viaHOPE
TEXAS MENTAL HEALTH RESOURCE

Recovery Institute Leadership Academy

Summary Report: October 2012

CENTER FOR SOCIAL WORK RESEARCH

Center for Social Work Research
University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703
Phone: (512) 232-0612
Fax: (512) 232-0617

Stacey Stevens Manser, PhD
Jillian Bellinger, PhD

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

our colleagues at Via Hope
Anna Jackson
Dennis Bach
Sarah Muñoz

our DSHS colleagues
Wendy Latham
Sam Shore

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

Please contact Stacey Manser by phone (512) 289-0148 or email stacey.manser@austin.utexas.edu for additional information about this report.

Table of Contents

List of Tables

List of Figures

Summary Report

Background Information

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 2011, 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 are 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) but the four levels of the 2011 Recovery Institute included:

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

The Recovery Institute Leadership Academy (RILA)

The Recovery Institute Leadership Academy (RILA) was created to promote recovery-oriented system transformation among organizations in earlier stages of the recovery learning process by focusing on organization leadership. The aim of this learning community was for organizations to (a) develop a deeper understanding of recovery orientation, (b) increase consumer and family involvement, (c) increase knowledge of recovery principles in participating organizations, and (d) begin to experiment with recovery-oriented practices.

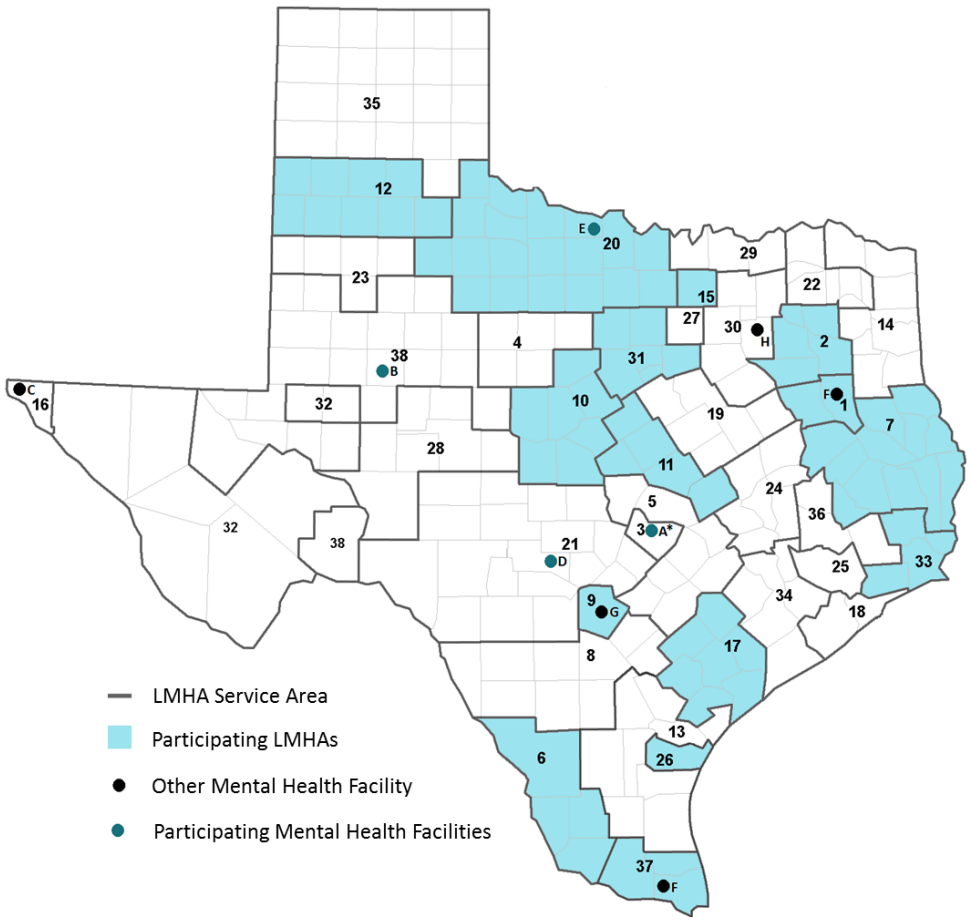
To participate in the RILA, organizations were required to participate in a competitive application process and agree to a number of commitments. Each organization had to assemble a team of at least 3 members of current or emerging organization leaders and teams were strongly encouraged to include a peer. Because executive sponsorship is considered a critical component of the program's success, one of the team members had to be either the Executive Director or a key staff person with delegated authority to implement the necessary changes. Applications were received from 21 organizations with 19 invited to participate. The RILA organizations and number of team members per organization is provided in the table below.

Table 1: Participating RILA Organizations

RILA Organization	Team Members at Survey Time 1	Team Members[a] at Survey Time 2
Anderson/Cherokee Community Enrichment Services (ACCESS)	3	3
Andrews Center	4	4
Austin Clubhouse	3	3
Big Spring State Hospital	5	5
Border Region MHMR Community Center	3	3
Burke Center	3	2 (-)
Center for Healthcare Services	5	5
Center for Life Resources	3	3
Central Counties Center for MHMR Services	3	3
Central Plains Center	4	4
Denton County MHMR	3	3
Gulf Bend Center	4	4
Helen Farabee Centers	2	2
Kerrville State Hospital	4	4
MHMR of Nueces County	4	4
North Texas State Hospital (Wichita Falls campus)	4	4
Pecan Valley Centers for Behavioral & Developmental Disorders	3	3
Spindletop Center	4	4
Tropical Texas Behavioral Health	3	3
Total	67	66

[a] Denotes the change in number of team members from the beginning to the end of the RILA. A minus (-) indicates that a member left the team.

Figure 1: Map of participating RILA organizations



CORE Components of the RILA

The Recovery Institute Leadership Academy (RILA) engaged formal and emerging mental health organization leaders in a learning process on recovery oriented mental health system transformation, cultivated a culture of learning in organizations, and introduced recovery-oriented practice. The RILA activities were designed to build on each other in a staged learning process, starting with webinars to introduce team members to recovery and continuing monthly webinars or all team calls to support and provide recovery content, a kick-off conference that went deeper into recovery content, regional seminars to further identify recovery first steps for the organization, and ending with a final conference call to determine recovery progress during project participation. A description of the core RILA components included:

Recovery Webinars and All Team Calls: Three webinars were hosted by Via Hope over the course of the RILA. Each webinar built on the previous webinar in a staged process and utilized expert consultants to guide learning on recovery. The first three webinars introduced recovery by providing a historical context for

the recovery movement (Dr. Dan Fisher and Tammy Heinz); introducing concepts of recovery-oriented practice (Dr. Larry Davidson); and providing a framework for leading organizational transformation (Anna Jackson and Olivia Flournoy). These were designed to prepare teams for participation in the kick-off conference. Surveys conducted after these webinars indicated high satisfaction with the content with teams reporting high potential to apply what they had learned to their organizational recovery work. Webinars and all team calls following the conference were designed to deepen understanding of specific recovery practices, provide support for making recovery change, and address questions, concerns, and experiences of team members, particularly after the regional seminars.

RILA Kick-off Conference: A 2-day kick-off conference connected the RILA teams, provided in-depth content on recovery practices, and set the stage for the regional seminars. The first day of the conference was focused on recovery stories, leading recovery change in the organization, and included a networking reception in the evening where teams prepared for the upcoming regional seminars. The second day of the conference focused on specific recovery oriented practices, such as building peer support and person centered planning with the final keynote on leading transformational change. For the first time, presenters and leaders of the conference were primarily local/state, and not national, experts. The conference also enabled teams from different organizations to share strategies for change with each other, and form collaborative relationships for future communication.

Regional Seminars: Following the kick-off conference, teams attended one of three regionally held 2-day seminars, led by David Stayner, an expert consultant in recovery-oriented organizational change. Prior to attending the seminar, teams were directed to lead three discussion groups consisting of five to seven people to identify opportunities for change at their organization. The groups were comprised of: 1) people working on the front lines at the organization; 2) people currently served by the organization; and, 3) leaders within the organization. During the conference, team members participated in work group sessions which focused on creating urgency, building a change coalition, developing change objectives, and establishing first steps for recovery oriented change. Customized organizational plans for recovery change were identified by each team using the information gathered from the discussion and work group sessions. Collaboration among participating teams was fostered so that organizations located in similar regions of the state could begin to rely on each other for recovery change support and ideas.

Final Conference Call: A final conference call was held with all of the participating RILA teams at the end of the initiative. Sixteen teams (84% of participating organizations) were represented on the call. Teams provided a wealth of information regarding their experiences with the Leadership Academy. Specifically, each team was asked to report on the following:

- Identification of an expanded change team
- Participation in a change team meeting following the regional seminar
- Changes or revisions to any of the first steps identified during the seminar
- Progress made on their first steps, if any
- Barriers or challenges encountered, if any
- Future plans for promoting recovery oriented change within their organization; and
- Additional resources/supports required from Via Hope, if any.

Throughout the RILA, Via Hope provided ongoing technical support, guidance, and assistance to Leadership Academy team members. In addition, the development of partnerships at the local, regional, and state level was fostered – the intent of a learning collaborative. At project end, team members noted that the resources and tools provided by Via Hope were beneficial and that they were motivated to move forward and continue working toward a recovery oriented system of care.

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 (at pre- and post- RILA):

- Recovery Orientation and Readiness
- Consumer and Family Involvement
- Peer Specialists and Consumer Operated Service Providers
- Recovery Knowledge
- Recovery Orientation

End of project measures (post- regional seminar):

- Recovery Change Team Activities
- Recovery-Oriented First Steps
- Barriers Encountered
- Recovery Accomplishments

Method of Data Collection

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 March and the follow-up data collection took place five months later in August. 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, and change team composition and activities. Respondents also completed the Recovery Knowledge Inventory (RKI; Bedregal, O'Connell, & Davidson, 2006) and the Recovery Self Assessment (RSA; O'Connell, Tondora, Croog, Evans, & Davidson, 2005). In addition, the end of project survey included supplemental measures to evaluate each team's progress over the course of the RILA. Specifically, the following measures were included: composition of the leadership change team, participation in recovery oriented activities, barriers encountered, and recovery oriented accomplishments. These measures provided additional information regarding the outcomes that occurred over the course of the initiative. Qualitative and quantitative data

regarding team member experiences, organizational challenges, and recovery oriented achievements was also gathered during the webinars, all team calls, and regional seminars. This information was used to provide context to each team's recovery work.

Results

RILA Team Members

Sixty-seven individuals, from nineteen organizations, participated in the Leadership Academy. Organizations were located across Texas in urban, suburban, and rural areas. At Time 1, 55 Leadership Academy team members (82.1%) provided demographic information via the online survey. Response rates were more modest at Time 2; 40 respondents (59.7%) completed all or part of the survey. At both Time 1 (94.5%) and Time 2 (90.0%) the majority of respondents were White. In addition, a higher percentage of females (58.2% at Time 1, 67.5% at Time 2) completed the survey than males (40% at Time 1, 32.5% at Time 2). Last, the majority of respondents at both time points were between the ages of 34 to 44, 32.7 and 42.5%, 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 between respondents at project beginning and end. Demographic information of Leadership Academy survey respondents is presented below.

Table 2: Age, Sex, and Ethnicity of Leadership Academy Respondents

Demographics			
		Time 1 (N = 55)	Time 2 (N = 40)
Ethnicity	Hispanic	20.0%	22.5%
	American Indian/Alaska Native	0.0%	0.0%
	Asian	0.0%	0.0%
	Black or African American	1.8%	0.0%
	Native Hawaiian or Other Pacific Islander	0.0%	0.0%
	White	94.5%	90.0%
	Other	1.8%	2.5%
	Not disclosed	1.8%	5.1%
Sex	Male	40.0%	32.5%
	Female	58.2%	67.5%
	Not disclosed	1.8%	0.0%
Age	18 – 24	3.6%	2.5%
	25 – 34	10.9%	12.5%
	34 – 44	32.7%	42.5%
	45 – 54	25.5%	20.0%

	55 – 64	27.3%	17.5%
	65 or older	0.0%	2.5%

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 higher percentage of individuals indicated that they were *trying* or *actively involved* in making recovery-oriented change at Time 2 compared to Time 1 (91.7% versus 78.1%). Respondents also reported whether their organization's mission statement explicitly included a recovery-orientation (1 = Yes; 2 = No). At project end, a higher percentage of team members (66.7%) indicated that their organization's mission statement reflected a foundation of recovery compared to the project baseline (54.7%). In addition, respondents reported increased recovery concept or practice knowledge and recovery-oriented practice use at project end. Specifically, a higher percentage of individuals reported *agree* to *strongly agree* that staff are knowledgeable about recovery concepts or practices at Time 2 (77.8%) than at Time 1 (67.3%). Team members also reported on the staff's use of recovery practices with individuals served. At project beginning and end a relatively consistent number of team members reported *agree* to *strongly agree* that the staff use recovery practices with individuals served, 60.0% and 66.7% respectively. This 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. Although the implementation of recovery-oriented practices was fostered, promoting an organizational culture that promotes and expects recovery was the focus of this initiative.

On the Community Connections domain, there was great variability among team member responses. Team members were encouraged to determine if additional organizations could be included in their community outreach and collaboration efforts. Due to the complexity of the Community Connections domain and the short time frame of this initiative (6 months), it was to be expected that gains in this area may not be apparent at project end. However, it is anticipated that over time organizational partnerships will be developed.

Overall, team members reported gains in each of the domains listed below, *except* Community Connections. Although reported gains 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 suggested that meaningful system level changes were achieved. Average response ratings on recovery orientation and readiness across organizations are reported in below in Table 3.

Table 3: Recovery Orientation and Readiness

	Time 1 (N = 55)		Time 2 (N = 36)	
Survey Item	**Mean**	**SD**	**Mean**	**SD**
Recovery Stage of Change	3.11	0.99	3.36	0.72

Mission Includes Recovery	1.47	0.54	1.33[a]	0.48
Current Recovery Concept or Practice Knowledge	3.55	0.90	3.78	0.72
Current Recovery-Oriented Practice Use	3.47	0.88	3.64	0.80
Community Connections	3.91	0.67	3.78	0.80

[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 and family members were reported as serving on boards and a lower number of consumers and family members were reported as serving on committees following the RILA. Team members gained a better understanding of consumer and family involvement in their organization over the course of the RILA. In addition, data collected at the two-day regional seminar indicated that change teams had engaged in activities to promote consumer and family involvement within their organization. Specifically, 89.5% of the organizations conducted discussion groups with staff and consumers to provide insight on their organization's recovery orientation. At the regional seminar and on the follow-up survey, team members indicated that the focus groups had been extremely beneficial and that their organization had benefitted from the increased engagement of consumers and family members. However, 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.

> "For the first time I think that our clients believe that recovery is possible. I really love knowing that!"

Table 4: Survey Responses of Consumer and Family Involvement

	Percentage of Respondents[a]	
Theme	**Time 1**	**Time 2**
Number of consumers serving on board		
None	63.5	47.1
One	1.9	8.8
Two	5.8	2.9
Three	0.0	0.0
Four	0.0	0.0
5 or more	1.9	2.9
Do not know	26.9	38.2
Consumers serving on organization committees or councils		

Yes	72.7	65.7
No	7.3	17.1
Do not know	20.0	17.1
Number of family members serving on board		
None	32.7	15.2
One	9.6	3.0
Two	5.8	15.2
Three	5.8	9.1
Four	3.9	3.0
5 or more	0.0	3.0
Do not know	42.3	54.6
Family members serving on organization committees or councils		
Yes	40.7	51.4
No	25.9	17.1
Do not know	33.3	31.4

[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. At project end, there was a significant increase in the number of peer specialist full time employees (p =.036). Specifically, 55.0% of survey respondents indicated that their organization employs 3 or more full time peer specialists compared to only 25.9% of respondents at Time 1. In addition, a higher percentage of team members indicated that two or more peer specialists had attended the Via Hope training at project end (68.2%) than start (34.8%). At project end, the most frequently reported services provided by peer specialists were one-on-one support (52.5%), helping people advocate (52.5%), connecting consumers to resources/networking (52.5%), educational services (50.0%), and facilitation of support groups (47.5%).

Table 5: Peer Specialists and Consumer Operated Service Providers

	Percentage of Respondents[a]	
Theme	**Time 1**	**Time 2**
Organization employs peer specialists		
Yes	63.0	68.6
Total peer specialist full time employees (at organizations employing peer specialists)*		
1	37.0	30.0
2	37.0	15.0
3	11.1	35.0
4	7.4	5.0
5	7.4	10.0
More than 15	0.0	5.0
Number of peer specialists who attended Via Hope training		
1	65.2	31.8

2	30.4	31.8
3	4.4	36.4
Consumer operated services providers (COSP) in your area		
Yes	11.3	11.4
No	26.4	40.0
I do not know	37.4	31.4
I am not sure what a COSP is	24.5	17.1

[a] Percentages were calculated based on the number of people who responded to each item.
* Denotes a statistically significant change between Time 1 and Time 2 ($p < .05$).

Recovery Knowledge Inventory

The Recovery Knowledge Inventory (RKI; Bedregal, O'Connell, & Davidson, 2006) examines knowledge and personal attitudes toward recovery concepts. The instrument measures four domains: Roles and Responsibilities, Nonlinearity of the Recovery Process, The Roles of Self-Definition and Peers in Recovery, and Expectations regarding Recovery. Participants responded on a 5-point Likert scale, where 1 = Strongly Agree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree. After participating in the RILA, teams reported small increases in knowledge and personal attitudes in all of the aforementioned domains *except* for The Roles of Self-Definition and Peers.

The greatest gains in knowledge were reported on the Nonlinearity of the Recovery Process domain. The increase in knowledge on this domain between Time 1 and Time 2 was determined to be statistically significant. Although gains were noted on the Expectations Regarding Recovery domain and the RKI composite, these increases were not statistically significant. This was to be expected given the small sample size and limited duration of the project (6 months). It is expected that over time continued participation in Via Hope initiatives, or other recovery focused activities, may lead to increased knowledge of and attitudes toward recovery issues. The overall average responses across all Centers participating in the RILA at Time 1 and Time 2 are presented below. *Note: Higher averages indicate stronger recovery knowledge.*

> Respondents reported stronger recovery knowledge following participation in RILA: "I see more hope now for recovery and actually have a better understanding of what recovery can be than I ever thought I would."

Table 6: Mean Responses on the Recovery Knowledge Inventory

	Time 1 (N = 52)		Time 2 (N = 31)	
RKI Subscales	**Mean**	**SD**	**Mean**	**SD**
Roles and Responsibilities	4.13	0.45	4.12	0.57
Nonlinearity of the Recovery Process	3.06	0.66	3.45*	0.72
The Roles of Self-Definition and Peers	4.20	0.42	4.10	0.56
Expectations Regarding Recovery	3.76	0.75	3.84	0.79
RKI Total	3.80	0.42	3.88	0.48

* Denotes a statistically significant change between Time 1 and Time 2 ($p < .05$)

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 Likert 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, which was to be expected given that survey data was collected only five months apart. This validated instrument may not be sensitive to small changes in recovery-oriented practices. Further, response data was modest, at best, at project end. 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 Centers participating in the RILA at Time 1 and Time 2 are listed below. *Note: Higher averages indicate stronger engagement in recovery-oriented practices*

> Although RSA scores were consistent at project beginning and end, participants noted improvements within their organization: "I see recovery expanding every day in this facility."

Table 7: Mean Responses on the Recovery Self Assessment

	Time 1 (N = 50)		Time 2 (N = 34)	
RSA Subscales	**Mean**	**SD**	**Mean**	**SD**
Life Goals	3.92	0.56	3.83	0.68
Consumer Involvement and Recovery Education	3.26	0.73	3.30	0.74
Diversity of Treatment Options	3.58	0.66	3.45	0.73
Choice - Rights and Respect	4.04	0.46	3.93	0.54
Individually-tailored Services	3.68	0.57	3.75	0.60
RSA Total	3.71	0.52	3.65	0.57

Regional Seminars

All of the organizations were represented at the regional seminars; however the number of team members attending from each organization ranged from 1 to 8. Prior to the regional seminar, teams were requested to lead three discussion groups consisting of five to seven people to identify opportunities for change at their organization. A majority of the teams conducted the interviews (12 out of 19; 63%). Team members reported that the discussion groups were insightful and provided valuable information regarding opportunities for recovery oriented change within their organization. During the conference, customized organizational plans for recovery change were created based on information gathered from the discussion and work group sessions. Common elements of organizational plans included finding and recruiting allies

for recovery, establishing consistent change team meetings, having peers and consumers participate in ongoing focus groups, creating a peer support network, and sharing recovery and success stories throughout the organization. Participants reported that the regional seminar cultivated partnerships between organizations located in similar regions of the state, the purpose of a learning collaborative.

Change Team Activities

The project end survey included supplemental measures to evaluate the composition of the leadership change team, participation in recovery oriented activities, barriers encountered, and recovery oriented accomplishments. At project end, the majority of respondents indicated that they had expanded their change team following the regional seminar (78.1%). In addition, nearly half of respondents (41.9%) reported that they had held a coalition meeting with their team. A high percentage of team members (80.7%) indicated that their change team had made progress on the first steps identified at the conference. This was very impressive as the Time 2 survey was administered only 4 weeks after the regional meeting, but could also indicate initial momentum that might fade without continued team attention. Some examples of the progress made included: expanding the change team, including recovery principles in new employee orientation, sharing success stories at team meetings, changing the environment to promote recovery, including peers in change team meetings, and increasing the use of recovery language.

> "Serving on the leadership change team is a tremendous honor and well worth the struggles involved in changing."

Team members were also asked to report if they had encountered challenges in the implementation of their first steps. Many of the respondents noted that they had encountered organizational barriers (40.0%). The most commonly reported challenges were changing the culture of the environment, finding time to meet with the recovery change team, and educating staff members about peer specialists. Last, team members noted whether additional resources or supports from Via Hope were required. The most frequently requested services were information on hiring peer specialists, certification training for peer specialists, opportunities for collaboration and training on recovery, and tools to promote organizational culture change. The percentage of respondents engaging in change team activities following the regional conference is presented below.

Table 8: Change Team Activities

Survey Response	Percentage of Respondents Indicating Yes[a]
Expanded change team	78.1%
Held a coalition meeting	41.9%
Made progress on first steps	80.7%
Encountered barriers implementing first steps	40.0%
Require additional resources or support from Via Hope	41.9%

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

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 was collected, UT-CSWR provided each organization with a "RILA Site Report." The RILA Site Report included the following information: the number of staff members who completed the survey at that individual organization, the average response for each item at the individual organization in comparison to the overall average response for each item for all participating organizations, the organization's highest rated items, areas of strength (in comparison to other organizations), the organization's lowest rated items, and areas of improvement (in comparison to other organizations). To obtain an individual site report, at least 2 individuals from each organizational team were required to complete the survey. At Time 1, 17 individual site reports were prepared (89.5%). At Time 2, 13 individual site reports were prepared (68.4%).

> "Our experience with Via Hope this past year has been one of excitement, growth, and realization. Thank you for allowing us to be a part of this experience."

Accomplishments

Participation in the RILA resulted in teams reporting many recovery-oriented gains over a short period of time (6 months). Participants from each of the organizations established a change team coalition, developed first steps to promote recovery-oriented change, and began experimenting with recovery-oriented practices. At project end, a higher percentage of individuals indicated that they were trying or actively involved in making recovery-oriented change. Respondents also reported higher recovery concept or practice knowledge and recovery-oriented practice use. A higher percentage of consumers and family members were also reported as serving on boards at the end of the project.

After participating in the RILA, team members reported significant increases in knowledge and personal attitudes on Nonlinearity of the Recovery Process and small increases in on Expectations Regarding Recovery. Responses on the RSA were consistent at Time 1 and Time 2, which was to be expected given the small sample size and limited duration of the project. It is anticipated that with prolonged participation and involvement in a recovery-oriented learning community, RSA scores will reflect changes in organizational recovery orientation.

> "I have been very encouraged and am excited about the future working in this field as we truly see recovery become real to everyone living with mental illness and substance abuse."

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.

Conclusion

The aim of this initiative was for leadership teams at organizations to (a) develop a deeper understanding of recovery orientation at their organizations, (b) increase consumer and family involvement, (c) increase the knowledge of recovery principles of the staff in participating organizations, and (d) begin to experiment with recovery-oriented practices. 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

Lessons about the Leadership Academy

Consideration: A stepped process of learning about recovery and recovery practices was used for the RILA with positive results for the participating leadership teams.

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.

Consideration: The regional seminars were seen as extremely valuable by most participants and were where much of the team learning and next steps development occurred. The conference provided a shared experience for the team, guidance from a national expert in the field of recovery, and collaboration among participating organizations. Although all participating organizations were represented at a seminar, some teams were represented by only one individual.

Recommendation: To facilitate team member collaboration during the regional seminar work group sessions, at least two change team members must be in attendance. The importance of sending at least two team members to the seminars should be stressed by the Via Hope project lead. In addition, the executive director of the change team should agree to this requirement in the application process.

Consideration: Team members indicated that they greatly benefitted from collaborating with participating organizations at the regional seminars and that they would like increased communication and technical assistance from change team members at other locations.

Recommendation: 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. In addition, team members should 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: Hospitals and center outpatient services have different missions and challenges.

Recommendation: Provide training and technical assistance resources that focus on the unique strengths and challenges of these differing organizations. Holding a webinar or conference call focused on this issue may be beneficial.

Consideration: Team involvement among the participating organizations widely varied. Teams (and individuals) had different levels of engagement and comfort with recovery practices and asking for help. Over the course of the five month initiative, one team requested additional information and/or supports on forty separate occasions, while another organization contacted Via Hope only once.

Recommendation: Communication between team members and the RILA project lead should be encouraged. The RILA project lead should strive to build a level of trust for messages to be received and acted upon. This message should be sent to participating team members early and often.

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. Change team leaders and executive sponsors may 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: Although team members were encouraged to discuss their varied responses to concrete recovery-related items on the Time 1 survey results from Time 2 still showed discrepancies in understanding many of these items.

Recommendation: To move forward with recovery plans, it is important for team members to have a common understanding of their organization's current recovery orientation. It will be difficult to move forward in making recovery changes without consensus, for example, on the number of peer specialists working at the organization, consumer and family member involvement on boards and committees, or if the organization's mission includes recovery. Future RILAs might include activities for this type of discussion to occur.

References

Bedregal, L. E., O'Connell, M., & Davidson, L. (2006). The Recovery Knowledge Inventory: assessment of mental health staff knowledge and attitudes about recovery. *Psychiatric Rehabilitation, 30*, 96-103.

O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: assessing perceptions of recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation, 28*, 378-386.

Texas Department of State Health Services. (n.d.-b). Texas Mental Health Transformation Web Site Retrieved 12.9.2011, from http://www.mhtransformation.org/