viaHOPE
TEXAS MENTAL HEALTH RESOURCE

Recovery Institute Leadership Academy

Summary Report: August 2013

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With much appreciation to our partners in the Texas Recovery Journey:

our colleagues at Via Hope
Anna Jackson
Dennis Bach

our DSHS colleagues
Wendy Latham
Sam Shore

And with many thanks to all our RILA teammates and co-learners.

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Table of Contents

List of Tables

List of Figures

Introduction

Brief History of Via Hope

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). 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 Services (DSHS), 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.

In 2009 Via Hope, Texas Mental Health Resource was funded by DSHS through the Texas MHT Project to help achieve this system transformation with sustained support from mental health block grant funds beginning in FY2011. Via Hope promotes mental health wellness to Texans by providing training and technical assistance resources and collaborative learning opportunities to consumers, youth, family members, and mental health providers (www.viahope.org).

Via Hope Recovery Institute

In 2012, Via Hope introduced the Recovery Institute (RI): http://www.viahope.org/programs/recovery-institute. The RI is an ongoing set of collaborative learning experiences intended to promote system transformation by: (a) helping organizations develop an organizational culture and practices that support and expect recovery, and (b) promoting consumer, youth, and family voice in the transformation process and the future, transformed mental health system. A variety of organizations throughout Texas were invited to apply for Recovery Institute initiatives, including local mental health centers, state psychiatric hospitals, consumer operated service providers, and consumer and family support organizations.

Via Hope provided four "levels" of participation in the RI (http://www.viahope.org/programs/what-we-do), with intensity of participation and expected readiness of the organization to engage in change increasing from the lowest (Level 4) to the highest (Level 1) level of the institute. Organizations submitted competitive applications to participate in RI Levels 1 – 3, with Level 4 open to participation by anyone who signed up.

This report focuses specifically on the content and outcomes of Level 3, the Recovery Institute Leadership Academy (RILA). The four levels of the 2012 Recovery Institute included:

Level 1: Person Centered Recovery Planning (PCRP);
Level 2: Recovery Oriented Change Initiative (ROCI);
Level 3: Recovery Institute Leadership Academy (RILA); and
Level 4: Recovery Awareness.

The Recovery Institute Leadership Academy (RILA)

RILA was a foundational project that supported diverse leadership groups within organizations to establish recovery-oriented organizational changes. The critical aspects were consumer involvement, community engagement, and shared leadership. The identified focus was a hallmark of recovery orientation—people in recovery influence all aspects of the organization. Therefore, the RILA assisted executive and emergent leadership to build their organizations' internal capacity for other recovery-oriented change work, like integrating peer specialists and implementing person-centered planning. The project introduced a leading change framework (Leading Change; Kotter, 1996) and key organizational change themes (your local recovery community, use of story and organizational messaging, and the recovery orientation of boards and committees) on which organizations could focus their efforts.

The focus of this evaluation was measurement of recovery-oriented organizational change and improvement. Data collection for the Leadership Academy was intended to determine if organizational teams mobilized to develop a plan for implementing recovery oriented change in their organizations and engaged in recovery-oriented activities. Results of this evaluation are intended to be part of a continuous process improvement effort that assisted teams with improving recovery orientation and collecting lessons for other community center and hospital sites.

The following evaluation questions were examined:

Evaluation Questions

1. Do organizations accomplish goals and/or objectives within their recovery plans in each of the three targeted practice areas (i.e., use of story, the recovery orientation of boards and committees, and your local recovery community)?
2. Do organizations show any movement in readiness for change (change in stage that is supported by Recovery Self Assessment data) or activities focused on recovery change?
3. Do other measures of recovery-orientation change over the course of the project (e.g. inclusion of clients and family members on boards/committees, number of peer specialists employed, peer provided services, recovery focused mission and vision statements, community linkages, etc.)?

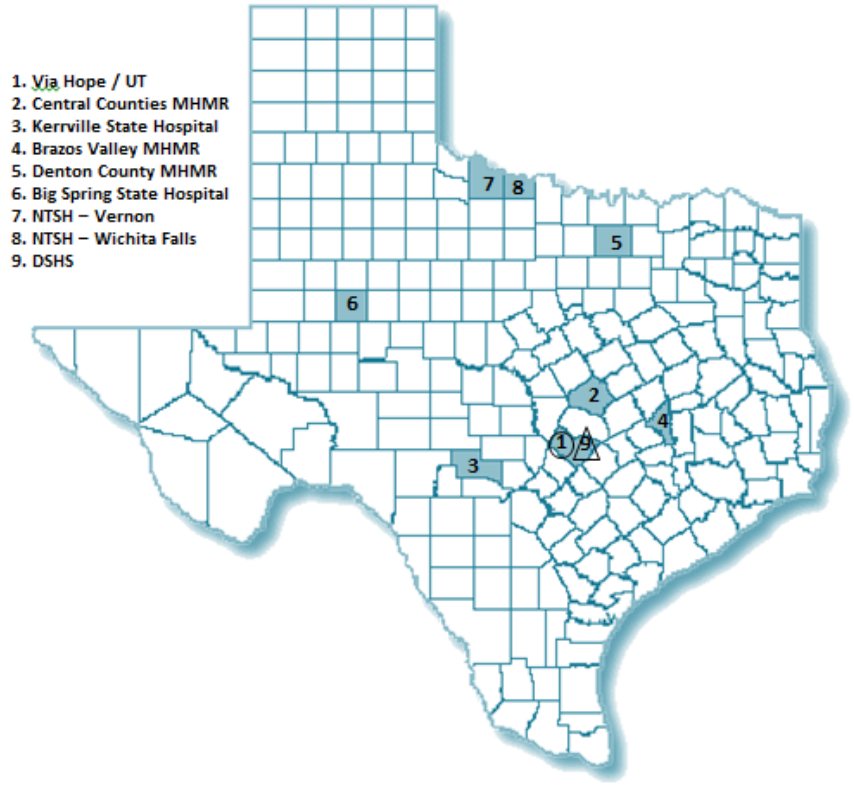
Method

To participate in the RILA, organizations were required to take part in an application process and agree to a number of commitments. Each organization had to assemble a team of at least three members of current or emerging organization leaders; teams were strongly encouraged to include a peer. Because executive sponsorship was 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. Applications were received from six organizations and all were invited to participate. The RILA organizations and number of team members per organization are provided in the table below.

Table 1 Participating RILA Organizations

RILA Organization	Number of Team Members
Big Spring State Hospital	22
Central Counties Center for MHMR Services	13
Denton County MHMR	6
Kerrville State Hospital	14
MHMR of Brazos Valley	21
North Texas State Hospital (Wichita Falls & Vernon campuses)	68
Total	144

Figure 1: Map of participating RILA organizations

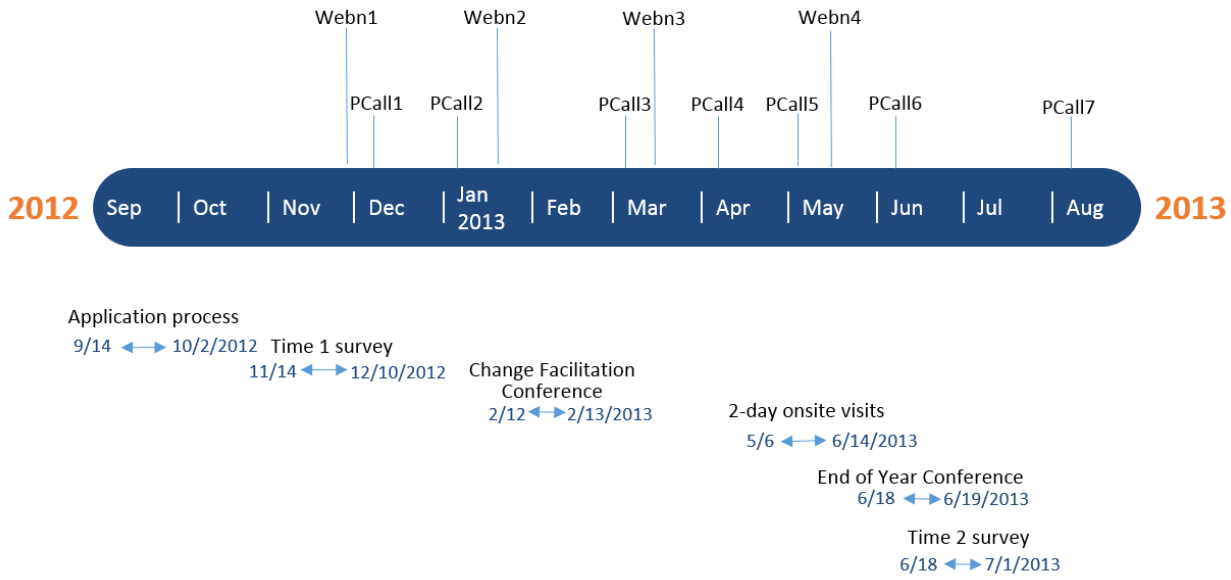


CORE Components of the RILA

The Recovery Institute Leadership Academy (RILA) engaged formal and emerging organization leaders in a learning process on recovery oriented mental health system transformation, cultivated a culture of learning in organizations, introduced recovery-oriented practice, and key organizational practice areas (i.e., your local recovery community, use of story and organizational messaging, and the recovery orientation of boards and committees). The RILA activities were designed to build on each other in a staged learning process. The project began with an application process that required organizations to form a core leadership team and agree to participate in a number of key training and technical assistance activities. Bi-monthly webinars focused on critical change concepts (i.e., increasing urgency, building guiding teams,

getting the vision right, communicating for buy-in, engaging and enabling the whole organization, and implementing and sustaining the change). The bmonthly all team calls focused on the targeted practice areas described previously. Individualized technical assistance was also provided through an individual coaching call at project start, middle, and end, a recovery project plan assistance call, and individualized communications with each of the sites initiated by resource requests. A number of in-person gatherings were also held throughout the project. The change facilitation conference at project start focused on facilitating change through the use of Liberating Structures, activity tools designed to promote inclusion and engagement (http://www.liberatingstructures.com) within each of the organizations. In addition, this conference promoted collaboration and communication among participating sites. A two day on-site training, led by an expert in recovery organizational culture, provided further support and guidance for recovery oriented change. At project end, a cross site wrap-up event was held to share and celebrate each of the organization's successes and accomplishments during the previous year. A final wrap up call was also held with each of the participating sites to determine their perspective on progress made, barriers encountered, management of resources, and next steps. Cross site collaboration was fostered throughout the project to encourage and promote continued recovery oriented work.

Table 2 Timeline of RILA Activities



The core RILA components included:

Change Facilitation Conference: A 2-day conference connected the RILA teams, provided in-depth content on recovery practices, and set the stage for recovery oriented change and practices. The conference was led by Keith McCandless, Liberating Structures co-creator. Liberating Structures are easy-to-learn microstructures that facilitate organizational communication and coordination. Their use can promote the active participation and engagement of each team member. Sites were given the opportunity to participate in an individual coaching session with Mr. McCandless or Michele Murphy-Smith, where

personalized tools and techniques were developed to promote change toward recovery within each organization. Teams from different organizations were encouraged to share strategies for change with each other and form collaborative relationships for future communication.

Recovery Webinars and All Team Calls: Four webinars and seven all team calls were hosted over the course of the RILA. Each webinar built on the previous webinar in a staged process and utilized the Leading Change framework (Kotter, 1996) to guide learning on recovery and organizational change. The following topics were addressed during the webinars: (1) Increasing urgency and building guiding teams, (2) Getting the vision right and communicating for buy-in, (3) Empowering action and enabling short-term wins, and (4) Implementing and sustaining the change: don't let up and make it stick. Surveys conducted pre and post webinar indicated satisfaction with the content and progress toward applying what they had learned to their organizational recovery work. The seven all team calls were used to deepen understanding of specific recovery practices, provide support for making recovery change, and address questions, concerns, and experiences of team members. These calls provided a forum for cross site collaboration among participating organizations. In addition, active participation and engagement during the calls was fostered through the use of Liberating Structures. Attendance and participant involvement during the calls and webinars was high. With the exception of two organizations that each missed a practice call and/or webinar, each of the organizations were represented on all of the webinars and all team calls.

Individual Coaching Calls: Teams participated in individual coaching calls at project start, middle, and end. In addition, teams were given the opportunity to have an individual TA call with a project consultant regarding the use and application of their team's recovery project plan. Four of the sites participated in this opportunity (Brazos Valley MHMR, Denton County, Central Counties Services, and North Texas State Hospital).

Recovery Project Plans: Recovery project plans were designed to be developed and updated by the teams on a monthly basis. The plans contained activities related to each of the targeted practice areas (i.e., your local recovery community, use of story and organizational messaging, and the recovery orientation of boards and committees) and specific to each organization. Only a few teams were able to provide monthly updates to their plans. The project facilitator and evaluator reviewed these plans to identify markers/indicators of recovery oriented change and practices, progress toward change, and factors that may foster/hinder change within the organization.

Onsite Visit: Each of the sites* received a 2-day onsite visit led by David Stayner, an expert consultant in recovery-oriented organizational change. During this visit, organizations were provided with information on recovery and resiliency. They also participated in a number of activities to create individual and team plans to foster change within their organizations and build resources to sustain recovery.
**MHMR of Brazos Valley did not receive an onsite visit during the current project year because this organization had previously participated in an onsite visit with David Stayner during their involvement in another RI initiative.*

Wrap-Up Conference: At the end of the project, teams joined together in Austin for a final 2-day meeting. Sam Shore, the Director of Mental Health Transformation at Texas Department of State Health Services, gave the opening remarks for the conference and experts in recovery based services, Janet Paleo and Harvey Rosenthal, provided key note speeches. Liberating Structures (LS) were used to explore self-chosen topics and issues related to the integration of peer specialists. In addition, a reception was held in which each of the teams was given a platform (through the LS Shift and Share) to discuss innovative work and successes that have taken place at their organization throughout the course of the project. Collaboration among participating teams was fostered so that organizations could begin to rely on each other for recovery change support and ideas.

Technical Assistance: Ongoing technical support, guidance, and assistance to Leadership Academy team members was provided by the project facilitator and Via Hope staff, as well as consultants from outside Texas when required. In addition, partnerships at the local, regional, and state level were fostered – an essential method to create knowledge across a learning community. At project end, team members noted that the resources and tools provided through the RILA experience were beneficial and that they were motivated to move forward and continue working toward a recovery oriented system of care.

RILA participants noted the importance of establishing connections among participating organizations:

"It was useful to collaborate with [participating] hospitals and centers. It is helpful to get out of our own 'box' and think from new perspectives."

Project Evaluation

Evaluation of the RILA included several components and focused on information gathered from the RILA team members. The number of team members representing organizations was small and is not considered representative of the organization. Because of this, evaluation results are limited but do offer insight into how a collaborative like the leadership academy can facilitate recovery change in an organization through a leadership team. Team member responses were collected on the following system level measures:

- Organizational structure
- Recovery orientation and readiness
- Consumer and family involvement
- Peer specialists and consumer operated service providers
- Recovery orientation
- Your local recovery community
- Use of story and organizational messaging
- The recovery orientation of boards and committees
- Recovery change team activities
- Use and application of liberating structures
- Connections among participating organizations
- Barriers encountered
- Recovery accomplishments

Data Collection

A brief organizational survey was completed by the executive sponsor from each organization at the start of the project.* The purpose of this survey was to provide a context and framework for each organization's recovery transformation process. To determine if changes occurred over the course of the initiative, Leadership Academy team members at each of the organizations completed an online survey at project baseline and end. Baseline data collection took place in November and the follow-up data collection took place seven months later in June. Each data collection window was approximately 2 weeks long. The online staff surveys were administered through Qualtrics, a secure, online survey administration tool, to facilitate data entry and analyses.

For both baseline and project end surveys, staff members provided information regarding their organization's recovery readiness and engagement, consumer and family involvement, peer specialists, local recovery community, use of story and organizational messaging, and recovery orientation of boards and committees. Respondents also completed the Recovery Self Assessment (RSA; O'Connell, Tondora, Croog, Evans, & Davidson, 2005), a validated assessment used to examine the degree to which respondents feel their respective organization engages in recovery-oriented practices. In addition, the end of project survey evaluated team member's participation in recovery oriented activities, perceived usefulness of RILA activities and resources, and recovery oriented accomplishments. These measures provided additional information regarding the outcomes that occurred over the course of the project. In addition, these data informed future planning of recovery oriented initiatives. Qualitative and quantitative data regarding team member experiences, organizational challenges, and recovery oriented achievements were also gathered during the webinars, all team calls, and regional seminars. This information was used to provide context to each team's recovery progress.

Results

RILA Team Members

One hundred forty four individuals, from six organizations, participated in the Leadership Academy. Organizations were located across Texas in urban, suburban, and rural areas. At Time 1, a total of 61 Leadership Academy team members (42%) provided demographic information via the online survey. Response rates were more modest at Time 2; with 55 respondents (38%) completing all or part of the survey. At both Time 1 (92%) and Time 2 (82%) the majority of respondents were White. In addition, a higher percentage of females (69% at Time 1, 64% at Time 2) completed the survey than males (31% at Time 1, 35% at Time 2). Last, the majority of respondents were between the ages of 34 to 44 at Time 1, and 45 to 54 at Time 2, providing percentages of 36 and 31, respectively. Results from Pearson Chi-Square analyses indicated that survey respondents were not significantly different in ethnicity, sex, or age at Time 1 and Time 2 ($p > .05$). This suggests that participation throughout the RILA was consistent and that differences in outcomes are not attributable to individual differences among respondents at project

beginning and end. Demographic information of Leadership Academy survey respondents is presented below.

Table 3 Age, Sex, and Ethnicity of Leadership Academy Respondents

Demographic		Percentage of Respondents	
		Time 1 (N =61)	Time 2 (N = 55)
Ethnicity	Hispanic	10	6
	American Indian/Alaska Native	0	0
	Asian	0	0
	Black or African American	3	11
	Native Hawaiian or Other Pacific Islander	0	2
	White	92	82
	Other	3	4
	Not disclosed	2	2
Sex	Male	31	35
	Female	69	64
	Not disclosed	1	0
Age	18 – 24	2	2
	25 – 34	15	11
	34 – 44	36	27
	45 – 54	23	31
	55 – 64	20	27
	65 or older	5	2

Table 4 Organizational Survey

Organization	Population served	Total clients seen per month	Average length of stay	Number of new clients seen per month	Number of clients who withdraw from services each month	Leadership change in past year	Staff turnover
Big Spring State Hospital	NR	200	25 - 75	45	NR	No	25% for direct care; lower in other areas
Central Counties Services	Children and adults	1,530	NR	62	43	No	20%
Denton County MHMR	Children and adults	NR	NR	NR	NR	Yes; New CEO	NR
Kerrville State Hospital	NR	187	1,044	1	0	Yes; Change in superintendent and clinical directors	2.5%

MHMR of Brazos Valley	Children and adults	1,800	NR	47	30	No	12%

Note. NR = No response; North Texas State Hospital did not complete the organizational survey.

Liberating Structures

At project start the teams joined together in Austin for the change facilitation conference. The purpose of this conference was to encourage team members to communicate and work together to spark more recovery-focused innovation through the use of Liberating Structures (http://www.liberatingstructures.com). Liberating Structures have been shown to help individuals work more effectively across functions and boundaries and overcome challenges. In line with the Leading Change framework, this conference also sought to teach participants methods for generating ownership of recovery change efforts and to recognize and celebrate short-term wins. Following the conference, nearly all of the participants responded 'agree' to 'strongly agree' to the statement that they had learned new techniques to lead change toward recovery and that they were planning to apply Liberating Structures to their work (93.6%).

Participants noted that the Liberating Structures conference was beneficial:

"Excellent conference-good material; feel increase in motivation"

Table 5 Liberating Structures Feedback

	Percentage of Respondents N = 31
I have learned new techniques to lead change toward recovery.	
Strongly Agree	45.2
Agree	48.4
Neutral	3.2
Disagree	0
Strongly Disagree	3.2
I am planning to apply Liberating Structures to my work.	
Strongly Agree	45.2
Agree	48.4
Neutral	3.2
Disagree	0
Strongly Disagree	3.2
I feel ready to use Liberating Structures to lead change in my work	
Strongly Agree	9.7
Agree	58
Neutral	25.8
Disagree	6.5
Strongly Disagree	0
I have first steps in mind for putting Liberating Structures into practice	
Strongly Agree	22.6

Agree	51.6
Neutral	22.6
Disagree	3.2
Strongly Disagree	0
I feel urgency to make progress on recovery-oriented change in my organization.	
Strongly Agree	53.5
Agree	43
Neutral	0
Disagree	0
Strongly Disagree	3.5

Systems Level Changes

Respondents provided information regarding recovery-oriented practices and systems level changes. Specifically, team members indicated whether their organization was: just beginning to learn about recovery, thinking about making recovery-oriented change, trying some things to promote recovery, or actively involved in making recovery-oriented change. A consistent percentage of individuals indicated that they were *trying* to make recovery-oriented changes (19% at Time 1; 23% at Time 2); however, fewer individuals indicated that they were *actively involved* in making such changes at Time 2 compared to Time 1 (56% versus 75%). There are several explanations for this decrease. First, the Time 2 survey occurred during the summer and many respondents were in the midst of vacation. Thus, their active engagement in project tasks may have been put on hold. In addition, as the project was coming to an end, many of the project activities and requirements had been previously accomplished. Respondents also reported whether their organization's mission statement explicitly included a recovery-orientation (1 = Yes; 2 = No). A consistent number of team members indicated that their organization's mission statement reflected a foundation of recovery at project baseline and end (77% and 68%, respectively). Respondents reported consistent recovery concept or practice knowledge and recovery-oriented practice use at project start and end. Interestingly, a higher percentage of individuals reported that they were uncertain of the staff's recovery knowledge at project end (23%) than start (13%). This change may indicate increased understanding of recovery practices among staff who did not fully understand the concept at project start and had an unrealistic positive view. Team members also reported on the staff's use of recovery practices with individuals served. At project end, a lower percentage of team members reported *agree* to *strongly agree* that the staff use recovery practices with individuals served, 62% and 81% respectively. Once again, a higher percentage of individuals indicated that they were "uncertain" of the practices being used at project end (28%) than start (11%). The lack of movement in this area was to be expected as the focus of the RILA was for team members to develop a deeper understanding of recovery orientation and recovery principals with a focus on the three organizational change themes (your local recovery community, use of story and organizational messaging, recovery orientation of boards and committees).

Following participation in the RILA, team members reported notable systems level changes:

"There's no question in my mind that it feels different and that staff are more savvy with recovery."

On the Community Connections domain, there was some variability among team member responses; however, a slightly higher percentage of individuals indicated that they *always* determine if additional organizations could be included in their community outreach and collaboration efforts at project end than start (19% and 15%, respectively). Due to the complexity of the Community Connections domain and the short time frame of this initiative (11 months), it was to be expected that gains in this area may not be

apparent at project end. However, data collected from the recovery plans did suggest movement in this area. Participating organizations noted that they had collaborated with NAMI, published recovery stories in the local newsletter, distributed recovery-oriented transformation brochures to the community, and presented information from a recovery rally on social media sites.

Overall, team members reported consistent scores in each of the domains listed below. Although reported changes were not statistically significant, this was to be expected given the small sample number of survey respondents and limited duration of the project. Nonetheless, information gathered throughout the initiative via the recovery project plans and year end conference calls suggested that some meaningful system level changes were achieved. Average response ratings on recovery orientation and readiness across organizations are reported below in Table 5.

Table 6 Recovery Orientation and Readiness

	Time 1 (N = 47)		Time 2 (N = 48)	
Survey Item	**Mean**	**SD**	**Mean**	**SD**
Recovery Stage of Change	3.62	.80	3.25	1.0
Mission Includes Recovery	1.23	.43	1.47	.78
Current Recovery Concept or Practice Knowledge	3.62	.95	3.62	.85
Current Recovery-Oriented Practice Use	3.72	.80	3.57	.77
Community Connections	3.91	.65	3.56	.92

[a] A lower mean for Mission Includes Recovery indicates that *more* team members reported that their organization's mission statement explicitly included a recovery orientation.

Consumer and Family Involvement

The engagement and involvement of participating organizations was also assessed. Specifically, team members reported the number of consumers and family members serving on their board and organizational committees from Time 1 to Time 2. A higher percentage of consumers were reported as serving on boards and committees following the RILA. In addition, a higher percentage of family members were also reported to be serving on boards, while a relatively consistent number of family members were serving on committees from Time 1 to Time 2. Data collected from the recovery project plans indicated that change teams had engaged in activities to promote consumer and family involvement within their organization. Specifically, one of the participating organizations reported that they were collaborating with NAMI to have family members share their perspective with staff. In addition, multiple organizations reported that information regarding recovery was published and distributed to family members and the local community to educate citizens regarding recovery.

RILA team members reported increased consumer and family involvement:

"You can see how the whole organization has changed from the board down."

At both time points, uncertainty remained among team members about actual consumer and family involvement in organization activities with team members differing in their responses to these items. Organizations that include high levels of consumer and family involvement tend to be more recovery

oriented. Continued participation in Via Hope initiatives, or other recovery focused collaboratives, may provide organizations with resources to promote consumer and family engagement within organizations. Survey responses of consumer and family involvement are depicted in the table below.

Table 7 Survey Responses of Consumer and Family Involvement

Theme	Percentage of Respondents[a]	
	Time 1 (N = 62)	Time 2 (N = 55)
Number of consumers serving on board		
None	41	60
One	6	10
Two	0	10
Three	0	0
Four	0	0
5 or more	0	0
Do not know	53	20
Consumers serving on organization committees or councils		
Yes	60	63
No	11	19
Do not know	30	19
Number of family members serving on board		
None	24	25
One	6	15
Two	18	5
Three	0	5
Four	0	5
5 or more	0	0
Do not know	53	45
Family members serving on organization committees or councils		
Yes	24	21
No	34	38
Do not know	43	42

[a] Percentages were calculated based on the number of people who responded to each item.

Peer Specialists and Consumer Operated Service Providers

Leadership Academy team members reported the number of peer specialists within their organization and about the existence of and connections to COSPs in their community. Although significant increases were not observed between Time 1 and Time 2, 63% of survey respondents indicated that their organization employed 2 or more full time peer specialists at Time 2 compared to only 34% of respondents at Time 1. In addition, a higher percentage of team members indicated that three or more peer specialists had attended the Via Hope training at project end (10%) than start (5%). The most frequently cited reasons for *not* employing a peer specialist included budget restrictions, recruitment, and transportation barriers. At project end, the most frequently reported services provided by peer specialists were one-on-one support (53%), facilitation of support groups (45%), helping people advocate (44%), connecting consumers to resources/networking (44%), and educational services (40%).

Table 8 Peer Specialists and Consumer Operated Service Providers

Theme	Percentage of Respondents[a]	
	Time 1 (N = 61)	Time 2 (N = 55)
Organization employs peer specialists		
Yes	77	75
Total peer specialist full time employees (at organizations employing peer specialists)*		
1	66	37
2	31	49
3	0	9
4	3	6
5	0	0
More than 15	0	0
Total	*100*	*101*
Number of peer specialists who attended Via Hope training		
1	68	62
2	27	21
3	5	10
Total	*100*	*93*
Consumer operated services providers (COSP) in your area		
Yes	12	NA
No	24	NA
I do not know	38	NA
I am not sure what a COSP is	26	NA

Note. Percentages were calculated based on the number of people who responded to each item. Information regarding COSP's was not collected at Time 2.

Webinars

Throughout the course of the RILA organizations participated in bimonthly webinars on leading change. The following key organizational change themes were discussed: Creating urgency and building guiding teams, getting the vision right and communicating for buy-in, enabling action and creating short-term wins, and implementing and sustaining the change. Given the short time frame between the pre and post webinar surveys (4 weeks), it was to be expected that scores would be relatively consistent. Therefore, qualitative feedback provided on the open ended survey items was particularly useful in evaluating movement within each of these change themes as well as frequently reported barriers. The biggest challenge noted during webinar 1 was time constraints, competing initiatives, and lack of communication between leadership and staff. Staff reported that it would be helpful if leadership placed a stronger emphasis on and commitment to recovery. Staff also noted that in-services, email communications, and newsletters would further promote recovery change efforts. On the second webinar survey, staff reported behaviors within their organizations that promote or hinder their vision of recovery. Staff stated that recovery should be discussed openly and honestly at all levels. In addition, interdepartmental unity, feedback from staff members, and additional recovery oriented trainings for all staff was requested. On the final webinar survey many short-term wins

were noted by participants such as hiring additional peer specialists, promotion of recovery within the organization, modified treatment plans to emphasize recovery goals, and person centered planning within the treatment team. However, many respondents indicated that their board and administrative staff have had limited exposure to the Recovery Initiative. The importance of recovery must be fostered at all levels within an organization in order to create and sustain recovery oriented culture change.

Table 9 Feedback on RILA Webinars

	Time 1 (N = 41)		Time 2 (N = 23)	
Topic	Mean	SD	Mean	SD
Webinar 1				
Creating urgency	4.61	.46	4.48	.32
Building teams	4.78	.35	4.59	.32
Webinar 2				
Getting the vision right	5.10	.39	4.90	.54
Communicating for buy-in	4.59	.61	4.54	.59
Webinar 3				
Enabling action	4.41	.58	4.15	.37
Creating short-term wins	4.85	.28	4.73	.35

Note. Due to time restraints, data was not collected on webinar 4: Implementing and sustaining the change. Responses on the Time 1 survey varied from 25 to 41; responses on the Time 2 survey varied from 7 to 23.

Practice Areas

RILA focused on three targeted practice areas to promote recovery-oriented culture change: (1) your local recovery community, (2) use of story and organizational messaging, and (3) increasing recovery orientation of boards and committees. Thriving communities of people in recovery are made up of informal relationships among peers that provide mutuality, wellsprings of hope, and empowerment outside of formal service settings. Within the first practice area (i.e., your local recovery community) organizations were encouraged to discover the local recovery community in their area and/or work to promote a sense of community outside the formal set of services their organization provides. For the second practice area (i.e., use of story and organizational messaging) organizations were asked about the stories being told in their organization—about the people in their community living in recovery, about their organization's transformation, and about the need for change. Using story within an organization's transformation efforts encourages people to imagine how things could be different for individuals served, and how organizations could help make that happen. The final practice area (i.e., increasing recovery orientation of boards and committees) examined progress on the development of recovery-oriented boards and other decision-making committees. Overall, organizations demonstrated the greatest increase in practice area 2: use of story and organizational messaging. Specifically, increases were noted in the development and maintenance of a speaker's bureau and implementation of a recovery story communications plan.

> "I feel very positive about the recovery movement and want to continue to be involved in helping my agency recognize the need for change."

Table 10 RILA Practice Areas

	Time 1 (N = 38)		Time 2 (N = 47)	
Practice Area	**Mean**	**SD**	**Mean**	**SD**
Local recovery community	3.39	1.16	3.67	1.00
Use of story and organizational messaging				
Development and maintenance of a speaker's bureau	3.96	1.21	4.30	1.13
Organizational-level recovery messaging	4.30	1.18	4.50	1.11
Implementation of a recovery story communications plan	3.45	1.24	3.78	1.31
Environmental wellness	3.89	1.26	3.90	1.13
Recovery orientation of boards and committees	3.39	1.20	3.63	1.05

Data acquired from the recovery project plans suggested that many of the organizations had made significant movement in each of the practice areas; however, completion of recovery plan activities may not have been detected by the survey. Notable practice area accomplishments documented in the recovery plans are noted below.

Practice Area 1: Local Recovery Community

- Presenting at NAMI
- Engaging local organizations to share information about recovery
- Utilizing social media to showcase recovery stories,
- Displaying information and pictures from a recovery rally within the local community
- Building connections with social service agencies, and
- Disseminating recovery stories (via newspaper and radio) to the community.

Practice Area 2: Use of Story and Organizational Messaging

- Holding a recovery rally
- Creating vision and mission statements that reflect principles of recovery
- Developing brochures with recovery stories
- Discussing recovery during staff meetings
- Helping persons in recovery communicate their story
- Increased patient voice, and
- Revising organizational materials (website, brochures, lobby) to include recovery oriented language.

Practice Area 3: Recovery Orientation of Boards and Committees

- Peer specialists had shared their recovery story with their board,
- Peer specialists were included on quality and utilization management committees
- Educational materials were provided to board members on recovery and the recovery movement, and Recovery was incorporated into the new employee orientation.

Recovery Self Assessment

The Recovery Self Assessment (RSA; O'Connell, Tondora, Croog, Evans, & Davidson, 2005) is a widely used, validated assessment, which examines the degree to which respondents feel their respective organization engages in recovery-oriented practices. The RSA was considered by UT-CSWR to be the measurement of recovery orientation for the organization, as perceived by RILA team members. It is a 36-item survey that measures five components: Life Goals, Involvement, Diversity of Options, Choice, and Individually Tailored Services. Participants responded on a 5-point scale, where 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, 5 = Strongly Agree.

Responses at Time 1 and Time 2 were fairly consistent, with no significant change on the total score or subscales. This validated instrument may not be sensitive to small changes in recovery-oriented practices. Further, response rates were modest at both time points. It is anticipated that with prolonged participation and involvement in a recovery-oriented learning community, RSA scores will reflect changes in recovery engagement and practices. The overall average responses across all organizations participating in the RILA at Time 1 and Time 2 are listed below.

> "Thank you. Even doing this survey shows more possibilities from which we can grow as an organization."

Table 11 Mean Responses on the Recovery Self Assessment

	Time 1 (N = 52)		Time 2 (N = 51)	
RSA Subscales	Mean	SD	Mean	SD
Life Goals	3.97	.56	3.78	.69
Consumer Involvement and Recovery Education	3.63	.62	3.40	.85
Diversity of Treatment Options	3.70	.58	3.64	.72
Choice - Rights and Respect	3.85	.62	3.71	.79
Individually-tailored Services	3.80	.68	3.87	.80
RSA Total	3.80	.52	3.68	.66

Note: Higher averages indicate stronger engagement in recovery-oriented practices.

The most varied responses within each subscale category are presented below:

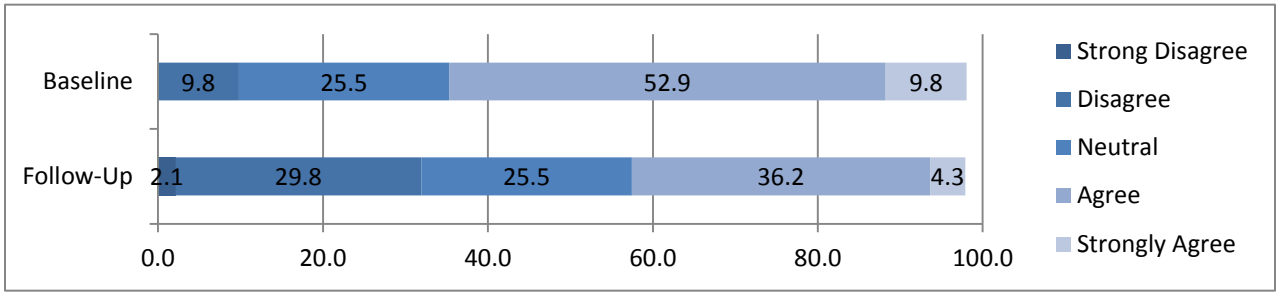
Table 12 Distribution (Percent of Total) of All Respondents Across 5 Response Options on the RSA

Life Goals

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. (23)

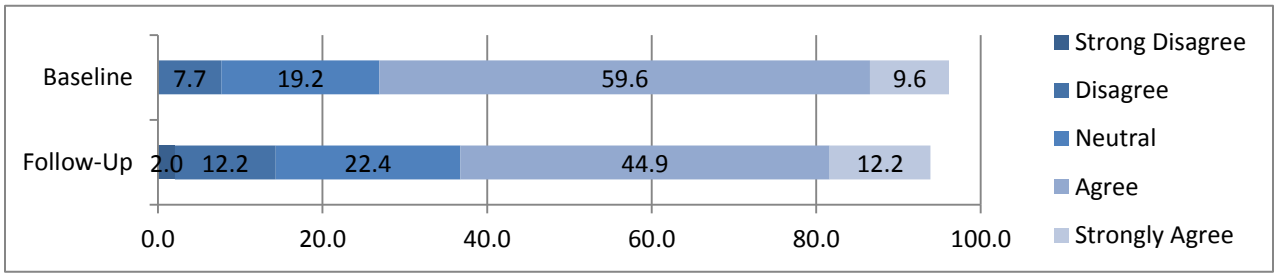
Consumer Involvement and Recovery Education

People in recovery work alongside agency staff on the development and provision of new programs and services. (30)



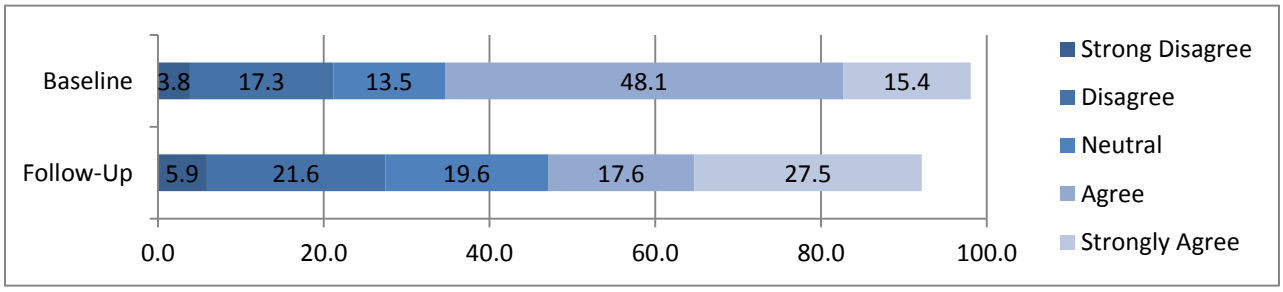
Diversity of Treatment Options

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. (18)



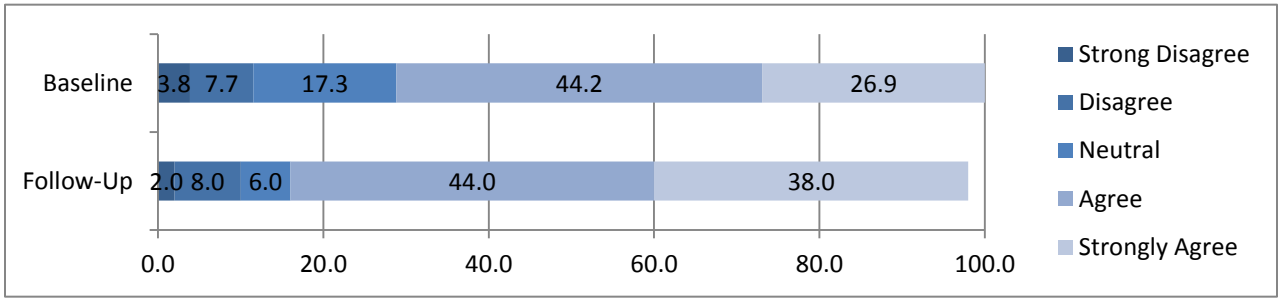
Choice -- Rights and Respect

People in recovery can choose and change, if desired, the therapist, psychiatrist, or other service provider with whom they work. (6)



Individually-tailored Services

This agency offers specific services and programs for individuals with different cultures, life experiences, interests, and needs. (2)



Wrap-up Conference

> "The Wrap Up session was outstanding! The last 2 weeks have energized me! Thank you so much for your help and guidance. "

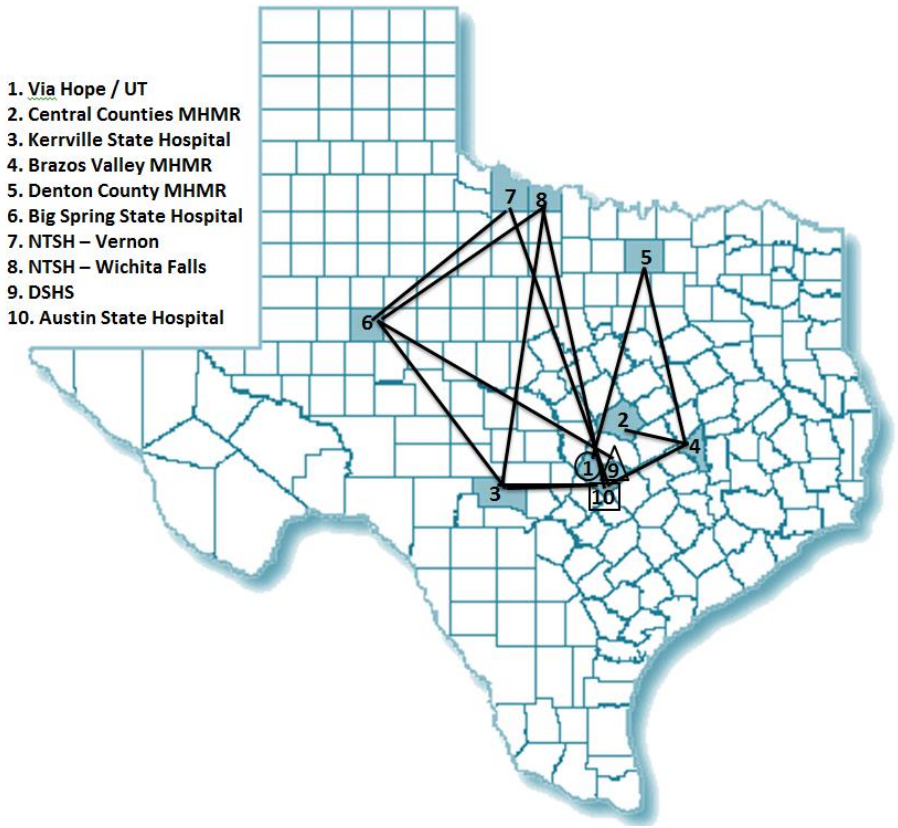
At the end of the project all of the organizations joined together in Austin for a 2-day wrap-up conference. The conference featured experts in the field, small work group sessions, and collaboration among participating organizations. An opening keynote on peer support and expansion of peer provided services by organizations through the 1115 waiver was presented by Janet Paleo, with the Texas Council of Community Centers, and a closing keynote on recovery transformation was delivered by Harvey Rosenthal, of the New York Association of Psychiatric Rehabilitation Services. All of the organizations were represented at the end of year wrap-up conference. Prior to the conference, teams were instructed to select one or two representatives to share something new or innovative their team was doing that may be of value to others. During the conference, every team "hosted" a station where other teams rotated to. Team members reported that the presentations were insightful and provided valuable information regarding opportunities for recovery oriented change within their organization. In addition, the small work group sessions fostered communication and collaboration among participants. Participants reported that the wrap-up conference cultivated partnerships among organizations, the purpose of a learning collaborative.

Connections among RILA Teams

> "Thank you for all the great info and connections with one another."

The development of partnerships at the local, regional, and state levels was fostered. At project end, team members reported connections they had established among participating organizations. Each line represents a connection. As depicted below, each of the organizations had established at least one connection. Teams noted the usefulness of fostering collaboration among participating organizations at the wrap-up conference and during the year end calls.

Figure 2 Connections among RILA Teams



Usefulness of RILA Activities and Resources

> "Thank you so much for all your efforts in "The Recovery Movement" in Texas, the expense and efforts have been so worth it!"

Team members were asked to rate the usefulness of each of the RILA activities and resources. Respondents rated each of the items on a scale from 1 to 5, where 1 = not at all helpful and 5 = very helpful. The 2-day onsite visit led by David Stayner and the end of year wrap-up conference received the highest ratings. Teams reported that individualized contact and feedback (via the onsite visit) helped to mobilize efforts and further promote recovery oriented change. Formal training opportunities were also noted as beneficial methods for generating excitement and sharing information. These tools were reported to be successful modalities of change.

Table 13 Usefulness of RILA Activities

	Mean
2-day onsite visit with David Stayner	4.41
Wrap-up conference	4.31
Individual project plan TA call	4.00
Liberating Structures conference	4.00

Bimonthly RILA webinars based on Kotter's Change Model	3.93
Bimonthly RILA practice calls	3.89
Leading Change Field Guide	3.82
Use of Liberating Structures within my organization	3.72
Information disseminated through RILA listserv	3.66

Site Reports

Qualitative and quantitative program evaluation data 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 were collected, UT-CSWR provided each organization with a "RILA Results Dashboard." The RILA Dashboard included the following information: the number of staff members who completed the survey at that individual organization, organizational change efforts, recovery practice areas, webinars on leading change, recovery self assessment, and connections among participating teams.

Accomplishments

> "We really made some progress this year...definitely the culmination of our efforts and affiliation with viaHOPE. Thank you for your continued support and belief!"

Participation in the RILA resulted in teams reporting many recovery-oriented gains over a short period of time (11 months). Participants from each of the organizations developed recovery project plans and began implementing recovery-oriented practices. It was understood that each team was participating in the Leadership Academy within a unique organizational culture, history, and leadership style. As previously presented (Figure 1), organizations were located across Texas in urban, suburban, and rural areas and they differed in size, resources, and services offered. The Leadership Academy model emphasized the local expertise of the team, and this was also assumed to be true of each person in the organization. All teams requesting additional resources and support received good faith consideration and consultation from Via Hope about the relevant issue(s). Many of the participating Leadership Academy team members expressed appreciation for the amount and quality of support provided by Via Hope throughout the RILA initiative and interest in continuing their participation in future Via Hope Recovery Initiatives.

Limitations

Limitations to the current study exist. The provision of recovery oriented care was primarily measured through staff completion of the project survey and self-reported data collected during group calls and the final phone interview. While adequate reliability and validity evidence exists for RSA total and subscale scores, the sensitivity of this measure has not been evaluated. Given the short time frame of this project, changes in the recovery orientation of participating organizations may not have been detected by this measure and the level of implementation of self-reported recovery practices could not be adequately measured. Similarly, during the project end interview calls, participants noted that more improvements could be made with additional time invested. The implementation of a longer term learning community should be evaluated as an extended timeline may lead to more meaningful and sustained changes. Additionally, feasibility, accessibility, and convenience of the survey completion may have reduced the response rates. Future data collection efforts should include interviews or focus groups with additional staff

beyond the change team and clients to further examine the quality of recovery practices being provided. These efforts could be supported by local peer specialists.

Policy Implications

> "I am excited about the direction the State of Texas is moving with a recovery-oriented system of delivery. Via Hope is a great resource in helping the movement."

Reforms should support strategies that improve communication between local and distant providers, educate individuals regarding recovery and use of local mental health care services, and ensure that individuals can receive recovery oriented care effortlessly. The learning community format and philosophy encourages the sharing of lessons learned by individuals and organizations across communities. Increased face-to-face time may further promote the development of trust and increase the collaboration among participating members. In addition, regionalized phone calls may assist organizations in addressing issues particular to their region, for example, issues specific to rural Texas. Further, while the current learning community emphasized hiring of peer specialists as a vehicle for the needed recovery oriented change, recovery-supportive cultures and processes are needed in order to support and sustain peer specialists' work. This culture change, together with professional skills training on practices to support recovery, could provide a recovery-oriented environment in which clients, clinical staff, and peer specialists could thrive.

Conclusion

> "Thank you for the wealth of knowledge, expertise and education you have given me this year."

The aim of this initiative was to engage formal and emerging organization leaders in a learning process on recovery oriented mental health system transformation, cultivate a culture of learning in organizations, introduce recovery-oriented practice, and facilitate movement in each of the three key organizational practice areas (i.e., your local recovery community, use of story and organizational messaging, and the recovery orientation of boards and committees). Results of this evaluation indicated that participating organizations made valuable gains in each of the aforementioned areas and obtained notable improvements in working towards a recovery-oriented framework. It is expected that with continued participation and involvement in recovery institute initiatives, team's organizations will continue to achieve recovery-oriented accomplishments. Moving forward, it is important for Via Hope to continue providing technical support and assistance to mental health agencies across Texas to cultivate a recovery-oriented system of care.

Recommendations

Consideration: Participants noted that more improvements could be made with additional time invested.

Recommendation: The implementation of a longer term learning community should be evaluated as an extended timeline may lead to more meaningful, measurable and sustained changes.

Consideration: A stepped process of learning about recovery and recovery practices was used for the RILA with positive results for the participating leadership teams. In addition, the RILA used targeted practice areas to focus the team's recovery work.

Recommendation: Based on evaluation results and qualitative feedback from teams, Via Hope should continue to offer recovery learning experiences using formats similar to the RILA. The stepped learning structure was helpful to organizational teams that were beginning to learn about recovery and wanted to explore recovery oriented practices. The targeted practice areas structured the recovery project plans and provided ideas for recovery oriented work, while allowing for flexibility and creativity. Focusing on a measurable client outcome related to the RILA activities might additionally focus the work of organizational change teams.

Consideration: The onsite visits were seen as extremely valuable by most participants and were where much of the team learning and next steps development occurred. The conferences provided a shared experience for the team, guidance from national experts in the field of recovery, and collaboration among participating organizations. Team members noted that the collaboration among participating teams was particularly useful.

Recommendation: Continue to increase opportunities for collaboration among participating organizations and develop more user-friendly ways of increasing communication across teams. For instance, facilitating regionalized conference calls, webinars, and/or initiating an online forum for participating organizations could be considered. This would promote communication across organizations on recovery-oriented change. Team members should continue to be encouraged to share their success stories and areas of expertise as well as the barriers they may be encountering as other teams could provide assistance based on their own experience.

Consideration: Team members noted that individualized calls would further promote recovery progress.

Recommendation: Teams should receive individual coaching calls on at least a monthly basis. Individualized calls would allow the project facilitator to monitor each team's adherence to their recovery project plan as well as provide teams with individualized assistance regarding barriers, next steps, and recovery oriented changes within their organization.

Consideration: Only a few teams were able to provide monthly updates to their recovery project plans. In addition, many of the participants noted confusion regarding the "percent complete" column on the recovery plans.

Recommendation: Individualized TA regarding the use and maintenance of recovery project plans should be provided to participating change teams at project start. Each change team should assign an individual to be responsible for updating, monitoring, and submitting the recovery project plan each month. In addition, the project facilitator should send out a reminder for teams to submit their recovery project plans each month. Instead of a "percent complete" column it may be helpful to explore alternative methods for tracking recovery progress. For instance, "backlog, in-process, or complete" may be a viable alternative.

Consideration: The evaluation survey was not completed by all respondents at project baseline and end. However, team members who received a site report indicated that it helped their organization identify strengths and areas for improvement as well as track progress on goals.

Recommendation: The importance of participating in the RILA data collection should be stressed by the RILA project lead and CSWR evaluator. Working collaboratively with participating teams regarding their specific evaluation goals and needs is recommended. Change team leaders and executive sponsors may also benefit from coaching on the ways to use data in support of change efforts. Promoting the usability of such reports may increase survey response rates. In addition, staff from CSWR should investigate convenient times to collect project evaluation data. The data collection period at project end took place over the summer and many team members were unavailable. Conducting the second data collection period at a later or earlier time period, when possible, should be considered.

Consideration: Data in the form of surveys or focus groups were not collected from clients receiving services at the organizations during the RILA.

Recommendation: Feedback from clients on the specific practice areas may validate not only the feedback from change team staff but also motivate and encourage change team efforts. This would also increase consumer involvement within the organization.

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