CENTER FOR SOCIAL WORK RESEARCH

Recovery Oriented Change Initiative: Peer Specialist Integration

Summary Report: October, 2013

viaHOPE TEXAS MENTAL HEALTH RESOURCE

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Recovery Oriented Change Initiative: Peer Specialist Integration

Quality Improvement Evaluation

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Introduction

Overview of the Initiative

The overall purpose of the Via Hope Recovery Institute is to promote mental health system transformation by (1) helping organizations develop culture and practices that support and expect recovery, and (2) promoting consumer (aka peer, person in recovery), youth/young adult, and family voice in the transformation process and the future, transformed mental health system. The Via Hope Recovery Institute interfaces with transformation efforts facilitated directly by Texas Department of State Health Services (DSHS) Mental Health and Substance Abuse Division and is a significant component of the Division's transformation strategy. The Institute is funded through DSHS and the Hogg Foundation for Mental Health and evaluated by The University of Texas at Austin Center for Social Work Research. (Via Hope, 2013)

One initiative within the Recovery Institute is the **Recovery Oriented Change Initiative - Peer Specialist Integration project (ROCI-PSI)**, which is designed to help provider organizations advance recovery orientation and improve the integration of peer specialists and use of peer support services within the organization utilizing a learning community approach. Organizations in this level of the Recovery Institute were provided with more intensive training and technical assistance activities and were expected to meet more requirements to increase organizational readiness and demonstrate commitment to the integration activities. To lead these efforts, each organization designated an Executive Sponsor and Change Team with substantive peer representation.

Goals of the ROCI-PSI

The primary goals of the ROCI-PSI are (1) the organization's leadership team / change unit staff (including peer specialists) participating in the ROCI-PSI improves the recovery orientation, recovery knowledge, and use/implementation of recovery-oriented practices in the organization, and (2) the organization increases peer specialist integration. A secondary goal is to identify and document organizational processes or policies that may require change or redesign to facilitate more effective integration of peers in a recovery oriented organization.

Goals of the formative evaluation

Because Recovery Institute programming is in its infancy, the evaluation of Via Hope's ROCI-PSI initiative is primarily formative in nature. In other words, it is an ongoing, iterative assessment of the value of program activities while they are evolving. The goal of this evaluation is to continuously improve upon the various aspects of the program. This report highlights some of the ways that the ROCI-PSI has impacted participating organizations, while also recognizing the processes in which organizational parameters affect program participation. Results of this evaluation will demonstrate if goals of the ROCI-PSI were achieved but are also intended to be part of a continuous process improvement effort and provide lessons learned to Via Hope in working with other community center and hospital sites.

The questions driving this Quality Improvement evaluation were:

- What was the quality of engagement of the participating organizations?
- What organizational activities are considered markers or indicators of recovery practices?
- Does recovery knowledge of staff change from Time 1 to Time 2?
- Does staff report of the organization's recovery orientation change from Time 1 to Time 2?
- Has the integration of peer specialists within the organization improved from Time 1 to Time 2?
- What barriers to peer specialist integration are identified?

This report of the ROCI-PSI's impact on the participating sites is not exhaustive and does not capture all of the changes and activities occurring as a result of the work. However, data is strategically presented to provide the context in which the program occurred as well as to answer specific evaluation questions (presented above). Together, this information will be used to shape future ROCI-PSI initiatives by refining training and technical assistance as well as improving understanding of the needs specific to Texas public mental health agencies.

Method

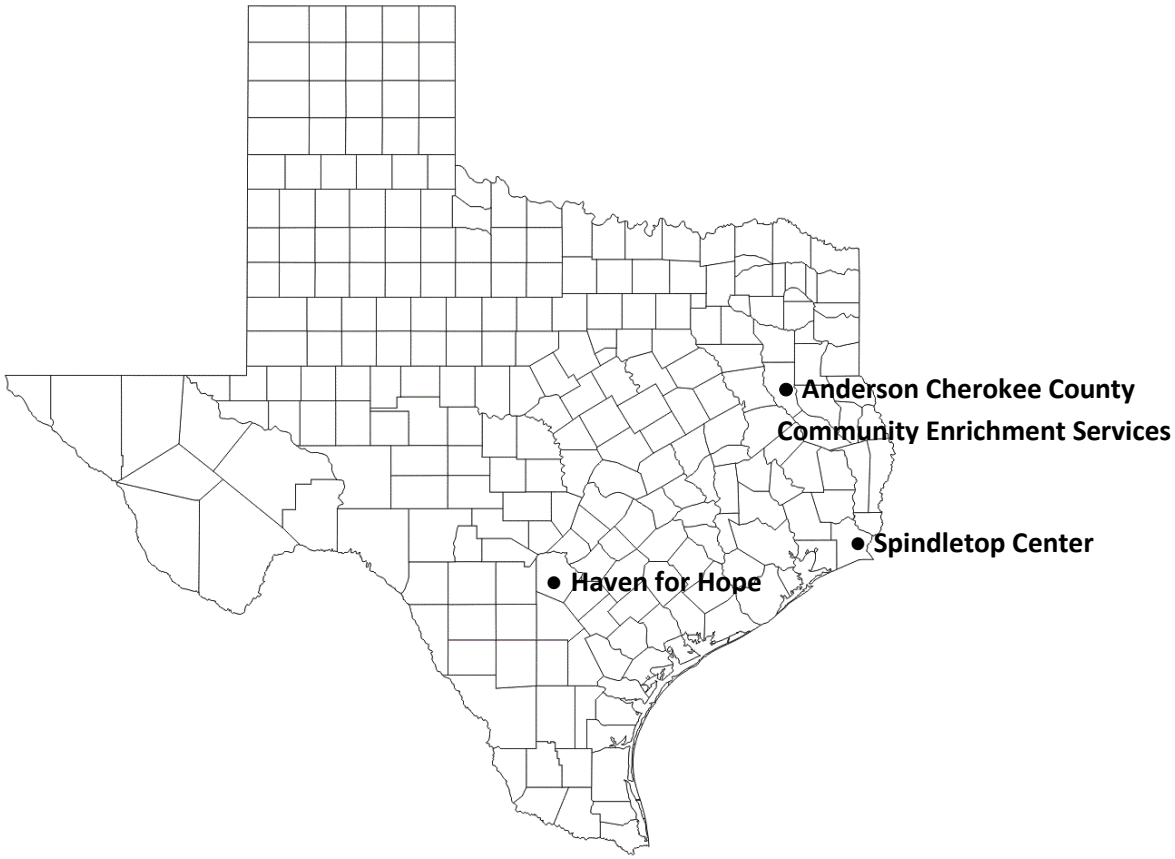
Participants

The ROCI-PSI fiscal year (FY) 2013 learning community was comprised of participants from (1) Spindletop Center (STC) in Beaumont, Texas, (2) Anderson Cherokee Community Enrichment Services (ACCESS) together with Cherokee County Peer Support Group (CCPSG) in Jacksonville, Texas, and (3) Haven for Hope (HH) together with the Center for Healthcare Services (CHCS; renamed *The Center for Hope*) in San Antonio, Texas (Figure 1). A core leadership/change team at each participating entity was responsible for implementing ROCI-PSI work in their change units. These teams also partnered with other employees who were working in the change units, but who were not directly responsible for project work. Core team size ranged from 6 to 17 members (Table 1), fluctuating very little throughout the project. For more information regarding evaluation of the ROCI-PSI initiative at the individual sites, please refer to Appendices A – C.

Table 1. Participating organizations

ROCI-PSI Organization	Change Unit	Number of Core Team Members
Haven for Hope & Center for Healthcare Services	Integrated Care Clinic	17
Spindletop Center	Community Support Services	8
Anderson Cherokee County Community Enrichment Services & Cherokee County Peer Support Group	"56" Rehabilitation Clinic	6
	Total	31

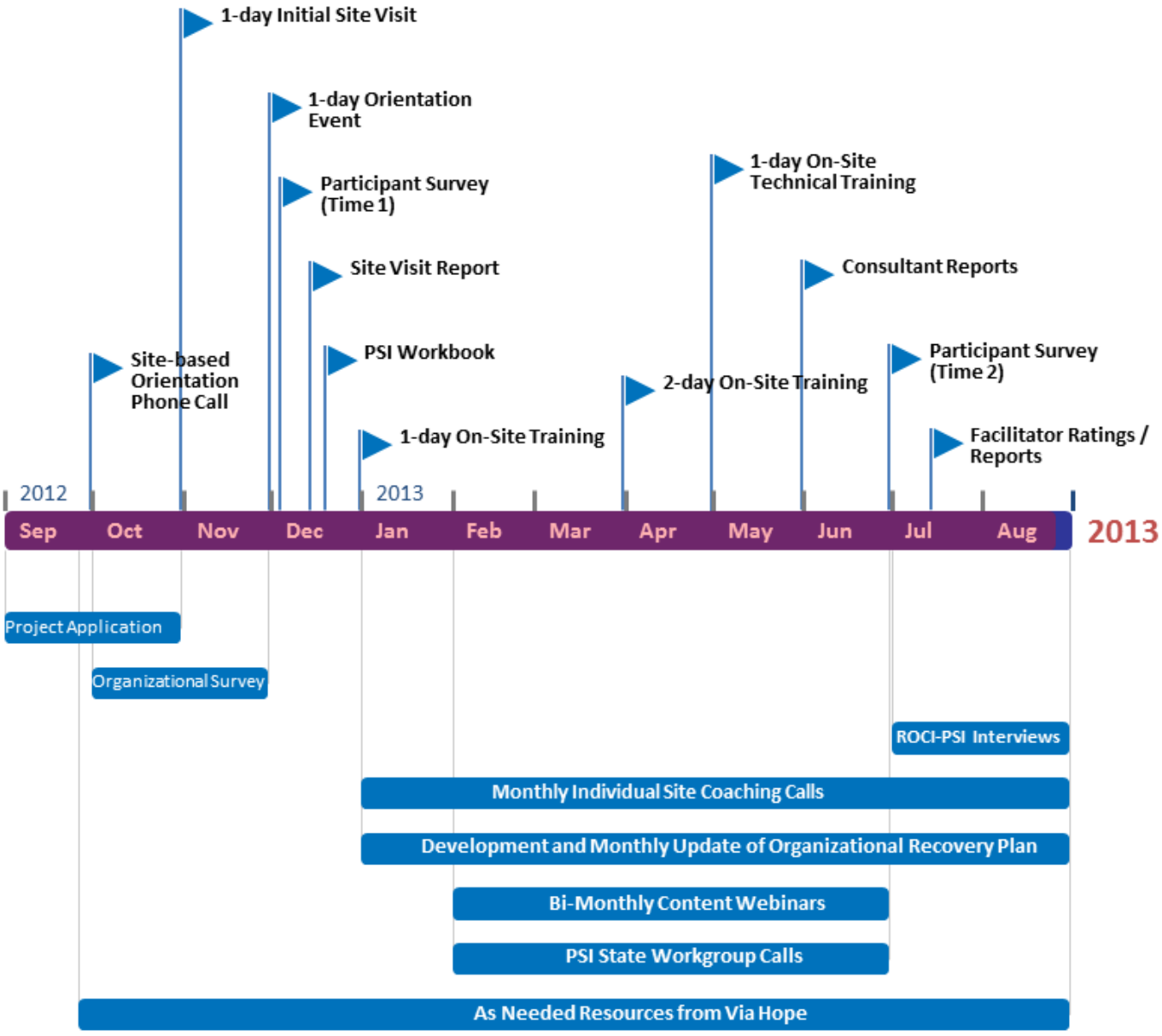
Figure 1. Map of participating organizations



Data Collection

Data collection for the Fiscal Year 2013 ROCI-PSI initiative took place over a period of 12 months, between September 2012 and August 2013. Sources of the information collected (Figure 2) were the training and technical assistance events that constituted the ROCI-PSI project. These events included the project application, initial organizational survey, a site-based orientation phone call, selected interviews regarding the PSI workbook (Via Hope, 2012), a participant survey administered at two time points, and all training and technical assistance (TTA) elements of the project. Data was collected in the format of discussion/interview notes, observations, checklists, and surveys.

Figure 2. Timeline of ROCI-PSI training and technical assistance events



Peer Specialist Integration Workbook

The PSI workbook was central to the ROCI-PSI project. The spiral bound book was distributed to change team members at the launch event and used as a reference and activity guide for change work throughout the project. This TTA element was used in conjunction with many others, often referenced on calls and during training events in response to questions and resource needs. Change team members each had their own copy of the workbook and were able to reference it as-needed whenever questions or the need for information or inspiration arose. The workbook used in FY2013 was a first draft and is being refined and re-published in subsequent years based on lessons learned, evaluation findings, and stakeholder and consultant feedback.

Results

Findings are based on all data collected including the application, initial organizational survey, a site-based orientation phone call, selected interviews regarding the PSI workbook (Via Hope, 2012), all training and technical assistance elements of the project, and a participant survey administered at two time points. An invitation to complete the participant baseline and follow-up survey regarding participation in the Recovery Oriented Change Initiative-Peer Specialist Integration (ROCI-PSI) initiative was sent to staff on the site change teams in December 2012 (Time 1) and July 2013 (Time 2). Table 2 (below) presents the response rates for each of these surveys.

Table 2. Survey response rates

Time	Site 1	Site 2	Site 3
1	40.0%	44.4%	33.3%
2	41.0%	50.0%	25.0%

Organizational Context

Organizational Context

Table 3 below summarizes results from an organizational survey completed by the ROCI-PSI change team executive sponsor at the beginning of the initiative. One organization had received funding to promote recovery oriented change and two organizations had a recent change in leadership. In the fiscal year prior to ROCI-PSI participation, all participating sites were participants in another Via Hope Recovery Institute initiative, the Recovery Institute Leadership Academy (RILA).

Table 3. Organizational survey

Measure	Site 1	Site 2	Site 3
Change in leadership in past year	Yes[1]	No	Yes[3]
Percentage of staff turnover at the change unit	N/A*	25%	50%
Percentage of staff turnover at the organization	20%	13%	-
Funding to promote recovery change	Yes[2]	No	No

* Change unit was not yet operational at time survey was conducted

- no response given

[1] Description of leadership change: *CEO retired; CFO resigned; HR Director resigned.*

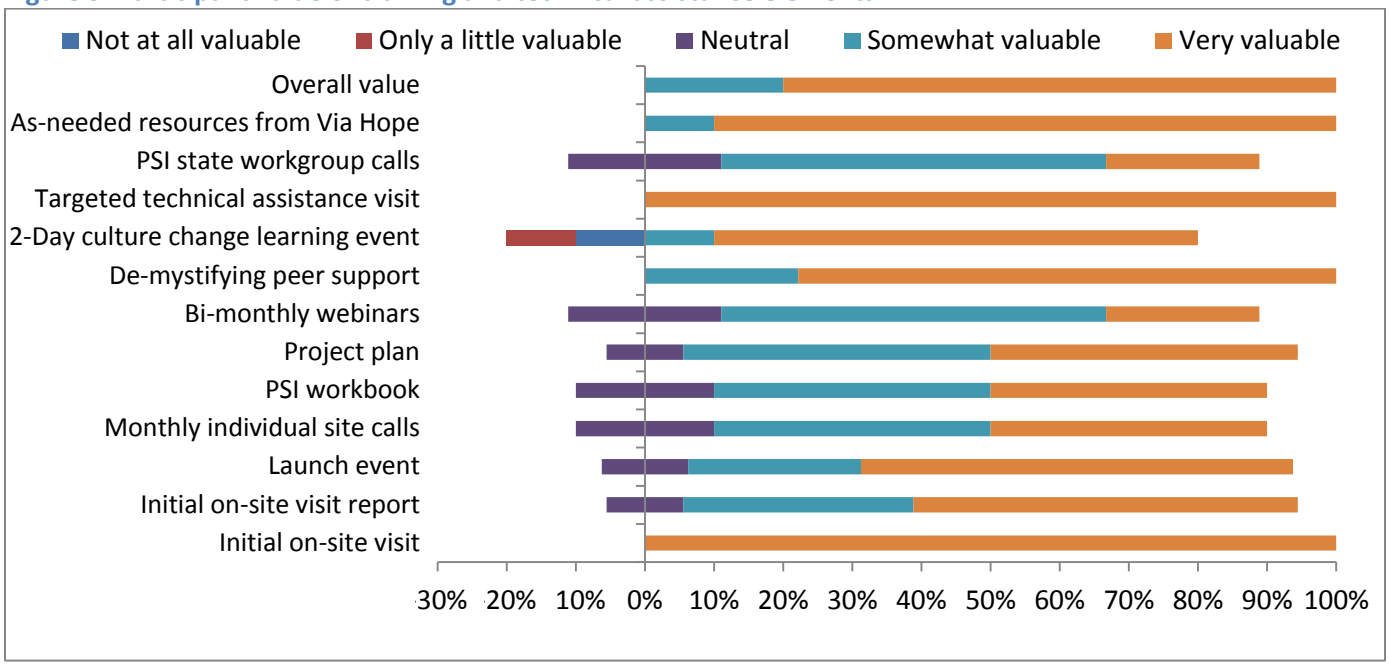
[2] Description of funding to promote recovery change: *CMS innovation grant; SAMHSA Housing initiative grant; PATH*.

[3] Change in leadership reported: *new Executive Director*

Quality Improvement findings

Findings from the ROCI-PSI surveys (Time 1 and Time 2) as well as other data collected from project activities are presented below to address the six questions guiding the evaluation. Overall, respondents thought that the project training and technical assistance *aligned very well* with their organizations' work regarding peer specialist integration (M=4.8 out of 5), though some TTA elements were more highly valued than others (**Error! Reference source not found.**).

Figure 3. Participant value of training and technical assistance elements



Evaluation question 1: What was the quality of engagement of the participating organizations?

Via Hope facilitators rated the engagement of sites with the ROCI-PSI, which was indicated by attendance at project trainings and TA elements, quality of participation, progress on project plan activities, and performance of work above and beyond project plans. Via Hope facilitator ratings aligned closely with specific indicators of engagement and progress (Table 4).

Table 4. Site engagement

Site	Observations	Facilitator Rating*
1	• *Engaged on monthly site calls* • *Provided helpful feedback to us regarding TA visits on the calls* • *Made considerable progress on project plan change activities* • *Maintained detailed project plan and with goals directly reflecting Via Hope recommendations* • *Had a high level of urgency*	4
2	• *Solid attendance on calls* • *Diverse group of staff (clinical, peers) on monthly calls* • *Visible progress on project plan change activities from month to month* • *Strong in group communication (ex: held conversation café activity)*	4
3	• *Did not appear that significant progress was made on project plan change activities* • *Provided updates primarily on the status of hiring peer support specialists on monthly calls* • *Staff did not ask many questions of Via Hope staff* • *No new potential change activities developed during TA visits were added to the project plan*	2

* = Engagement rating on a scale of 1 “not at all engaged” to 5 “very engaged”

Evaluation question 2: What organizational activities are considered markers or indicators of recovery practices?

One source that evidenced team engagement in activities indicative of recovery-oriented practice were the goals listed on the ROCI-PSI project plan (Table 5), which were organized by key area of peer specialist integration work. For one highly engaged site, all goals listed were in response to feedback and recommendations from Via Hope. For two sites, consistent progress was made with regard to these goals, many of which became ongoing practices. A third site did not make regular progress toward goals due to initial hiring barriers.

Table 5. Project plan goals by peer specialist integration target area

Target Area	Site 1	Site 2	Site 3
	Goal		
Organizational Culture	Increase staff, leadership, and consumer participation within recovery-oriented approach model.	Educating staff on recovery.	Build connections within the center.
	Increase staff, leadership, and consumer knowledge about peer support specialist integration and the recovery-oriented approach model.	Recovery emails.	Educate center and community about recovery.
	Increase consumer involvement in development and facilitation of agency programming.	Provide education to community on mental health recovery.	Meet the needs of other cultures.
Funding	Increase efforts to sustain peer support specialist funding.	Secure funding for recovery projects.	Acquire finances.
		Develop purchase request process for recovery projects.	Establish a budget.
Roles	Clarify peer support specialist job description and roles for the clinic.	Clarify roles of peer specialist in the change unit.	Develop staff standards.
			Create job descriptions.
	Develop practice guidelines specific to clinic staff.	Clarify roles of peer volunteers.	Keep staff informed.
Recruitment, Retention, and Hiring	Develop peer support specialist job descriptions specific to hiring program.	Clarify ADA issues for applicant screening and interviewing.	Train staff.
	Establish recovery-oriented hiring practices.	Recruitment.	Educate the community and staff.
	Develop supervision support plan to address evidenced based service needs.	Training newly hired peer providers.	
Supervision	Establish ongoing and consistent peer consultation network.	Ensure appropriate types of supervision for peer specialist.	Peer specialist clinical supervision.
	Develop mentorship program model for peer support staff.	Ensure appropriate supervision for peer volunteers.	
	Develop positions in key program and organizational meetings for peer support specialist.		Peer supervision by peer specialists.

Accomplishments which evidence movement of the teams towards achieving goals and engagement in related recovery-oriented practice activities include, but are not limited to:

- A 2-page overview of highlights from the ROCI-PSI project was created, primarily to explain and clarify the peer specialist role to the team. The handout was shared at a partner meeting in which the organization and community partners convened so that the division was made aware of progress and work being done (Site 1; key PSI area(s): roles, organizational culture);
- Developed a peer support specialist training module to be used to deliver information about the peer specialist role, how they fit into clinic, and how peer specialists could be integrated in other areas of the organization (Site 1; key PSI area(s): organizational culture, roles, and recruitment/retention/hiring);
- Established organization's first two official peer support positions, responsible for campus orientation and assistance with Person Centered Plan (PCP) preparation (Site 1; key PSI area(s): roles);
- Peer specialists throughout the organization created a PowerPoint video about the role of peer support specialists and highlighting how peers fit in to existing systems, how they fit into the recovery-oriented model, and the value they add to existing services. It will be used in new employee orientation training and in divisional trainings and presentations to the community (Site 1; key PSI area(s): roles, organizational culture, recruitment/retention/hiring);
- Presented on recovery and trauma-informed care at Board of Directors meeting, specifically on statistics related to people experiencing homelessness (Site 1; key PSI area(s): organizational culture);
- A peer support career ladder was established, including qualifications for different positions, competencies, pay grade, and first step in credentialing (Site 1; key PSI area(s): recruitment/retention/hiring);
- Distributed SAMHSA peer support pamphlets at BOD meeting (Site 1; key PSI area(s): organizational culture);
- Established precedence of reallocation of clinical position into 2 peer specialist positions by looking beyond current job descriptions (Site 2; key PSI area(s): recruitment/retention/hiring);
- Human Resources established guidelines regarding the hiring of peer providers, including creation of a pay scale, title, and job description within state-defined parameters (Site 2; key PSI area(s): recruitment/retention/hiring, roles);
- Created a strategic peer specialist supervisor position (also an LPC supervisor) (Site 2; key PSI area(s): supervision); and
- Asked staff to share their versions of recovery, of what it meant to them, and shared with all unit staff (Site 2; key PSI area(s): organizational culture).

Processes developed in progress toward selected change goals

What is perhaps more important to consider than discrete goals, goal achievement, or other accomplishments are the ongoing processes that organizations develop, which are essential for viable change. Project sites established a number of sustainable processes that have helped and will continue to help the organizations move toward greater peer specialist integration and recovery-oriented care. Recovery-oriented change processes developed by the project sites include, but are not limited to:

- Using the project plan to maintain processes of identifying and working toward specified project plan goals (i.e., identifying who's responsible and potential barriers when taking steps toward recovery work goal; Site 2);
- Adopting a Liberating Structures tool (Conversation Café) used during meetings (Site 2);
- Establishing a monthly change team meeting (Site 2);
- Refining Human Resources processes (i.e., interview questions, defining roles, onboarding) promoting integration of peer providers into status of "any other employee" (Site 2);
- Integrating information learned from the ROCI-PSI workbook as well as trainings and technical assistance to define and refine peer worker policies and practices (e.g., to get a clear understanding of what roles a peer provider could and could not perform at the agency; Site 2);
- Utilizing the PSI workbook to find concrete solutions to issues (e.g., to develop interview questions; Site 2);

- Utilizing information gathered from on-site peer specialist TA and PSI state workgroup calls to improve the screening process for peer employee candidates (i.e., addition of attestation statement; Site 2);
- Establishing more formal co-supervision group meetings among peer staff (Site 2);
- Holding brown-bag meetings to discuss peer support and CPS duties (peers are encouraged to convene and discuss their roles and expectations; Site 2);
- Change team staff reported creating a more collaborative working relationship between partner organizations (Site 1);
- Using the project plan not only to initially identify specified project plan goals (i.e., identifying who's responsible and potential barriers when taking steps toward goal), but also transferring activities into workgroups where ongoing work was needed (Site 1);
- Translating project plan goals into workgroup agendas where various groups took charge of activities (Site 1);
- Management team began requiring team members to give a weekly report on what they worked on related to recovery. This signaled to staff that using recovery on an ongoing basis is expected, leading to notable buy-in from the team. This practice fostered a sense of urgency in the team (Site 1);
- Disseminating recovery messages at weekly supervision meetings and larger partner group divisional meetings, in which each program administrator reports how recovery processes are being integrated (Site 1);
- Workgroup to create peer career ladder, establish standard operating procedures (SOP) for peer specialist integration, and standardize peer roles throughout the organization (Site 1);
- Workgroup to bring together all the peers in the center with a single LPHA peer mentor/coach with the overarching goal of sustainability of the peer workforce and ongoing goal of developing a sustainable billing process (Site 1);
- More training opportunities related to peer integration and recovery orientation made available (Site 1);
- Bi-weekly workgroup meetings focused on overall peer integration (Site 1);
- Identification of an LPHA to provide supervision to all the peers in the agency (Site 1);
- Developing and refining effective supervision processes / protocols in the change unit. For example, processes established include: individual and group supervision, professional development plans, video/audio recording of client sessions to provide feedback to peer staff, regular team meetings dedicated to resolving complex issues encountered, a process for having as-needed one-on-one meetings with non-peer staff regarding peer specialist role clarification, and a feedback loop for letting peer staff know that their concerns have been communicated to the larger agency (Site 1);
- Establishing strategic planning leadership meeting to support overall shared vision moving forward (Site 1); and
- Establishing campus orientation group for everyone coming into the organization, including assistance with Person-Centered Plan preparation. Everyone that comes on campus is slotted to complete a PCP in their first 30 days to assist them with identifying life goals (Site 1).

Evaluation question 3: Does recovery knowledge change from Time 1 to Time 2?

Beyond peer specialist integration, general recovery knowledge of staff at the sites was assessed at Time 1 (RILA FY12 survey Time 2) and Time 2 (ROCI survey Time 2) using the Recovery Knowledge Inventory (RKI; Bedregal, O'Connell, & Davidson, 2006), a measure of recovery attitudes and beliefs (subscales include *roles and responsibilities in recovery; non-linearity of the recovery process; roles of self-definition and peers in recovery; & expectations regarding recovery*). While some sites increased recovery knowledge, others did not. Overall, recovery knowledge remained relatively high and stable in the timeframe of the project (Table 6). At Time 2, teams rated the RKI subscale 'Roles and Responsibilities' (M=4.33) highest, indicating that they were most knowledgeable regarding the respective roles of people in recovery and practitioners. This aligns with teams' overall focus on the 'Roles and Role Clarification' area of peer specialist integration in their change work. At Time 2, teams rated lowest on the 'Nonlinearity of the Recovery Process' subscale (M=3.44), suggesting that they were least knowledgeable regarding the nonlinear nature of recovery and the role of symptom management. However, the validity of this subscale is questionable because all of its items are reverse-scored.

Table 6. Recovery knowledge

Survey Item	Time 1 Mean	Time 2 Mean	Results
Recovery Knowledge Inventory (RKI) Total Score	3.95	3.98	No change

Note: The RKI is scored on a scale that ranges from 1 to 5, with higher numbers indicating greater recovery knowledge.
Note$_2$: Time 1 scores are derived from the organizations' participation in the Recovery Institute Leadership Academy Fiscal Year 2012.

Evaluation question 4: Does staff report of the organization's recovery orientation change from Time 1 to Time 2?

The overall recovery orientation of sites was assessed at Time 1 (RILA FY12 survey Time 2) and Time 2 (ROCI Survey Time 2) using the Recovery Self Assessment (RSA; O'Connell, Tondora, Croog, Evans, & Davidson, 2005). The RSA is a measure of the recovery orientation of organizations (subscales include *life goals; involvement; diversity of treatment options; choice; & individually tailored services).* While some sites increased their recovery orientation, others did not. Overall, perceived recovery orientation remained relatively stable in the timeframe of the project (Table 7). At Time 2, teams rated the RSA subscale of 'Life Goals' highest (M=3.88), which indicates that staff help persons in recovery with the development and pursuit of self-defined life goals. This aligns with observations that, during ROCI-PSI, staff were very receptive to the idea of self-determination for clients; although teams were aware that practices and policies needed to change to support client self-direction. At Time 2, teams were rated lowest in the subscale 'Involvement' (M=3.43), indicating that persons in recovery had limited involvement in the development and provision of programs, trainings, and management/advisory board meetings. As project participants took notice that consumer involvement was lacking at their organizations, two of three teams developed interest/goals in getting clients onto the Board of Directors or otherwise involved in developing agency programming over the course of the ROCI-PSI. While these goals have not yet been fully realized, planning to take steps in that direction is now underway.

Table 7. Recovery orientation of the organization

Survey Item	Time 1 Mean	Time 2 Mean	Results
Recovery Self Assessment (RSA) Total Score	3.79	3.71	No change

Note: The RSA is scored on a scale that ranges from 1 to 5, with higher numbers indicating greater recovery orientation of the organization.
Note$_2$: Time 1 scores are derived from the organizations' participation in the Recovery Institute Leadership Academy Fiscal Year 2012.

Evaluation question 5: Has the integration of Peer Specialists within the organization improved from Time 1 to Time 2?

Overall, staff perception of peer specialist integration improved but was relatively consistent from Time 1 to Time 2 (Table 8) but responses also demonstrate room for improvement related to overall integration efforts. Presented below, the policies and practices related to five key areas of peer specialist integration improved across the board. A key indicator of peer specialist integration is referrals from treatment team members; overall, change units increased the frequency of referrals to peer specialists (Table 9).

Table 8. Overall peer specialist integration

Survey Item	Time 1 Mean	Time 2 Mean	Results
I feel that peer specialists are well integrated within my organization.	2.73	2.93	

Note: Item response choices ranged from 1 'strongly disagree' to 5 'strongly agree.' Responses are reported as means (scale of 1-5).

Table 9. Referrals to peer specialists

Survey Item	Time 1 Mean	Time 2 Mean	Results
How often do you refer clients to peer specialists?	3.13	5.11	

Note: *Item response choices ranged from 1 'never' to 7 'daily.' Responses are reported as means (scale of 1-7).*

The following sections summarize change in status from Time 1 to Time 2 in the following areas of the peer specialist integration process:

- Organizational Culture
- Funding
- Recruitment, Retention, and Hiring
- Roles and Role Clarification
- Supervision

Organizational Culture

Respondents answered questions regarding organizational culture, as it relates to recovery orientation and the integration of peer specialists (Table 10). Some markers of an organizational culture of recovery orientation increased, while others did not change.

Table 10. Organizational culture supporting peer specialist integration

Survey Item	Time 1 Mean	Time 2 Mean	Results
The environment of this organization supports hope and recovery.	4.08	4.07	No change
My team has taken action to improve our organizational environment so that it is more supportive of hope and recovery.	--	4.50	Strongly Agree
This organization supports inclusiveness and diversity among staff and persons in recovery.	4.08	4.07	No change
My team has taken steps to increase inclusiveness and diversity among staff and persons in recovery.	4.25	4.33	↑
My organization is working with a broad coalition of staff within the organization to promote a recovery orientation.	3.85	4.29	↑
My organization is working with other community organizations to promote a recovery orientation.	3.92	3.93	No change
My team understands the relationship between a recovery-oriented organization and the success of peer support staff.	4.13	4.36	↑

Note: Item response choices ranged from 1 'strongly disagree' to 5 'strongly agree.' Responses are reported as means (scale of 1-5).

-- = Item was not administered at Time 1

Furthermore, the sites demonstrated a strong readiness for culture change, as indicated by leadership's increasing commitment to recovery orientation (Table 11). Management commitment to change is one of the strongest factors contributing to organizational readiness for change (Holt, Armenakis, Field, & Harris, 2007).

Table 11. Leadership commitment to recovery orientation

Survey Item	Time 1 Mean	Time 2 Mean	Results
Leadership at this organization demonstrates commitment to recovery orientation.	4.31	4.47	↑
Leadership has increased commitment to a recovery orientation	--	4.50	Strongly Agree

Note: Item response choices ranged from 1 'strongly disagree' to 5 'strongly agree.' Responses are reported as means (scale of 1-5).

-- = Item was not administered at Time 1

Funding

Respondents were asked to select the response that best describes their level of agreement with statements regarding the organization's current status related to the funding of peer specialist positions (Table 12). At Time 2, the sites had a better understanding of the differences in the roles of volunteer versus paid peer specialists. This is likely due to effective roles/role clarification technical assistance received through ROCI-PSI and to the development of a pay scale/career ladder at one site. Sites did not increase their awareness of funding and documentation requirements for additional potential sources of funding for peer workers.

Table 12. Funding of peer specialist positions

Survey Item	Time 1 Mean	Time 2 Mean	Results
My organization has identified differences in the roles of volunteer versus paid peer specialists.	4.11	4.25	↑
My organization is aware of the funding and documentation requirements for potential sources of funding for peer worker positions.	4.00	3.92	No change

Note: Item response choices ranged from 1 'strongly disagree' to 5 'strongly agree.' Responses are reported as means (scale of 1-5).

Recruitment, Retention, and Hiring

Respondents were asked to report on policies and considerations relating to the recruitment and hiring of peer specialists within the organization, as well as policies that relate to the retention of these employees (Table 13). Changes on all items were positive, revealing that organizational challenges to integration decreased while supportive policies and practices increased.

Table 13. Recruitment, retention, and hiring practice and policy

Survey Item	Time 1 Mean	Time 2 Mean	Results
Policies utilized by my organization create barriers/challenges for integrating peer specialists.	3.15	2.54	↓
Policies utilized by human resources support the integration of peer specialists.	3.50	3.67	↑
My team has considered both the challenges and benefits of employing former clients.	4.00	4.33	↑
My organization's new employee orientation training includes information about peer specialists.	2.69	3.40	↑
Training received by newly hired peer support staff is adequate.	2.88	3.73	↑
I feel that my organization is ready to hire more peer specialists.	3.64	3.60	No change

Note: Item response choices ranged from 1 'strongly disagree' to 5 'strongly agree.' Responses are reported as means (scale of 1-5).

Roles and Role Clarification

Survey respondents were asked to report on knowledge and practices relating to the roles of peer specialists within the organization as well as the types of services currently offered by peer specialists in the organization (Table 14). At Time 2, survey responses indicated that the team has taken action to educate other staff about peer specialists, to reduce the tasks performed by peer specialists that undermine their ability to deliver effective peer support, and to add new peer-provided programs, groups, services, or other activities to the existing service array. Respondents also reported that not only did their understanding of the roles and activities of peer specialists increase, but so did the understanding of other staff. This learning process was facilitated in part through the engagement of the sites with the ROCI-PSI TTA elements focusing on clarifying the roles of peer specialists (i.e., PSI workbook (Via Hope, 2012), a webinar, and three on-site trainings/technical assistance consultations).

Table 14. Peer specialist roles knowledge and practices

Survey Item	Time 1 Mean	Time 2 Mean	Results
My organization's staff understand the roles and activities of a peer specialist.	2.69	3.14	↑
I understand the roles and activities of a peer specialist.	3.77	4.27	↑
My team has taken action to educate other staff about peer specialists within our organization.	--	4.25	Agree
My team has taken action to reduce and/or eliminate the tasks performed by peer specialists which undermine their ability to deliver effective peer support.	--	4.09	Agree
My team has taken action to add new peer-provided programs, groups, services, or other activities to the existing service array.	--	4.09	Agree

Note: Item response choices ranged from 1 'strongly disagree' to 5 'strongly agree.' Responses are reported as means (scale of 1-5).

-- = Item was not administered at Time 1

Supervision

Survey respondents were asked to report on practices relating to the supervision of peer specialists (Table 15). Boundary issues between peer specialists and clients increased from Time 1 to Time 2, while supervisors reported that they were less confident in addressing boundary issues from Time 1 to Time 2. As peers become more integrated into their organizations, and fulfill more "peer" roles, boundary issues are being recognized more frequently. This is an unavoidable growing pain experienced during early peer specialist integration that may require more specific, content focused TTA.

Table 15. Supervision of peer specialists: Issues and practice

Survey Item	Time 1 Mean	Time 2 Mean	Results
Boundary issues often arise between peer specialists and clients.	3.07	3.29	↑
Boundary issues often arise between peer specialists and other staff.	3.00	3.00	No change
I feel confident working through boundary issues that arise with peer specialists. (supervisors only)	4.33	4.25	↓
My team has reviewed the adequacy of the current supervision structure for peer specialists.	3.44	4.18	↑

Note: Item response choices ranged from 1 'strongly disagree' to 5 'strongly agree.' Responses are reported as means (scale of 1-5).

Evaluation question 6: What barriers to peer specialist integration are identified?

When asked to identify areas that posed the greatest barriers to the integration of peer specialist employees, respondents indicated a shift in the constellation of barriers from Time 1 to Time 2 (Table 16). Organizational culture, knowledge of peer specialists, hiring and funding in general were reported less frequently as barriers at Time 2. However, many 'other' barriers emerged following ROCI-PSI participation. While these other barriers were in fact related to organizational culture, knowledge of peer specialists, and funding, respondents named them specifically, indicating first-hand experience with these challenges. Knowing intimately the barriers specific to one's organization is a prerequisite in designing effective ways to address them. It is also likely that these issues will be identified by other organizations hiring peer specialists. Documenting and disseminating locally developed solutions to organizations that

are new to peer specialist hiring may facilitate more rapid integration. Other barriers may need to be addressed at the state policy and program level.

Table 16. Barriers to peer specialist integration

Barriers	Number Identified (tally)	
	Time 1	Time 2
Organizational culture	XXXXXXX	XXX
Knowledge of peer specialists	XXXXXXXXX	XXXXX
Recruitment and hiring	XXXXX	XXXXXXX
Retention	X	XX
Funding	XXXXXXX	XXXXXXX
Supervision	XXXXX	XXX
No barriers	X	X
Other	XXX[1]	XXXXX[2]

[1] **Other challenges reported at Time 1 include:** (1) *training,* (2) *meeting requirements such as having a car and car insurance, valid driver's license, and* (3) *rural community limits available consumers willing to become [peer specialist]*
[2] **Other challenges reported at Time 2 include:** (1) *funding challenges,*(2) *ignorance of recovery model,* (3) *other […] staff not understanding fully the role of the [peer support specialist],* (4) *some staff resistance to change,* (5) *some apathy,* (6) *[peer specialists] not included in treatment plans, and* (7) *not authorized in crisis services*

Other barriers or challenges to peer specialist integration were identified throughout the course of ROCI-PSI, many of which were addressed directly by project activities, include, but are not limited to:

- Applicants for peer specialist positions not meeting certain job requirements such as having a car;
- Peer specialists uncertain about the potential benefit losses (i.e., SSDI) associated with full time employment;
- Two major hiring challenges: applicants not following up on the application process and background checks not coming back within limits;
- Peers not authorized to provide crisis services;
- Difficulties in integration between partnering organizations due to being at different developmental stages with regard to hiring peers;
- Difficulties in assessing where a potential new hire is in the recovery process during the interview stage;
- Need to be transparent in communicating how the newly developed career ladder relates to the training hierarchy;
- Issues with database access for all staff (i.e., confidentiality);
- Challenge to redefine the peer support role within the clinical team (e.g., not doing traditional case management);
- Role confusion and boundary issues (e.g., database access) for peer specialists living on campus;
- Administrators' attempts to address boundary issues received from a personal perspective rather than a clinical perspective, such that outside sources of training for peers (re: boundary issues) are needed; and
- Confusion surrounding necessary qualifications and expectations to become a peer specialist. Many interested parties had lived experience only, but were not otherwise qualified to fulfill roles and responsibilities of a peer specialist.

Barriers to improve recovery orientation

Information collected throughout the ROCI-PSI revealed several salient barriers to establishing a strong recovery orientation:

- Shifting policy and practice toward recovery has been challenged by inherent difficulties in coordinating between administrative systems and intra-organizational divisions with different barriers and executive decision-making channels;
- Organization viewing budget constraints as a barrier to being more recovery-oriented;
- Stigmatization of peer staff by clinical staff;
- Lack of recovery knowledge among staff;
- Staff not being open to recovery education;
- Misuse of the drop-in center as a place to "stash" clients;
- Apathy among non-peer staff regarding recovery;
- Little or no value placed on client self-determination;
- Disputes about peers on staff disclosing mental health history; and
- Administration not realizing the value of peer specialists in engaging consumers.

Conclusions and Recommendations

Limitations

Note that the time period in which this evaluation was conducted was relatively short (less than one calendar year). Thus, the observable impact of the ROCI-PSI was very early in development. What is most important to consider are the ongoing processes established by the change teams, which will continue to impact the organizations in future years.

Furthermore, when considering quantitative data collected via surveys, even with average response rates, limited numbers of participants may restrict the generalizability of the results to organizational structures beyond the change team. Consider the lessons learned as pilot data.

External factors such as previous recovery oriented system consultation, grant monies for recovery oriented change, and other initiatives in which the organizations participated also interacted with the influence of the ROCI-PSI. This would make it difficult to say that discrete activities or impacts were due to one influence or the other. What is more useful to consider is how ROCI-PSI participation aligned with other work, and how knowledge gained from the initiative can serve as a bedrock for future recovery-oriented system work.

Another limitation is that, at one site, the change unit clinic was not operational at the time that Time 1 surveys were administered. Thus, responses at Time 1 were related to peer specialist integration in the organization at the time, but not in the change unit specified for ROCI-PSI. However, the state of peer specialist integration practice and policy in the organization was likely reflected in the change unit upon its opening, thus allowing conclusions to be drawn regarding changes from Time 1 to Time 2.

At another site, peer specialists were neither employed nor contracted to provide services for the organization at the outset of ROCI-PSI (Survey Time 1); although, change team employees were very familiar with the peer specialists having worked closely with their consumer operated service provider for nearly a decade. This would certainly have affected responses to some survey items at Time 1. This limitation was also likely a barrier to this participating site receiving optimal benefit from the ROCI-PSI training and technical assistance elements.

Finally, peer specialist integration into mental health provider agencies is still in its infancy in Texas. ROCI-PSI organizations are truly fulfilling a pioneer role as resource centers like Via Hope learn what successful integration looks like. Consider the evaluation formative and that hindsight accumulates from year-to-year with the help of an entire community of Texas providers.

Summary and Recommendations

Summary

Value of training and technical assistance

The two most highly valued TTA elements were the initial on-site orientation visit facilitated by Via Hope and the targeted TA visit facilitated by consultant Lyn Legere. Although the purpose of the two events were different, both offered sites the opportunity to express their unique context and immediate needs surrounding peer specialist integration. The third most valued TTA element was as-needed resources provided by Via Hope. The flexibility and tailoring of resources to individual requests was easily accessible to and highly valued by project participants.

The two TTA elements receiving the most mixed reviews were the bi-monthly webinars and the 2-day culture change learning event. The bi-monthly webinars likely received mixed reviews due to a combination of factors including: limited interaction allowed via webinar, primarily didactic format, and content was tailored to needs across sites but may not have been specific enough for site's unique needs. Feedback revealed that participants thoughts some of the content was not specific enough to Texas Administrative Code. Mixed reactions to the 2-day culture learning event were likely due to multiple influences including differences in communication style between facilitator and participants as well as participants not having a clear understanding of intentions and expectations of the event prior to scheduling and thus not being able to make the most strategic invitations to staff who should have been present. The PSI state workgroup calls also received mixed reviews, however, only a few representatives from sites were requested to participate, therefore only a few PSI participants would have found it directly valuable.

When asked to comment on what was most helpful about the initiative, survey respondents reported that:

- "Without the support and technical assistance provided through Via Hope, we would not be nearly as progressed in ROSC [Recovery Oriented Systems of Care] or peer integration [as] we now are. The resources have been invaluable in moving our organization from one of a behavioral system to one of recovery;"
- "The support and knowledge of the individuals encountered in this initiative was the most helpful;"
- "Via Hope staff and the TA [technical assistance] staff are all so responsive and really helped keep us on track. Loved the project plan; that was invaluable. I did not utilize the workbook as much as I should have due to distractions from job and life, however, I believe it valuable as well;" and
- "As a CPS the PSI Initiative helped with the merging of CPS and clinical staff."

Site commitment to project

Overall, participating sites did fulfill their commitments to the project (e.g., attendance, submission of updated project plans, on-site trainings, etc.). Change team members were at times limited in attendance on calls or at trainings, which was often due to competing demands. On all but one occasion, all sites had a minimum number of participants at these events. Scheduling confusion was cited as the reason that one site did not meet a required minimum number of participants.

General recommendations

General recommendations for both Texas DSHS (Table 17) and Via Hope (Table 18) regarding the ROCI-PSI initiative are presented on page 18. Recommendations specific to TTA elements can be found in (Table 19) starting on page 20.

Table 17. Recommendations for Texas DSHS

Summary	Recommendation
Out-of-state consultants bring valuable insight and experience from their home states, however, in-state experts with their proximity and intimate knowledge of Texas' mental health care landscape can provide the tailoring of TTA that is highly valued by participating sites.	While subject matter experts from places outside of Texas are invaluable to creating urgency and buy-in, more in-state expertise needs to be developed in order to cost-effectively and efficiently expand Recovery Institute operations as well as to allow for more intimate tailoring of TTA to state-specific and site-specific needs.
One largely untapped resource that could be leveraged to promote peer specialist integration in Texas LMHAs are local COSPs. In fact, two of the participating sites do have local COSPs with whom they are very familiar, however the relationships between the organizations remain at the referral stage.	An LMHA simply recruiting and employing peer staff from local COSPs is a somewhat nominal connection between the organizations; more substantive leveraging of a COSPs' clout and operations is needed to effectively promote peer specialist integration. The State should consider promoting other models of LMHA-COSP partnerships for peer specialist integration beyond simple employment. For example, fund support for LMHA-COSP partnerships interested in developing contracts to provide services aligned with the COSPs' missions.

Table 18. Recommendations for Via Hope

Summary	Recommendation
The order of the information was at times not conducive to building momentum.	Consider revising the order and timing of TTA elements with regard to building momentum and creating urgency.
Some consultant trainings did not address several important immediate TA needs of the sites.	Trainings should be tailored to better meet the needs of each site at the given time.
Training participants requested copies of the PSI workbook and new hire toolkit throughout the project year.	Consider posting future versions of these workbooks on the Via Hope website and/or printing copies available for distribution at every training/technical assistance visit.
Change team members expressed confusion regarding distinguishing between different ROCI-PSI constituent groups: leadership team, change team, change unit, and coalition.	Clarify or revise terminology to stress the importance of each unique group and to avoid confusion with other initiatives.
Feedback from on-site trainings revealed that participants wished that many others had been in attendance. Doctors, secretaries, and community partners were just a few of those listed.	Training participants recommend Via Hope ensure that more employees of participating sites are included in all trainings/workshops provided. Consider revising recommendations and/or requirements around who should attend trainings in future ROCI-PSI years. Evaluators recommend identifying and documenting learning objectives ahead of time to provide better guidelines around who should attend events.
Site attendance was at times limited on calls, webinars, and some technical assistance visits/trainings.	Specify the minimum number of participants that are required to host calls, webinars, and technical assistance visits/trainings (in addition to specifying a maximum number of participants).
While resource limitations dictated the number of on-site trainings that Via Hope staff provided to the sites, these events are the most engaging of all project activities.	Training participants recommended that Via Hope provide more on-site trainings and technical assistance. Implementation science suggests that more face-to-face contact results in strengthened program/practice implementation (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005).

Summary	Recommendation
Participants consistently stated that it would be beneficial to see peer specialist integration working well in other organizations.	Document and disseminate locally developed solutions to organizations that are new to peer specialist hiring to facilitate more rapid integration.

Table 19. Training and technical assistance: Benefits, limitations, and recommendations

TTA element	Benefits	Limitations	Recommendations
Initial on-site visit	First activity of the project allowed for a baseline "snapshot" of the organization in the five areas of focus critical to PS integration Tour of facilities allowed for observation of a variety of indicators such as environmental wellness Allowed Via Hope to learn about the sites in order to better tailor TTA	Traditional semi-structured interview format questions did not elicit discussions Reading materials on historic/political context were distributed, but with no follow-up, it did not seem that participants engaged with these Resource intensive	Consider using Liberating Structures formats to engage focus group participants in more meaningful dialogue Make intentional choices about printed information distributed to sites (i.e., if it is not expected that most will engage with/use the material, then it should not be distributed, although it can be referenced for interested individuals)
Initial on-site visit report	Provided strengths-based feedback to sites regarding baseline "snapshot" of the organization in the five areas of focus critical to PS integration Provided recommendations for improvement in the five areas of focus, which could inspire initial change activities Presented report in-person at launch event, allowing facilitators to highlight key points, explain how report was structure, and get feedback on any inaccuracies for correction	Not all team members used the report for information or recommendations	Consider structuring report into a format that is less text-heavy to make it more accessible to a wider audience Reference the report more often throughout the project to remind sites of that resource; especially if they are "stuck"
Launch event	Introduction of change teams to Liberating Structures tools Distribution of workbook allowed for hands-on teaching sites how to use Two half days format minimized participant fatigue Liberating Structures instructions on PowerPoint allowed participants to	Limited inter-site interaction	Encourage greater inter-site collaboration (beyond impromptu networking) Spend time emphasizing the value of the learning community among participants and opportunities to collaborate throughout the project Consider inviting previous PSI participants to present regarding their successes through the project

TTA element	Benefits	Limitations	Recommendations
	reference as-needed		While Liberating Structures is effective and inviting interaction and dialogue, don't discount the effectiveness of individuals in the field with name recognition at motivating teams and creating a sense of urgency
Monthly individual site calls	Participants noted that calls (and webinars) were valuable in that not all members of the team needed to be on every one allowing more flexibility for members to perform daily tasks	Number of calls were difficult to accommodate for members of the team	In the project application process, emphasize the number of hours required to be dedicated to the project by team members Clarify how many team members are expected to be on each monthly site call; when appropriate, clarify which team members are most appropriate to be on each call based how the content presented aligns with specific job roles
PSI workbook	Roles and hiring sections of the workbook were used most often Users of the workbook stated that content was used more often than appendices Some users browsed the workbook looking for eye-catching topics, while others went directly to the chapter(s) they felt most relevant to them Site staff were able to make copies of certain sections from the workbook and hand out to other staff, using as a tool for discussion	Users did not use exercises for team discussion in the workbook Users suggested that the PSI workbook may have been more useful in a regular binder to allow users to add to it continuously, inserting printed information obtained from other sources Users highlighted the value in framing peer specialist integration from multiple perspectives: volunteer, CPS, employer, other staff, community	Print future versions of the PSI workbook in binder format so that documents may be easily added to the book by users finding helpful, related information from other sources. Continue developing and revising the workbook content to optimize use from multiple perspectives (e.g., volunteer, CPS, employer, other staff, community) Reduce the number of printed exercises throughout the workbook and instead use more live facilitation strategies to increase dialogue and creativity among team members Consider adding an index so that users can

TTA element	Benefits	Limitations	Recommendations
			more easily access a particular topic or question of interest
Project plan	Teams found the project plan to be helpful to get started on setting goals and activities Teams reported that the project plan was helpful at organizing persons responsible for different activities and considering potential barriers Project plan motivated teams to sit down and think about goals as an agency As activities matured, teams found that they were referring to the project plan in an indirect way, but still found it helpful to look at before calls or to reference periodically Teams found the format easy to use and it even inspired ideas to use in different ways on other work projects beyond ROCI-PSI	'Date of completion' on the plan was not useful to teams as many activities were ongoing Similarly, monitoring the percent that each activity was complete was not useful ; teams found it difficult to quantify their progress in the project plan format as many projects were ongoing Teams reported difficulty in following through on some planned activities because new ideas were initiated along the way as a result of TTA Team members reported desiring more support in the project planning process, more assistance in making goals concrete (e.g., Via Hope being more specific about how to include peer specialists in treatment plans)	Consider redesigning the project plan template to better quantify/document progress on site's ongoing activities Identify sites that may need additional support in parsing out goals into concrete activities and provide support in the form of brainstorming, direction to specific materials in the workbook, examples of what other sites have done, or facilitating liberating structures that will assist team members in developing actionable steps toward goals Assist teams in re-prioritizing goals on an ongoing basis as new goals are added as a result of TTA events
Bi-monthly webinars	Allowed opportunities for staff to ask questions via phone or chat box, through whichever modality they felt most comfortable Liberating Structures format allowed sites opportunities to break out into smaller groups via Adobe Connect technology, increasing site interaction Liberating Structures encouraged audience participation via role play	Didactic formats discourage audience participation/interaction Limited attendance ranged from 7 to 21	Consider balancing didactic webinar delivery through the use of more Liberating Structures methods to promote more communication Move sharing successes up in the timeline of activities (e.g., mid-project) allowing teams to motivate and inspire one another, and encourage inter-site communication Consider creative ways to market the webinars so that they do not seem like just another project requirement, but rather a

TTA element	Benefits	Limitations	Recommendations
	Sharing successes webinar allowed sites a chance to learn about the ongoing work of their peers as well as to ask questions of those who have "been there, done that"		valuable source of information Identify and document learning objectives ahead of time to enhance learning and augment perception of value of the webinar
De-mystifying peer support	Having peer specialists facilitate the class set the tone for the integration project	Too many didactic sessions did not allow for full facilitation of audience participation "Role play" exercise did not seem to be effective and did not involve audience participation	Revise curriculum and facilitation format to be more interactive and appeal to different learning styles (e.g. through use of Liberating Structures) Discussion sessions should be used throughout the day, not just in the afternoon Participants expressed interest in new-hire and PSI workbooks; consider distributing these during future trainings
2-Day culture change learning event	Many participants were truly engaged with this training as they valued Dr. Stayner's dynamic and interactive facilitation style Varied communication methods (i.e., group discussion, film, Liberating Structures, one-on-one dialogue, handouts, storytelling, limited didactic presentation)	Team members reported that the timing of this training was not conducive to building momentum, rather the event would have been a great project kick-off Participants indicated that they would have liked to have covered pragmatic topics such as: how to get upper board involved, success in projects similar to theirs, and more time on what recovery looks like Participants also thought that the event would have been more beneficial if other staff such as doctors, administrative staff, caseworkers, upper management, decision makers, intake therapists, more consumers, and "everyone" were present Differences in communication style	Need for in-state expertise which would allow for clearer messaging of this type of event as well as a facilitation style attuned to Texas participants Training should be more targeted to site's specific TA needs through facilitation by in-state expertise Consider moving this event up in the project timeline to leverage the motivational effects Clarify recommended and/or required invitees to ensure broader audience Determine what pragmatic topics participants wish to cover during this event and consider incorporating into the training agenda and provide to organizing team

TTA element	Benefits	Limitations	Recommendations
		between facilitator and some participants Organizing team members not having a clear understanding of intentions and expectations	members well in advance
Targeted technical assistance visit	Consultant Lynn Legere facilitated concrete, nuts and bolts discussion and site-specific Q&A with attendees	This event occurred over halfway through the project, after team activities had been formed and momentum was at a low Resource intensive	Providing this targeted TA event earlier on could allow site's chosen project activities to be more intentional as well as hasten progress The tailoring offered by this visit fostered readiness for action in the sites, consider providing more than one of these targeted TA days over the course of the project
PSI state workgroup calls	Opportunity for direct contact between sites and DSHS representative (i.e., Via Hope contract manager Wendy Latham) State voice can clarify existing policies and take note of where policies do not exist but would be beneficial/essential for moving forward Resources can be shared among workgroup participants, who can then disseminate more broadly	Some state level policy issues are slow to change given competing demands for staff time and/or can only be changed via legislation on a bi-annual basis Some sites initially thought that their entire leadership team should attend the calls, but most did not contribute to discussion	Clarify that sites should be limited to 1-2 representatives Participants from previous-RI sites should be encouraged to continue participating in the PSI workgroup as many issues will be ongoing from year-to-year
As-needed resources from Via Hope	Teams found resources on various peer related topics to be helpful Highly valued individualized TA	Participants never began to take advantage of the online resource request form that was created in the middle of the project Most resources were requested via phone call or group/private e-mail, many of these requests were not recorded in a central log Resource intensive	Market resource request form to encourage use Assign Via Hope staff member(s) to maintain the request form and ensure that all requests are documented and responded to

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