellness and Recovery

- Attitude that recognizes the importance of being a positive role model
- Skill in facilitating peer run wellness and recovery groups
- Skill in facilitating peer support and self-help groups
- Skill in helping a person develop a WRAP (including use of self-disclosure)

Rights Protection and Advocacy

- Skill in telling one's own story to effectively change negative attitudes about people in recovery

The Job Description

A job description provides a summary of the primary duties, responsibilities, and qualifications of a position. It is important to reflect priorities and current expectations.

Components of the job description:

Function:
Summarize the main purpose of the position within the department/organization in one sentence.

Reporting Relationships
Describe the "chain of command" and the types of supervision the employee will get and will give, indicating the specific job titles of the supervisors and the positions supervised.

Responsibilities
List 4 to 6 core responsibilities of the position and identify several specific duties within each of the core responsibility areas.

Qualifications/Competencies
List required and preferred qualifications, credentials, and competencies in order of importance. These might include educational requirements (e.g., a high school diploma or equivalency), training or certification as a peer specialist, or specify that the employee must be a person in recovery (e.g. "Be a self-identified current or former user of mental health or co-occurring services who can relate to others who are now using those services" or "Must be a self-disclosed individual with a mental illness)

Note: Texas requirements for Medicaid reimbursement require that a peer provider must have received a high school diploma or a high school equivalency certificate; have at least one cumulative year of receiving mental health services for a disorder that is treated in the target population for Texas; and be under the direct clinical supervision of a Licensed Professional of the Healing Arts (LPHA).

-From the Texas Certified Peer Specialist Learning Community Implementation Toolkit (Via Hope).

Employment Conditions

Describe any relevant circumstances, such as any physical requirements (e.g., standing, lifting), environmental conditions, unusual work schedule (e.g., rotating shift, on-call hours), and any other requirements (e.g., driver's license, background check, random drug screen).

Tips from the Small Business Association (http://www.sba.gov):

- A good job description begins with a careful analysis of the important facts about a job, such as tasks involved, methods used to complete the tasks, and the relationship of the job to other jobs.
- It's important to make a job description practical by keeping it dynamic, functional, and current.
- Don't get stuck with an inflexible job description! A poor job description will keep you and your employees from trying anything new and learning how to perform their job more productively. A well-written, practical job description will help you avoid hearing a refusal to carry out a relevant assignment because "it isn't in my job description."

http://www.sba.gov/smallbusinessplanner/manage/manageemployees/SERV_JOBDESC.html

Sample Peer Specialist Job Description Components*

Sample function statements

- Provide vision driven hope and encouragement to support people in their recovery and assist them in connecting to the community
- Provides opportunities for individuals receiving services to direct their own recovery process (self-determination) and acts as an advocate for the needs and rights of persons served
- Works with individuals in groups and on a one-to-one basis to provide recovery training and outreach to individuals who use mental health services in the community
- Shares personal recovery experiences and develops authentic peer-to-peer relationships
- Offers instruction and support to help people develop the skills they need to facilitate their individual recovery
- Informs people served of available service options and choices while promoting the use of natural supports and resources within the community
- Supports people to articulate and describe their needs, wants and desires to providers and family members (self-advocacy)
- Provides peer mentoring and support for individuals with psychiatric disabilities receiving mental health services
- Assists individuals in navigating the mental health services system and in achieving resiliency and recovery as defined by the person

Sample responsibility statements

- Assist in the orientation process for persons who are new to receiving mental health and/or co-occurring disorders services
- Educate and support people in the use of Wellness Plans, including Wellness Recovery Action Plan, as a means to recognize early triggers and signs of relapse, and use of individual coping strategies as an alternative to more restrictive services
- Outreach/accompany to ensure the individual is making a successful transition to community integration and is continuing their progress toward recovery goals
- Support the individual in seeking to connect/reconnect with family, friends, significant others and in learning how to improve or eliminate unhealthy relationships
- Provide education and advocacy within the community that promotes awareness of psychiatric disorders while reducing misconceptions, prejudice, and discrimination
- Keep treatment team informed about individual's strengths, accomplishments and obstacles in relation to their recovery goals
- Complete all required documentation in a timely, legible manner
- Educate professional staff about the recovery process and the damaging role that stigma can play in undermining recovery
- Visit community resources with people using services to assist them in becoming familiar with potential opportunities
- Facilitate (via personal coaching and WRAP groups) the transition from a professionally directed service plan to a self-directed Recovery Plan
- Model personal responsibility, self-advocacy, and hopefulness through telling one's personal recovery story, how needs are respectfully met, and how a belief in oneself is maintained
- Ensures confidentiality of individual information

- Assess emergency situations, notifies supervisor and/or appropriate clinical and administrative personnel of actual or potential problems
- Exhibits a nonjudgmental approach, effective listening, good eye contact, and positive interactions

*adapted from job descriptions and materials from Pennsylvania, North Carolina, Recovery Innovations of Arizona, Florida Peer Network Inc., the Transformation Center (Boston, MA), and Collaborative Support Programs of NJ

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Most of the materials listed are available on-line.

Part IV Plenary Session: Org. Culture/Staff Attitudes -Recovery

The speaker, Dr. Fisher, traces the evolution of the concepts and recovery and wellbeing, as they have been developed from his and other peoples' lived experience with severe emotional distress. He presents the empowerment paradigm of recovery and wellbeing, and the implications of this approach in transforming the mental health system. He shows ways that consumers/ survivors are collaborating with providers in services, training, evaluation, and policy formation (STEPs to recovery and wellbeing).

Objectives:

1. Participants explore empowerment paradigm of recovery and wellbeing
2. Participants discuss ways consumer/survivors are participating in STEPs to recovery and wellbeing to bring about transformation

This toolkit contains additional materials about what reactions and attitudes you might expect from your current staff, particularly the licensed professionals, and ways you can change these attitudes. Review the paper at the end of this section, "Developing Strategies to Integrate Peer Specialists into the Staff of Mental health Agencies."

Exercise #1: This is a conference homework assignment. Using the information from the speaker and the toolkit, each team should begin to develop an internal draft "marketing plan" to start changing staff attitudes. The following approach is based on a "System Ecological Framework". Teams will have an opportunity to discuss their plans or ask questions during the conference wrap up session.

1. Draw a series of four or five concentric circles. You may need to add additional circles as you go.
2. Make a list of the types of staff that will be directly or indirectly affected by adding peer specialists to your team. Virtually all staff should be on the list.
3. For the inner circle, identify the staff or groups of staff that are most directly affected by adding peer specialists. You may have one or more types of staff in this circle.
4. For the remaining circles, identify the types of staff that are progressively less affected. Use as many or as few circles as necessary.
5. For the group(s) in the inner circle, describe whether the impact is likely to be seen as primarily positive or negative initially.
6. Identify what you need to provide for these staff in the way of support. What do you need to do to motivate them?
7. Answer the same questions for the groups in the next circle and so on.
8. Identify ways that the work you do with one group may impact (positively or negatively) on other groups. If the impact is potentially negative, what can you do to mitigate the impact?

Personnel issues can be complicated for all types of staff, and peer specialists are no exception. Following are six difficult situations you may encounter. Think about how you would handle them if this were your agency.

1. Joel has been a client of the ABC MHMR Center since 1999. He was recently hired as the Center's certified peer specialist and a problem has arisen. In order for the Center to bill for his services, and for services he provides to count toward minimums and averages, they have to be charted in the electronic medical records system.

The problem is that he is not supposed to enter the chart room or certain designated patient record areas. Other clients who have known Joel through Center support groups at the Center are also complaining that they do not like that he has access to their personal records. Is there a way to work this out so that Joel's notes can be entered, and at the same time patient privacy is not compromised?

2. Maryann has been employed as a QMHP by the HELP ME MHMR Center in El Grungo for the past sixteen years. There were tasks and services that only she or her subordinates could perform according to the TAC rules.

   In the last year and a half, the Center has begun employing certified peer specialists, and so far three have worked at the Center. One stayed for two months, and was replaced, and a new one was hired, for a total of three certified peer specialists working at the Center now. One of them became a client during Maryann's tenure and she remembers him being 'brought in' while he was in a psychotic state.

   All Maryann can think is, 'I went to school for six years to get my degree and license, and now clients are serving clients in a manner similar to the way I do'. She is concerned for her job security, and honestly doesn't know if she can go along with this consumer stuff anyway. How could you get Maryann to support the use of peer specialists?

3. Lenore has noticed troubling behavior regarding a certified peer specialist where she works. Sherry is a certified peer specialist at the I HATE THE WORLD MHMR Center and has been there for 8 months. Even though other professional staff call in sick or late, and this is never an issue, the response that Sherry receives when she is sick or late usually includes a comment about her being a consumer, and that this is the reason for her absences. Sherry's behavior on the job would not lead one to this conclusion, yet more than once, comments have been made about Sherry's performance standards and work ability being inferior because she has a mental illness. Where does this thinking come from, and what can be done about it?

4. Edna is a peer specialist, the only one your Center employs. She does a really job being supportive to Center clients and overall, there seems to be a positive response to her from both the clients, and subsequently the staff seem to see her as harmless at the worst, and many times quite helpful. You provide intake at the Center so you get to see interactions that perhaps get missed by others. You have on more than one occasional heard Edna tell clients incorrect information about their illness, symptoms, and side effects. There was no ill intent that you could see, but sometimes you worry that one of these days, something like this could cause real harm to a client. You don't want to rock the boat, or ruin things for anyone, but sometimes you think you should be telling somebody. What should you do?

5. In the last year, your Center has hired two new peer specialists for a total of three working at the crisis respite facility during daytime hours. Among other case management type duties, each peer specialist is supposed to be teaching WRAP classes. Because there are not enough peer specialists available to teach all classes as a team the way they were intended, the classes are being taught to groups of six to ten people by one peer specialist.

You just received your graduate degree in social work, and are working as a case manager II at the respite facility. Your job supervisor, or boss, who is off site is also supervising you for your required 2000 hours of practicum for licensure, which is very important for your career. You know from your WRAP training that the WRAP classes should not be taught this way, and more importantly, you also see that the peer specialists are uncomfortable and have heard them describe feeling like they are 'in over their heads'. You'd like to come up with a possible solution or suggestion for resolving this issue before taking it further. What might be done to maintain integrity of the class while supporting the peer specialists?

Part V Workshop: Outcomes from Carter Center Summit

The ability to fund peer support services is critical to the creation of peer specialist positions, and Medicaid is becoming a significant source of funding for peer support. In November, 2009, twenty three states who currently have authority in their Medicaid state plan to bill for peer support met in a summit to compare their experiences. This workshop is the first public presentation of the results of that summit. This presentation highlights what those states agree is going well for the new trained peer workforce, recommendations on how to strengthen that workforce, and system transformation innovations like Peer Support Whole Health.

Objectives:

1. Participants are able to identify two minimum requirements established by the Center for Medicare and Medicaid Services when electing to provide peer support services.
2. Participants can identify five key supports for a trained peer workforce that emerged from the Pillars of Peer Support Services Summit held at the Carter Center in November 2009.

Part VI Workshop Putting the Human in Human Resources

HR Policies ideally promote the health and wellness of all workers, including peer workers. This workshop describes an approach to employment practices that results in universal policies that are meaningful and equitable for all employees while being inclusive of people with psychiatric conditions other disabilities.

The workshop examines factors to consider when determining where to place peer specialists in the organization once their job responsibilities have been defined. It discusses appropriate supervision of peer specialists, and what the current Texas Medicaid TAC rules say about supervision.

The workshop also discusses things to look for in the agency's personnel policies that may pose unintentional barriers to successful employment, such as criminal background checks, new employee orientation and training, and sick leave policies.

Objectives:

1. Participants can explain the concept of "universal design" and apply it in practice.
2. Participants can explain the concept of "essential functions".
3. Participants can describe common functional limitations and work accommodations for people who have been diagnosed with a psychiatric condition.
4. Participants can list at least three personnel policies that would effectively support peer staff.

Exercise #2: This is another conference assignment. Each team should have a copy of their current organization structure and any other materials that illustrate how peer specialists are (or will be) integrated into their service delivery structure. In this exercise, each team examines their current organizational structure, compares it to the information presented, and then develops a revised structure that shows where the new positions will be placed organizationally and how they will be supervised.

1. Identify the types of activities the peer specialists will be involved in.
2. Next, identify those staff who are directly affected and those staff who are indirectly affected.
3. Identify who should supervise the peer specialists, based on the responsibilities you have identified.
4. Look at your current organizational structure. Where in the current structure would peer specialists be housed based on who supervises them. Is it appropriate, given their job responsibilities?
5. Based on what you learned in the workshop, draw your ideal organizational structure including the peer specialists. This may be based on your current structure, or it may require changing your structure somewhat.
6. If you need to change your organizational structure, what do you need to do to affect this change? Who in the organization needs to approve any changes? What are the potential ramifications of changing it (e.g. effects on other staff)?

Following is a copy of the Power Point presentation from the Workshop.

Part VII Plenary Session: Wellness Coaching

Wellness is a conscious, deliberate process that requires a person to become aware of and make choices that help promote a more satisfying lifestyle. Wellness includes eight dimensions and a wellness lifestyle includes a balance of health habits. The wellness approach is even more important as too many peers live in poverty and with co-occurring health condition that impact lifespan and quality of life. This session challenges conference participants to assume a lead role in creating socially inclusive environments that foster recovery. Learn about exciting peer delivered initiatives including the peer wellness coach certificate.

Wellness coaches are an exciting new use of Peer Specialists to help address the research findings that consumer have an average life expectancy that is twenty five years less than the general population. The principals taught in this plenary session will be incorporated into the peer specialist training curriculum being developed for Via Hope.

Objectives:

1. Participants examine opportunities to develop skills, knowledge and support to implement wellness coaching and other wellness services.
2. Participants can identify peer delivered services they can design and deliver that focus on wellness oriented supports and foster wellness.

Part VIII Workshop: Financial Sustainability

This workshop highlights sustainable funding sources for peer support services delivered by a trained peer workforce. Although Medicaid has become a major source of funding for peer specialists in many states, there is a downside to using it for peer support. This workshop describes some of the financial implications for using Medicaid under current Texas rules. For providers that do not choose to use Medicaid for peer support, this workshop also discusses alternate funding sources for peer specialists.

Objectives:

1. Participants can identify one or more barriers to billing Medicaid for peer support services in Texas.
2. Participants can identify two Medicaid funding options to bill for peer support services.
3. Participants can describe two ways in which funding peer specialist positions with general revenue funds is cost effective.

Following are copies of the two Power Point presentations from the Workshop.

Part IX Workshops: The Power of Offering Wellness (Alt.)

Want to stop managing and controlling people and discover and discover new ways to support recovery? Remarkable things can happen we offer the opportunity to enjoy the process of getting well physically and mentally. The key is to plan programs that are irresistible, and that inspire people to build on their strengths.

Objectives:

1. Participants can identify steps necessary to create a structure that supports wellness services
2. Participants can identify key elements of a wellness service

Following is a copy of the Power Point presentation from the Workshop.

Part IX Workshop: Recovery Relationships (Alt.)

Positive relationships are vital to the recovery process. In this session, participants explore ways to create and maintain relationships that foster recovery. These relationships include those with organizations, mental health professionals, family, and peers. Relationship repair, peer support and ways to find, develop and maintain mutually beneficial relationships are covered.

Objectives:

1. Participants can identify at least three ways to meet people in a healthy environment.
2. Participants can explain the importance of mutuality in a relationship.
3. Participants can identify the importance of healthy boundaries in a relationship and ways to establish and maintain those boundaries.

Part X Workforce Development for Certified Peers Providers (Alt.)

This workshop provides examples of and statistics on the benefits of integrating peer specialists in the workforce from one of the leading peer specialist training and placement agencies in the country.

Objectives:

1. Participants will understand the elements of the peer specialist code of ethics.
2. Participants will learn how adding peer specialist to their workforce can significantly reduce the cost of treatment over time.

Following are two articles from Behavioral Health Care and a copy of the Power Point presentation from the Workshop.

Part X: Connecting the Dots (Alt.)

Everyone can benefit from peer support but that support can be difficult to find and develop. This session explores ways to find supporting peer relationships and avoid isolation in a geographically diverse state such as Texas. The use of technology, conference attendance, and other means of connecting with peers is examined and how to develop peer support systems is covered.

Objectives:

1. Participants can identify at least three ways to connect with peers.
2. Participants can identify at least three ways to identify peer support relationships and use them for mutual support.
3. Participants can explain at least two ways they can help others find and develop meaningful peer support.

Part XI: Gateway to the Future; Evaluation and Next Steps

The end of the conference is just the beginning of the Learning Community. This session provides information about how to complete your implementation plans and keep the momentum going when teams return home. Evaluating the success of your peer specialist program over time is essential to understanding whether changes need to be made. A simple, user-friendly evaluation model is provided.

The initial peer specialist training class will be conducted in March, 2010. Peer specialists who are currently working for providers but have not had formal training, and consumer members of implementation teams who desire to become peer specialists, will have priority enrollment for the training.

Volume three of the implementation toolkit contains information about post-conference activities.

Appendix F:
Peer Specialist Learning Community Individual Call Script – April

Script/questions for PSLC April Follow Up calls

Hello, this is _____ with _____. I'm calling to ask you a few questions about your implementation plan for the Peer Specialist Learning Community. Do you have a few minutes to talk? (If the answer is no, schedule a time to call back.)

We recognize the time pressures of doing your day to day jobs and also working on the implementation plan, so there are no right or wrong answers to these questions. We have a few general questions first before we get to the specifics of your plan.

As you recall, the manual you received at the conference in January included an organizational structure for the implementation plan. In one of the first workshops, Via Hope staff discussed what should be in each section. Then, the workshops were designed to provide more background in each of these areas.

1. My first question is whether you found that information useful and whether you felt you knew how to begin developing your plan once you got back home?

2. Has your team met as a group since you returned from the conference or has the work on the plan been done individually?

3. Has the team discussed the conference and/or the implementation plan with upper management since you returned?

4. Has the team discussed the conference and/or the implementation plan with other staff in the agency since you returned?

5. We reviewed the draft which you sent to us recently. Would you agree the following is an accurate description? (Use whichever statement is appropriate.)
    a. We have worked on less than half of the sections in the plan.
    b. We have developed at least some information for more than half of the sections.
    c. We have a complete draft (at least some information in every section).
    d. We have a final plan and are working on carrying it out.

6. What difficulties or barriers, if any, have you encountered in developing your plan?

7. Are there specific areas in which you could use more assistance from the Via Hope contractor, their conference faculty, other PSLC teams, or DSHS? What are those areas?

8. Are there specific topics or information you would like to see covered in future monthly conference calls?

9. The Learning Community is scheduled to last for nine months, so there are about six months remaining. Have you identified, as an agency, what specific outcome(s) you want from this process? What do you want to accomplish? Are you on track to get there?

Appendix G:
Peer Specialist Learning Community Individual Call Script – August

Script/questions for PSLC August Individual Calls

1. At the conference in January, Wendy Latham presented the conceptual model for the Learning Community. Do you feel like this process followed the model that was presented?

2. Where there aspects of the LC track at the conference that you particularly liked or disliked?

3. You were presented with a template for an implementation plan (basically a series of questions to answer). Did you find this useful? Did you attempt to complete it? If no, why not? If yes, did you have difficulty with particular parts of it?

4. Have you found the monthly conference calls to be helpful? If yes, how? If not, why not?

5. Were there any specific barriers that impeded your team from participating in the monthly conference calls, or any other reasons you or your team members were unable to participate?

6. In between the monthly conference calls, did your team meet to work together on implementation plan activities or other learning community activities? How often did your team meet? On average, how many of your team members participated?

7. Do you think the one day, onsite training your Center participated in should be included in future Learning Communities? If not, why not? If yes, are there things about it that need to be changed? If yes, should it be optional or a standard part of the LC for every team?

8. Is the length of the LC too long, too short, or about right for what is expected of you?

9. Overall, has this process helped you implement the use of peer specialists in your organization, or could you have done it as well without this program?

10. As a result of participating in this year's learning community, did your Center CREATE, ENHANCE, and / or EXPAND peer specialist positions? Please explain how.

    [When we say CREATE, we are referring to creating one or more peer specialist positions where before none existed. When we say ENHANCE, we are referring to using peer specialists differently or more extensively than before. When we say EXPAND, we are referring to expanding to add additional peer specialist positions, possible across multiple locations.]

11. Regarding the Recovery Self-Assessment surveys your staff completed, did you find the results summarized in your organization's Recovery Profile useful? If so, how? If not, why not?

12. Do you believe there has been any change in your organizational culture as a result of participating in the Learning Community? What could the Learning Community have done to help you with this organizational change?

13. How did your Executive Director participate in the learning community?

14. During the last round of individual calls, your Center did not identify outcomes to accomplish as a part of the Learning Community process. What outcomes is your Center working to accomplish?

15. For the next Learning Community, we are considering placing more emphasis on the concept of becoming a recovery oriented organization, with the use of peer specialists as a major component of that process, rather than focusing primarily on developing peer specialists with culture change as a required element. Do you think this change in emphasis would be useful or not?

16. We are planning a one day wrap up conference in September where teams can report of their experience with the Learning Community. Do you see this as a valuable part of the PSLC?

17. What other advice do you have to help make this process more effective in the future?

Appendix H:
Peer Specialist Learning Community Site Visit Agenda

[Name of Center] Recovery Site Visit

Chris Martin & Lori Ashcraft

Monday, May 24, 2010

8:30	Welcome
9:00	A Story About a Recovery Workforce
10:00	What Recovery Looks Like in the Workplace
10:15	Break
10:30	What Recovery Looks Like in the Workplace
12:00	Lunch
1:00	How Peers Enhance Recovery Services
2:00	"Keeping the Recovery Skills Alive" – *A Welcoming Environment*
2:15	Break
2:30	What Constitutes a Recovery Environment – *Taking Our Temperature*
3:00	Putting Our Plan into Action
4:00	Farewell and the Work Begins!