Results of Recovery Initiatives and Assessments: FY2009 - present

Stacey Stevens Manser, Michele Murphy-Smith, Wendy Brooks, Laura Kaufman
Texas Institute for Excellence in Mental Health
University of Texas at Austin, Center for Social Work Research

Center for Social Work Research

TEXAS Department of State Health Services

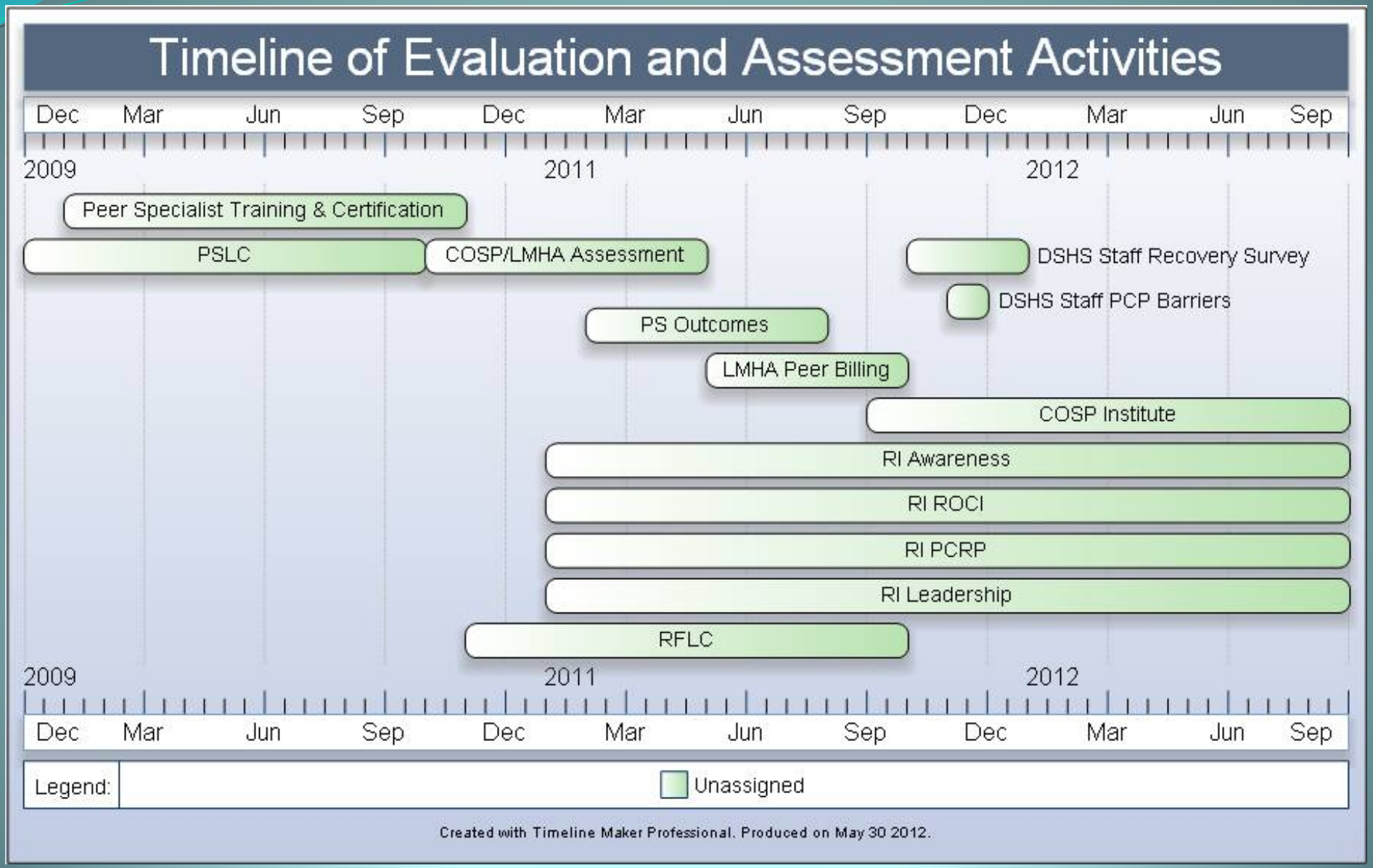
viaHOPE TEXAS MENTAL HEALTH RESOURCE

"The other thing that surprised me was the contrast between the recovery model and the traditional medical model … we're so revolved around the doctors … and the medications… I mean I've been tempted almost … when people get hung up on their medications… I'm almost tempted to say 'don't worry about the medications what you're going to do is more important than the medication.'"

- physician on the RFLC change team

Presentation Overview

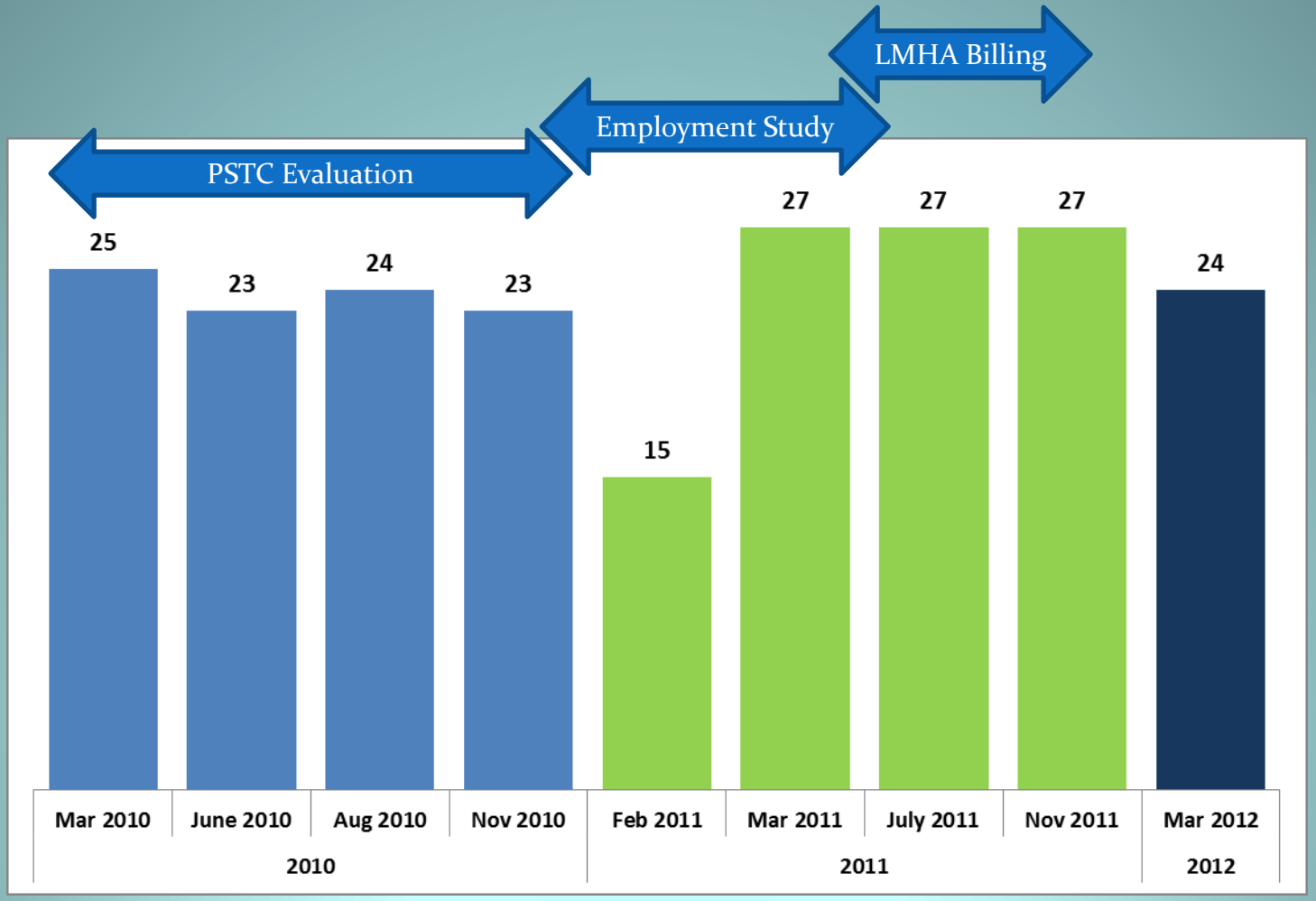
1. Review results from FY2009 to present
   - Peer Specialists
   - Consumer Operated Service Providers/LMHA Assessment
   - LMHA Peer Billing
   - Peer Specialist Learning Community
   - Recovery Focused Learning Community
   - DSHS Staff Survey of Recovery Capacity and Readiness
   - Recovery Institute (4 Levels)
     - Awareness; Leadership; Recovery Oriented Change Initiative; Person Centered Recovery Planning
2. A context or framework to view results
3. Discuss ideas to continue the recovery movement


Timeline of Evaluation and Assessment Activities
Dec
Mar
Jun
Sep
Dec
Mar
Jun
Sep
Dec
Mar
Jun
Sep
2009
2011
2012
Peer Specialist Training & Certification
PSLC
COSP/LMHA Assessment
DSHS Staff Recovery Survey
DSHS Staff PCP Barriers
PS Outcomes
LMHA Peer Billing
COSP Institute
RI Awareness
RI ROCI
RI PCRP
RI Leadership
RFLC
2009
2011
2012
Dec
Mar
Jun
Sep
Dec
Mar
Jun
Sep
Dec
Mar
Jun
Sep
Legend:
Unassigned
Created with Timeline Maker Professional. Produced on May 30 2012.

1. Results

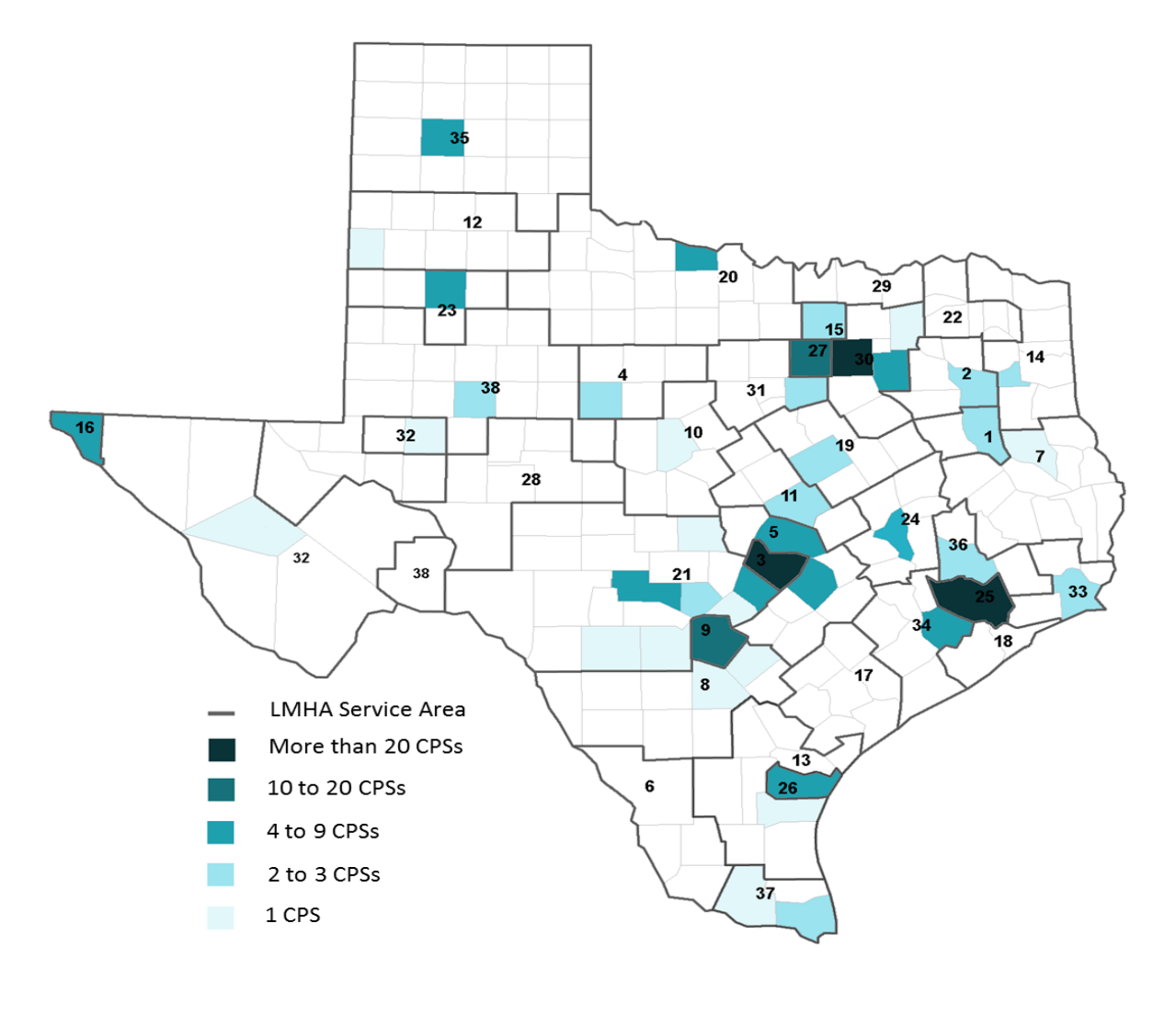
Context: Much of our work to date should be considered developmental or formative evaluation – with a focus on quality improvement and diffusion. This approach involves DSHS and Via Hope as partners participating in the process.

(Certified) Peer Specialists (CPSs)



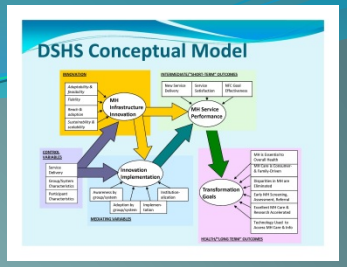
Total Certified Peer Specialists as of March 2012: 228
VH Trained: 215 + Grandfathered: 13

CPSs Locations



210 CPSs

PSTC Results (2010)



Direct Results

- 1st Peer Specialist Training – 30 peer specialists trained
- Train-the-Trainers Training – 9 peer specialists trained as trainers
- 2nd Peer Specialist Training – 27 peer specialists trained
- *11 Centers engage in learning community activities (albeit to varying degrees)*

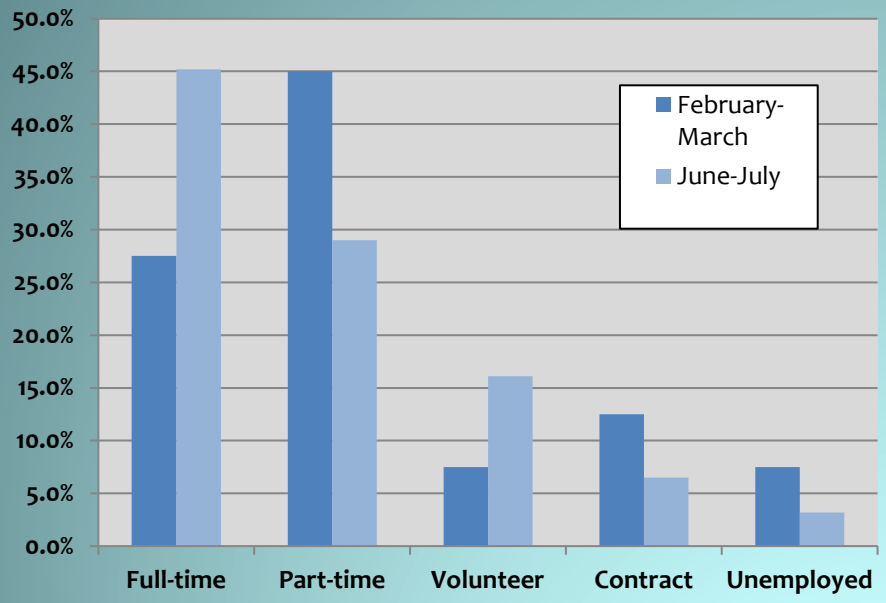
Intended Outcomes

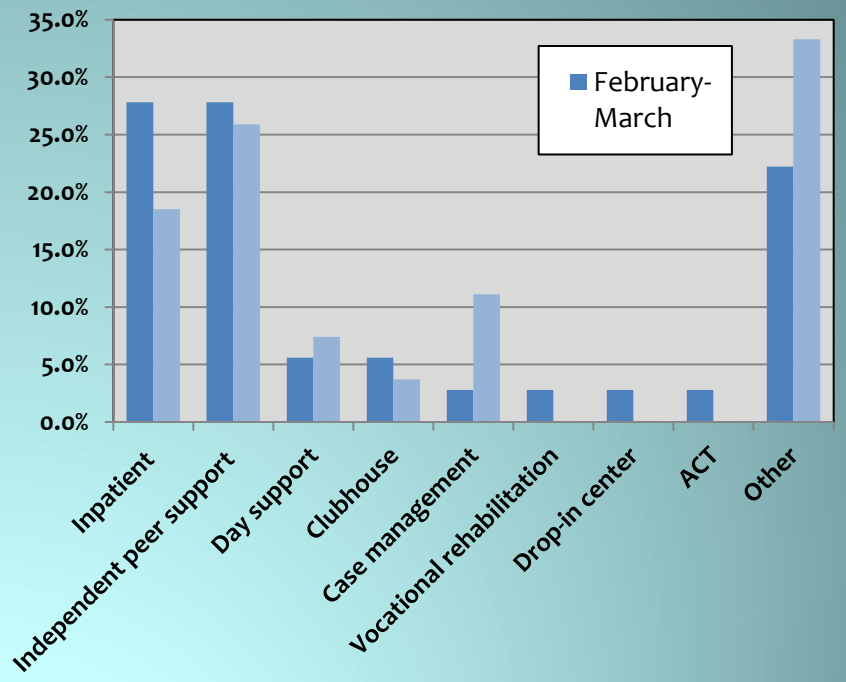
- 46 certified
- Trained peers will develop / enhance the knowledge, skills, attitudes needed to function as peer specialists, and demonstrate these gains in their jobs Preliminary data are supportive of gains
- Providers will send staff to peer specialist training, and hire peer specialists
- *Trained and certified peers will be employed as peer specialists, doing work aligned with the peer specialist job description*

PS Employment Outcomes (2011)

- 1st year cohort of peer specialists
- Conducted at two time points
- PSs more valued over time evidenced by:
  - PS serving more consumers
  - Greater job satisfaction
  - Association of RSA with job satisfaction
  - Association of RSA with confidence using peer specialist skills
  - Association of supervisor supportiveness with job satisfaction
  - Increased pay (still relatively low)
  - Increased hours worked; higher "caseloads"
  - Provision of direct MH services, as well as changes in services provided (e.g., on a treatment team)
  - Diversification of work settings
  - With each passing day that PSs are in the trenches changing the culture of mental healthcare recovery-oriented changes are being met with less resistance

PS Employment Outcomes (2011)





"Other" employment: crisis support and psychiatric emergency services, HIV/STD education and risk reduction, in-home peer support, homeless programs, and substance abuse programs

Barriers to Employing PSs

Reported across PSTC, LMHA Peer Billing, RFLC evaluations

Reported Barriers
Identifying and recruiting appropriate candidates
PSs ability to maintain personal recovery
Lack of financial resources for training/hiring
Credentialing/training issues
Need for paradigm shift (acceptance by nonclinical staff)
Transportation issues
Supervision requirements/Lack of supervision
Need to legitimize PS position
Dependability and attendance
Appropriate job descriptions
Rural location
Office space
Difficulties related to disability benefits
Difficulty accessing training and certification program
Lack of career ladder
Lack network of peers in the field/support
No barriers

Benefits to Employing PSs

Reported across PSTC, COSP, LMHA Peer Billing, RFLC evaluations

Reported Benefits
Connection with PSs due to similar life experiences
Promoting recovery – more belief that recovery is possible
Providing insight for consumers and staff
Sense of hope
Consumer engagement
Broadening service array
Role modeling
Bridging gap between provider and consumer
Strengthening support system
Destigmatization
Seeing the difference with their clients

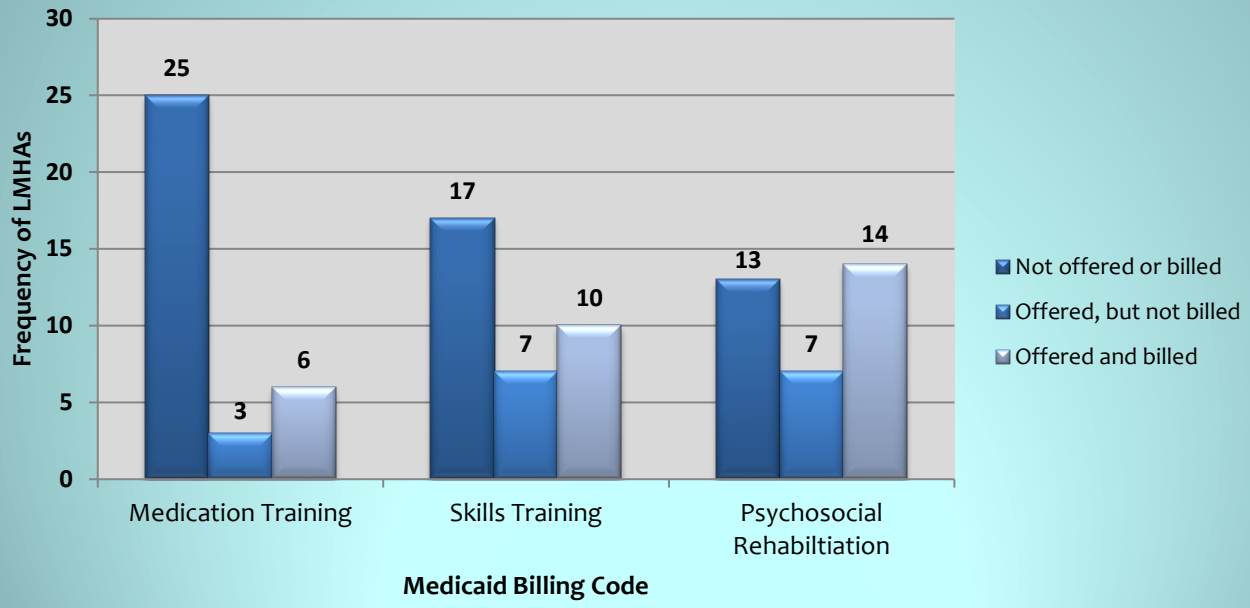
LMHA Peer Billing Assessment (2011)

- Why done? PSTC, PSLC, COSP/LMHA, Rehab Rule Review
- 37 LMHAs responded (NorthStar excluded):
- 25 (67.6%) employed PSs
  - 83 PSs currently employed (between 1 and 14 employed per LMHA)
  - Slightly more than 1/3 employed only 1 PS
  - 21 PSs were FTEs and 59 were PTEs
  - 92% knew # who attended VH PSTC (total = 51)
  - Salary range: $7.25 to $15.48 per hour (M = $10.57 hr)
  - Annual Salary:
    - 20 hours a week = $7,540 to $16,099 annual salary (average = $10,993)
    - 40 hours a week = $15,080 to $32,198 annual salary (average = $21,986)
- 12 (32.4%) did not employ PSs
- Total Reported LMHA Consumer Volunteers = ~ 145

Billing Medicaid

- Opportunities to bill Medicaid for peer provided services

	Not offered or billed	Offered, not billed	Offered *and* billed
Medication Training and Support	67.6%	8.1%	16.2%
Skills Training	45.9%	18.9%	27.0%
Psychosocial Rehabilitation	35.1%	18.9%	37.8%



Billing Medicaid - Barriers

- **Barriers to billing for peer provided services:**
  - Not employing any PS staff
  - Utilizing other staff to provide these services
  - PSs provide other (nonclinical) services
  - Bill using the QMHP code rather than Peer Provided code
  - PSs lack training necessary to provide services
  - PS serve in a volunteer capacity so not reimbursed
  - Lack supervision necessary to bill
  - Currently working on setting up billing codes for PSs
  - Lack of clarity around billing codes
  - Need to change Anasazi system matrix
  - Issues with documentation
  - PS lack computer skills
  - PSs serve in advisory capacities only

Billing: Medication Training & Support

Summary of LMHA Responses:

Offered and billed (17.6% of responding LMHAS)	Offered, but not billed (8.8% of responding LMHAS)	Not offered or billed (73.5% of responding LMHAS)
Services offered: • *Patient and Family Education programs* • *Texas Implementation of Medication Algorithms (TIMA)* • *Presentation of medication training materials developed by organization*	*Explanations:* • *Credentialing issues* • *Not meeting group requirements*	*Explanations:* • *No PS staff currently employed* • *Other staff provide these services* • *PSs utilized in other capacities* • *Billing using QMHP code* • *Lack of necessary training* • *PSs serve in a volunteer capacity* • *Lack of appropriate supervisor* • *Currently working on setting up peer provider billing codes*

DSHS Billing Information:

		FY2010	FY2011
Individual Medication Training and Support	*Client Hours*	*154.85*	*62*
	Clients Served	*106*	*47*
Group Medication Training and Support	*Client Hours*	*1205.65*	*2039*
	Clients Served	*834*	*1057*

Billing: Skills Training

Summary of LMHA Responses:

Offered and billed (29.4% of responding LMHAS)	Offered, but not billed (20.6% of responding LMHAS)	Not offered or billed (50% of responding LMHAS)
Services offered: • *skills for managing daily responsibilities* • *communication skills* • *problem-solving skills* • *social skills* • *stress reduction techniques* • *skills to manage the symptoms of mental illness and to recognize and modify unreasonable beliefs, thoughts and expectations* • *skills to identify and utilize community resources and informal supports* • *skills to identify and utilize acceptable leisure time activities* • *independent living skills* • *recovery skills* • *coping skills*	*Explanations:* • *Peers utilized in other capacities* • *Peers offer services primarily to SP3 clients, whom do not generally receive skills training* • *PS is volunteer, not paid employee* • *Lack of appropriate credentials*	*Explanations:* • *Issues related to credentialing, supervision, or group requirements* • *In process of setting up billing* • *Skills training typically offered by licensed professionals* • *Billed under Rehabilitation Option, rather than Peer Provided Skills Training (PSs are QMHPs)*

DSHS Billing Information:

		FY2010	FY2011
Individual Skills Training	*Client Hours*	*112.01*	*277*
	Clients Served	*33*	*45*
Group Skills Training	*Client Hours*	*312.25*	*1497*
	Clients Served	*44*	*98*

Billing: Psychosocial Rehabilitation

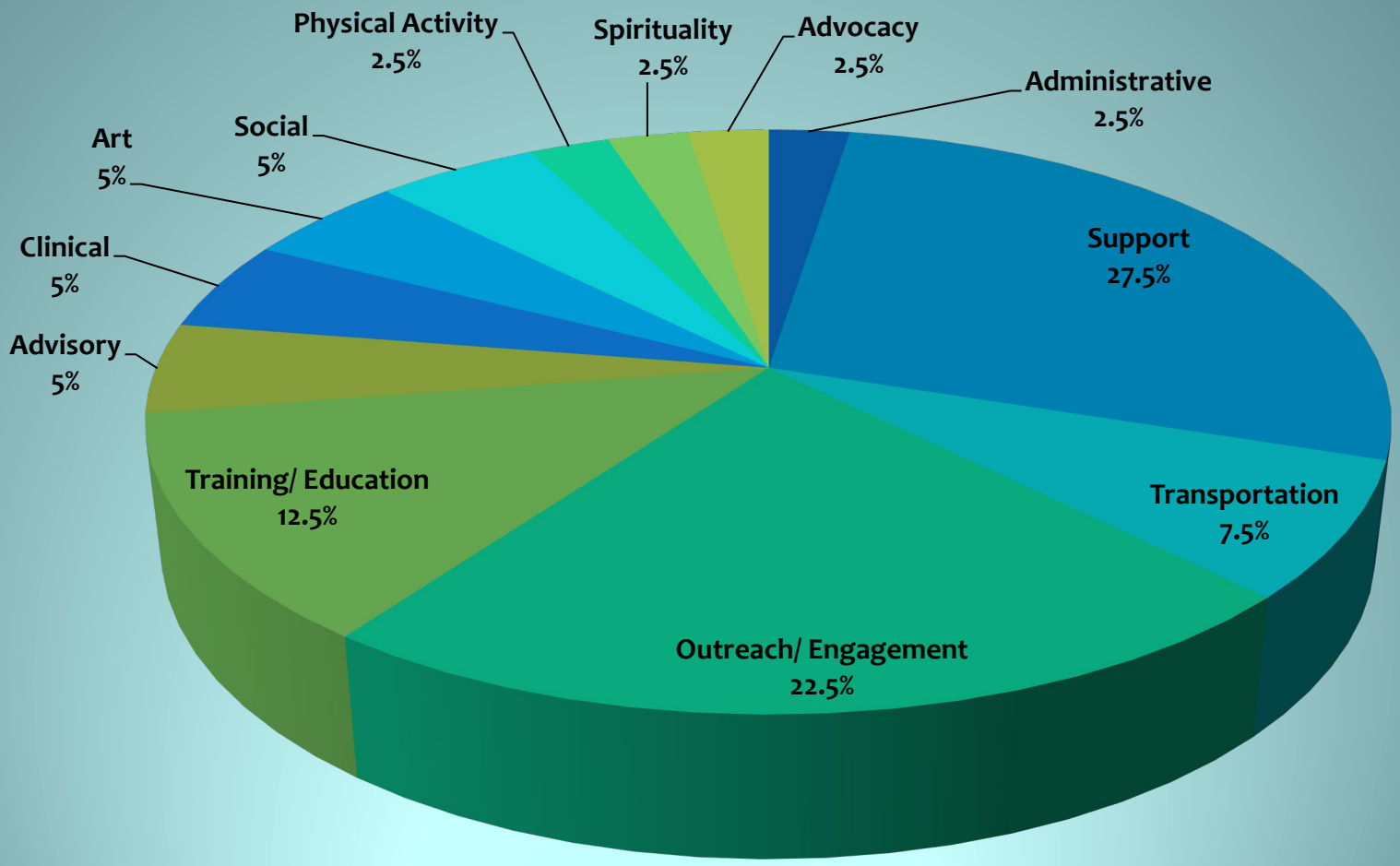
Summary of LMHA Responses:

Offered and billed (41.2% of responding LMHAS)	Offered, but not billed (20.6% of responding LMHAS)	Not offered or billed (38.2% of responding LMHAS)
Services offered: • *Independent living services* • *Coordination services* • *Employment related services* • *Housing related services* • *Medication related services* • *"General psychosocial rehabilitation"* • *"Psychosocial rehabilitation for A3 and A4 UM Guidelines and TAC definitions"*	*Explanations:* • *Bill as QMHPs* • *Credentialing issues* • *Not meeting group requirements* • *LPHA supervision requirements*	*Explanations:* • *Not employing PSs* • *Peers work only in volunteer capacity* • *PSs serve in advisory capacities only* • *PS positions currently being created* • *Skills training typically offered by other staff*

DSHS Billing Information:

		FY2010	FY2011
Individual Psychosocial Rehabilitation	*Client Hours*	*2256.22*	*1040*
	Clients Served	*490*	*201*
Group Psychosocial Rehabilitation	*Client Hours*	*1360.31*	*2525*
	Clients Served	*260*	*266*

“Other” Peer Provided Services



Other services also reported in the COSP/LMHA assessment and the Peer Outcomes study.

In the last 2 years, peers specialists have really improved services here. One woman has not been in hospitalized in a year and a half--she had 41 admissions over the previous 4 years. So I think this has really made a difference for her. She's gone to WRAP training, she has an exercise program that she follows, she hasn't been drinking in 3 years and every time I see her she's just… glowing. To me, that's the proof right there.

- RFLC change team member

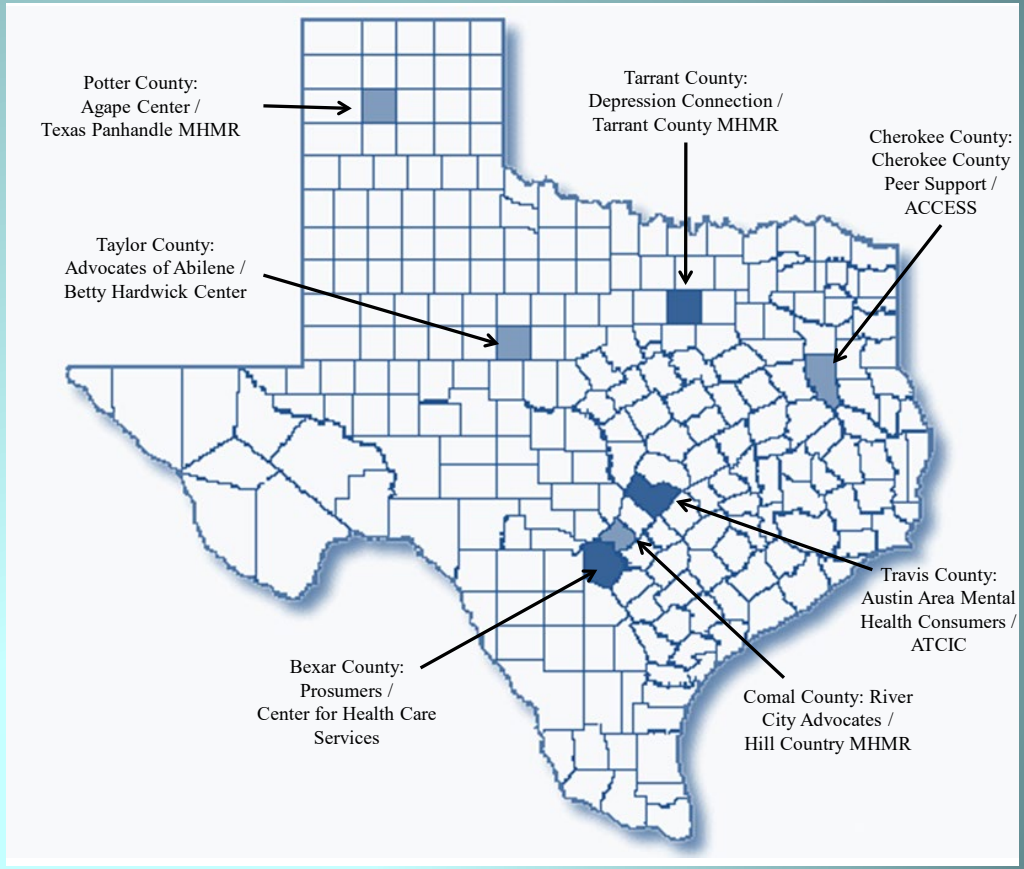
LMHAs requested …

- Twenty-six of 32 organizations (81.3%) expressed interest in TTA to increase use of PSs.
- **Requested TTA:**
  - measuring outcomes of peer services
  - educating patients and family members
  - skills training
  - psychosocial rehabilitation
  - PS service modality
  - initiatives similar to the RFLC
  - identifying qualified PS candidates
  - expanding peer provided services
  - roles, job descriptions, supervision

Consumer Operated Service Providers (COSPs)

COSP/LMHA Assessment (2010-11)

- 7 funded by DSHS through LMHA
- Review COSP/LMHAs models, identify TTA needs to develop organizational capacity for sustainability
- Surveys/Interviews
- Funding: $23,760 to $71,500
- 10-40 served per day (M=15.86)
- Complementary Organizations, Independent Missions
- “Stage of Collaboration”
  - 4 referral
  - 3 coordination
- TTA for sustainability identified
- Form N to count service



COSP/LMHA Assessment (2010-11)

Service Provided	# Providing Service
One-on-one peer support	**6**
Facilitating peer support groups	**6**
Transportation assistance	**6**
Accessing community resources	**6**
Recreation/socialization	**6**
Computer/technology	**6**
Teaching	5
Recovery Education	5
Navigating the public mental health system	5
Wellness Recovery Action Planning (WRAP)	4
Vocational/employment assistance	4
Housing assistance	4
Advocacy training	4
Skills training	4
Crisis support	4
Fitness/wellness	4
Other	4
Education/GED assistance	2
Warm lines	1

***Bold** items indicate services provided most frequently*

COSP Institute (FY2012)

- **Focus on:**
  - Infrastructure Sustainability (TANO)
  - Program Development and Sustainability (Laurie Curtis)
- **Current Activities:**
  - Monthly Calls & Periodic Topical Webinars
  - Individual strategic planning (2 individual visits)
  - 3-day gatherings (3)
  - Individual on-site program assessment and TA
    - Providing more services than first assessment indicated
    - Data Collection (lack resources to utilize current data as effectively as they could)
- **Future:**
  - Targeted TA (for different levels of need)
  - Use of FACIT
  - Revised Form N

Instruments

Recovery Self Assessment (RSA)

Recovery Knowledge Inventory (RKI)

Person Centered Care Questionnaire (PCCQ)

Primary instruments used in the PSLC, RFLC, Peer Specialist Outcomes Study, DSHS MHSA Staff Survey, and the Recovery Institute: Leadership Academy, Recovery Oriented Change Initiative, Person Centered Recovery Planning

Instruments – Quick Review

- Recovery Self Assessment (RSA)

  32-item instrument with six domains that assess attitudes towards recovery as well as practices associated with the principles of recovery. Six domains: Life Goals, Consumer Involvement and Recovery Education, Choice, Diversity of Treatment Options, Individually Tailored Services, and Invite (O'Connell et al., 2005)

- Recovery Knowledge Inventory (RKI)

  20-item instrument with four domains that assess practitioner knowledge of and attitudes toward recovery. Four domains: Roles and Responsibilities in Recovery, Non-linearity of the Recovery Process, Roles of Self-definition and Peers in the Recovery Process, and Expectations Regarding Recovery. Results can help identify topics and focus points for future education and training (Bedregal, O'Connell & Davidson, 2006)

- Person Centered Care Questionnaire (PCCQ)

  32-item questionnaire that assesses experience with specific practices that are part of person centered treatment planning (Tondora & Miller, 2009)

Learning Communities … Intent

- Peer Specialist Learning Community (PSLC; FY2010)

  Limited intervention.

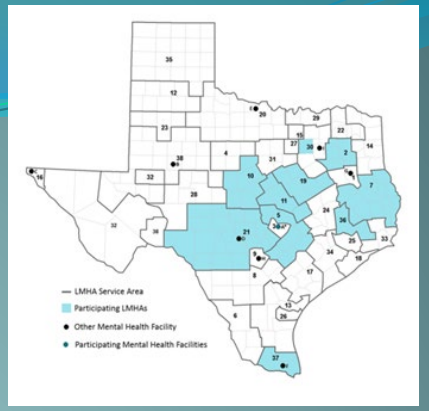
  Primary Intent: Increase the number of peer specialists.

- Recovery Focused Learning Community (RFLC; FY2011)

  More intensive intervention.

  Primary Intent: Improve Recovery Orientation, Engage in Activities to Improve RO, Increase number of peer specialists.

PSLC … Outcomes

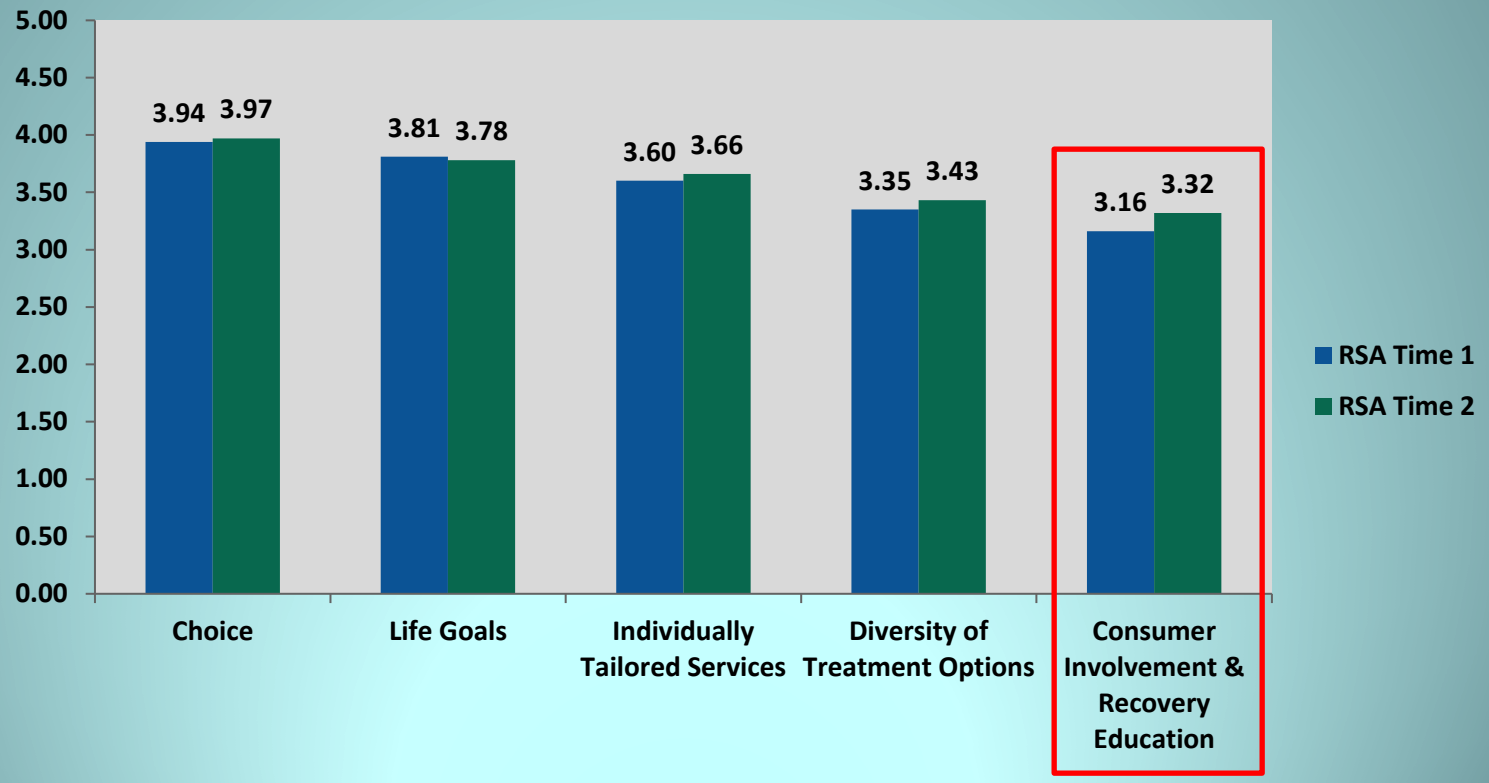


Direct Results

- Of 12 participating organizations:
  - 1 Created
  - 5 Enhanced
  - 6 Expanded peer specialist positions
- Other:
  - Leadership support is critical
  - To benefit from collaborative learning, participants should be present and engaged (50% all calls/83% individual) … provide more tools for assistance
  - ***Focusing on peer supports without organizational change may be ineffective***

PSLC … Change Unit RSA Staff Outcomes

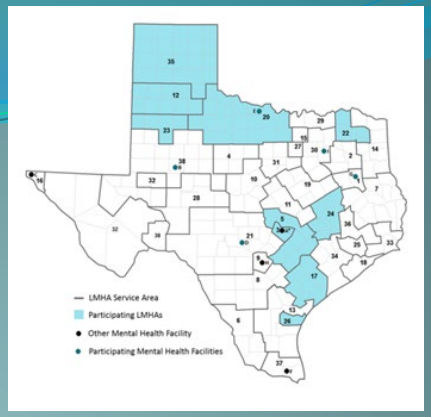
RSA Time 1: 422 STAFF surveys from 12 Centers
RSA Time 2: 127 STAFF surveys from 6 Centers



People in the consumer group here are just blossoming out in all kinds of different directions, going back to college, pursuing employment opportunities, taking some small steps, but very courageous steps towards the idea of recovery in their lives.

- RFLC change team member

RFLC Results (2011)

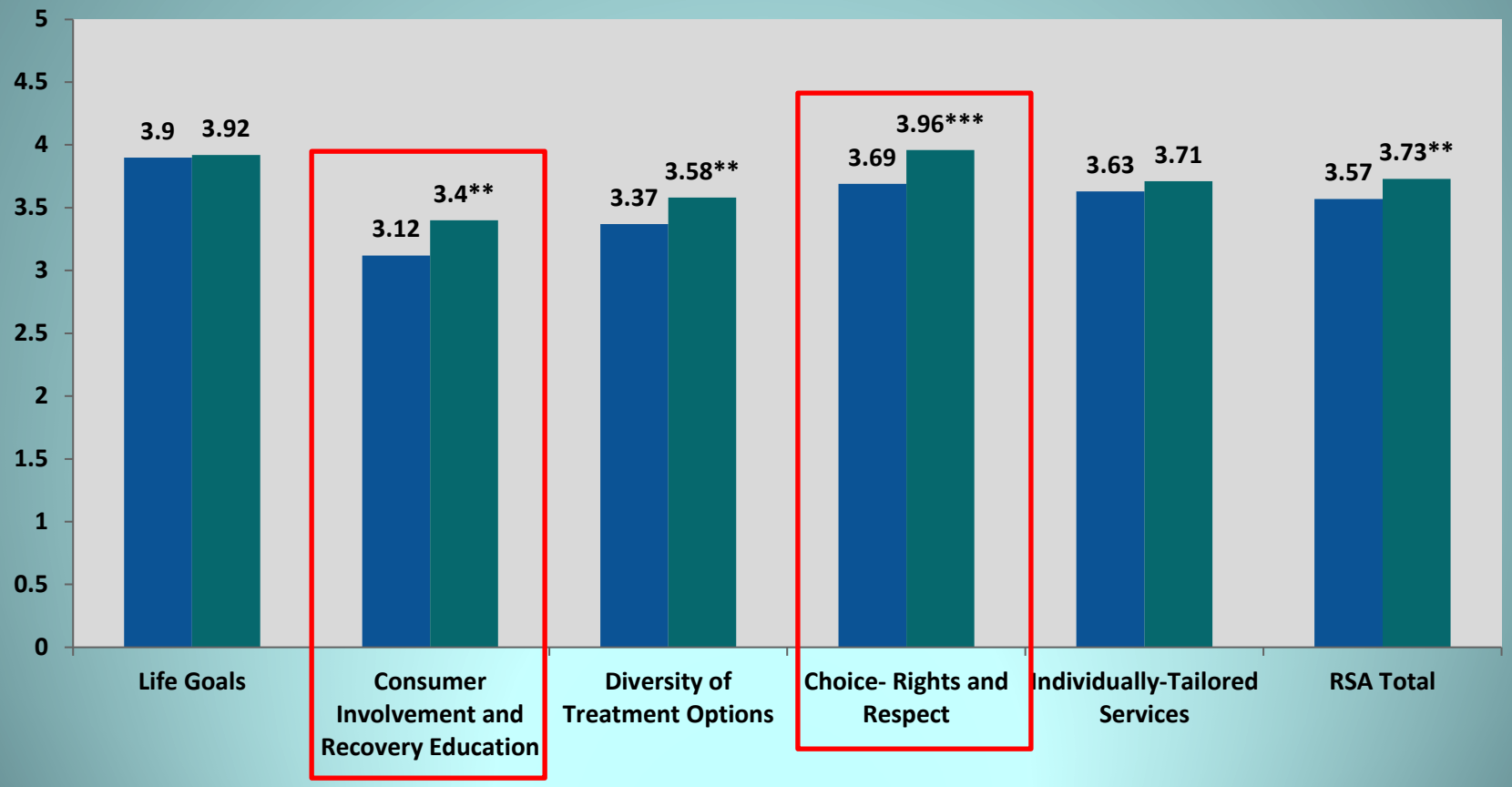


Direct Results

- Peer specialists employed increased from 22 to 45 (104%)
- All teams expanded peer support services offered
- Recovery tools were adapted, change activities shared, connections made, and faculty support provided as needs became apparent
- Majority of activities revolved around expanding peer support services, increasing numbers and integration of peer specialists, and supporting clinical staff to provide recovery support services.
- Statistically significant changes in one to three subscales of the RSA for 12 of 15 agencies. (2 sites had no statistically significant changes and 1 site did not provide sufficient data)
- Major areas of improvement:
  - Recovery education and consumer involvement (6 of 12 sites)
  - In general, consumers gave higher RSA ratings than did staff

RFLC … Change Unit RSA Staff Outcomes

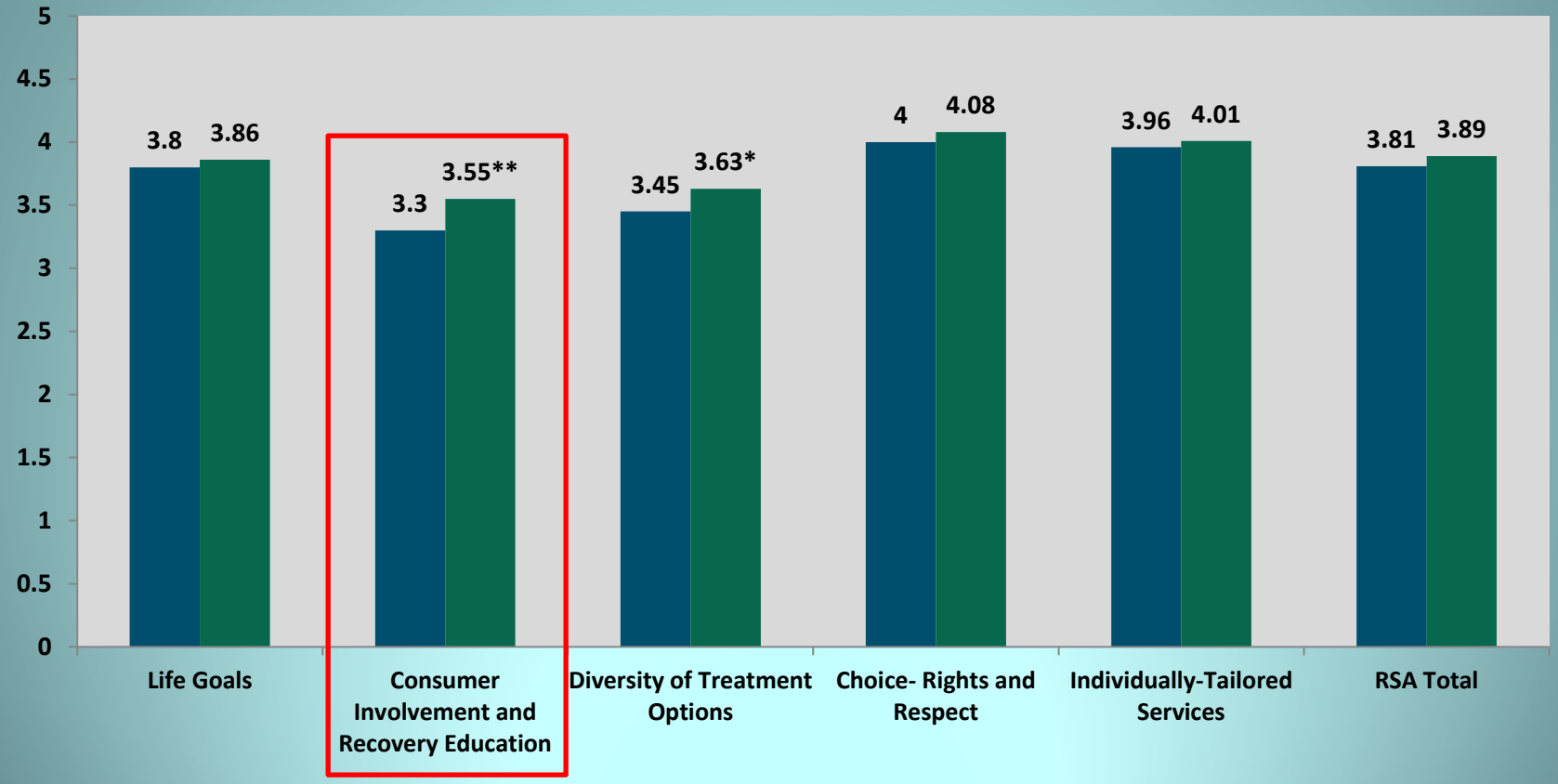
RSA Time 1: 217 STAFF surveys from 10 Center Change Units (2,067 total)
RSA Time 2: 177 STAFF surveys from 10 Center Change Units (1,418 total)



statistical significance at **p≤.01, and ***p≤.001

RFLC … Change Unit Consumer RSA Outcomes

RSA Time 1: 438 CONSUMER surveys from 10 Center Change Units
RSA Time 2: 267 CONSUMER surveys from 10 Center Change Units



statistical significance at *p≤.05, and **p≤.01

Consumer Involvement & Recovery Education

- 8 items comprising this RSA factor:

• **People in recovery are regular members of agency advisory boards and management meetings.**
• **People in recovery work alongside agency staff on the development and provision of new programs and services.**
• **Persons in recovery are involved with facilitating staff trainings and education programs at this agency.**
• **This agency provides structured educational activities to the community about mental illness and addictions.**
• **People in recovery are routinely involved in the evaluation of the agency's programs, services, and service providers.**
• **Agency staff actively help people become involved with activities that give back to their communities (i.e., volunteering, community services, neighborhood watch/cleanup).**
• **This agency provides formal opportunities for people in recovery, family members service providers, and administrators to learn about recovery.**
• **The development of a person's leisure interests and hobbies is a primary focus of services.**

RFLC … Change Unit RKI Outcomes

	Center Change Unit T1 (n=213)	Center Change Unit T2 (n= 173)
Roles and Responsibilities	3.66	3.73
Nonlinearity of the Recovery Process	2.37	2.49
The Roles of Self-Definition and Peers	3.97	4.11**
Expectations Regarding Recovery	3.21	3.39*
RKI Total	3.30	3.42**

statistical significance at *p≤.05, and **p≤.01

RFLC … Outcomes

Reported Value of RFLC Resources

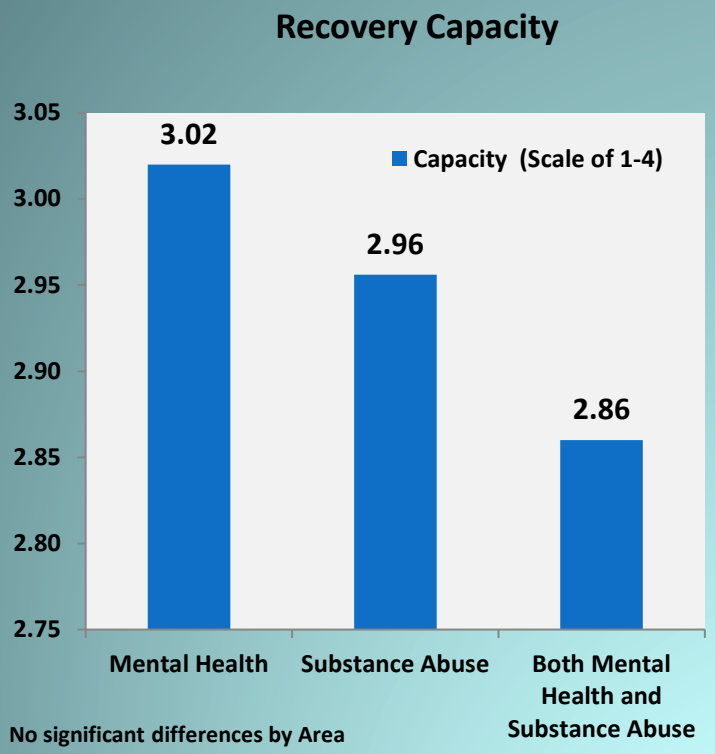
RFLC Sites Not Hosting a FFL training		RFLC Sites Hosting a FFL Training	
Resources	Importance (%)	Resources	Importance (%)
Kick-Off Conference	28.3	Kick-Off Conference	20.1
Onsite TA (Recovery 101)	21.0	Focus for Life	20.0
Individual Site Calls	14.2	Onsite TA (Recovery 101)	15.0
All Teams Calls - Didactic	12.5	Individual Site Calls	10.7
Individual Via Hope Resources	8.3	Via Hope Digest Emails	8.2
Via Hope Digest Emails	8.3	All Teams Calls - Didactic	8.0
All Teams Calls - Participative	8.0	All Teams Calls -Participative	8.0
MHT Online	6.3	Individual Via Hope Resources	7.8
Focus for Life	0	MHT Online	5.2

Used for planning Recovery Institute

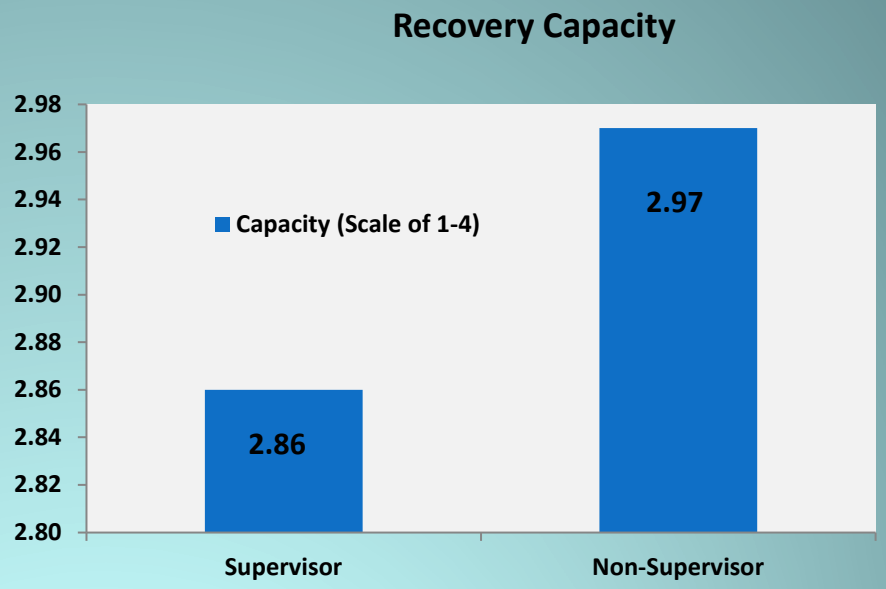
"This thing stuck. Here we are, 8 months later, and we're still meeting, we're still restructuring forms, we're still fixing lobbies, new staff are getting trained, we're hiring new people and they're learning about recovery-based language and strengths, and person-centered stuff. It hasn't gone away."

- RFLC change team lead

DSHS Staff Surveys: Recovery Capacity



No significant differences by Area

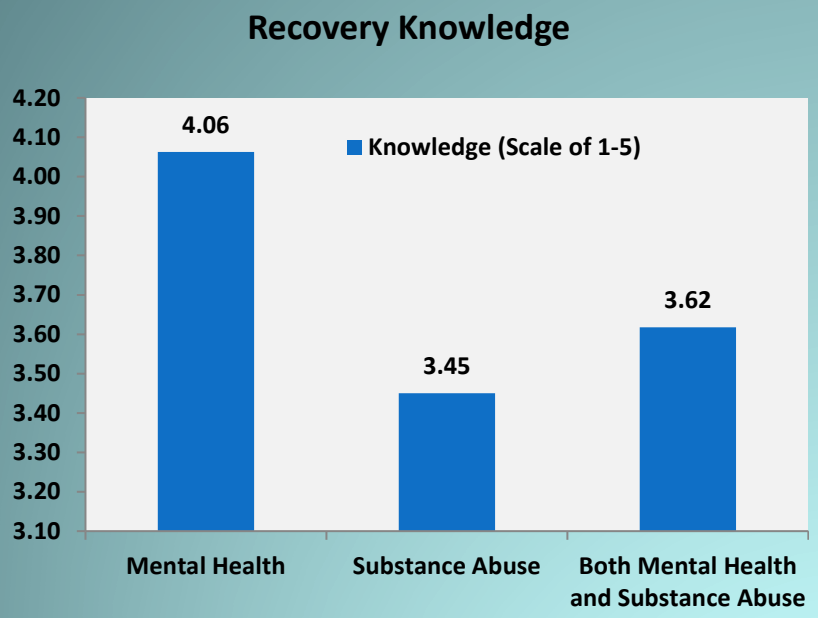


No significant differences by Area

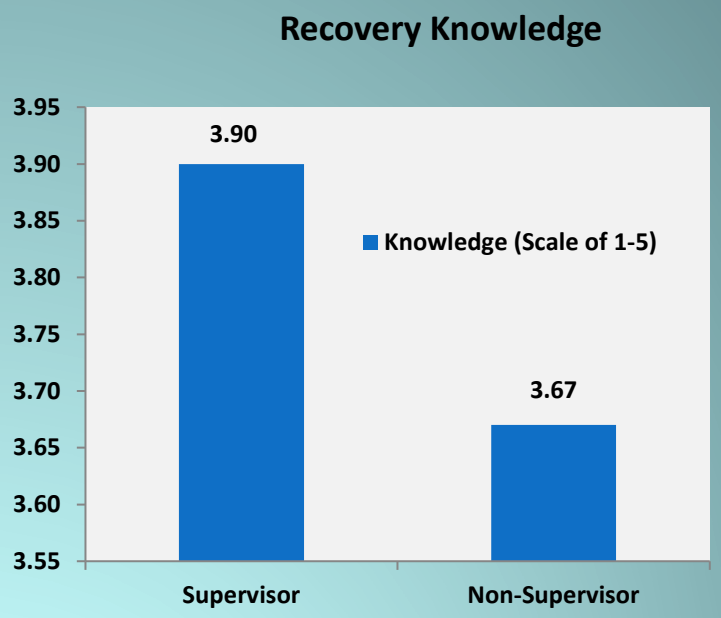
Examples of Capacity Items (34 items):

- Division Vision, Mission, Goals explained by leadership so staff understand role in achievement
- There are enough staff in unit to make changes needed to provide recovery oriented services
- My unit is concerned about readiness of the field to implement new vision and mission
- Staff believes system can be changed to be better and barriers overcome in reasonable period
- Division is ready to assess individual recovery outcomes using data reported by providers

DSHS Staff Surveys: Recovery Knowledge (RKI)



ANOVA is significant by Area: $F(2, 71) = 8.00$, $p=.001$, $Eta_p=.19$



No significant differences by Area

Examples of RKI items (20 items):

- Only people who are clinically stable should be involved in making decisions about their care.
- The more a person complies with treatment the more he/she is to recover.
- Other people who have a serious mental illness or are recovering from substance abuse can be as instrumental to a person's recovery as mental health professionals
- Not everyone is capable of actively participating in the recovery process.

RKIs Across Projects

RKI Factors (Time 1)	RFLC	MHSA	ROCI	PCRP	LA
Roles and Responsibilities	3.66	4.05	4.01	3.95	4.13
Nonlinearity of the Recovery Process	2.37	3.00	2.77	2.80	3.06
The Roles of Self-Definition and Peers	3.97	4.20	4.19	4.16	4.20
Expectations Regarding Recovery	3.21	3.67	3.56	3.30	3.76
RKI Total	3.30	3.73	3.64	3.60	3.80
	n=213	*n=64*	*n=216*	*n=115*	*n=52*

Need focus on RKI (recovery knowledge and attitudes) before RSA?

Non-linearity of the Recovery Process

- 6 items comprising the non-linearity RKI factor:

• **Recovery is characterized by a person's making gradual steps forward without major steps back.**
• **Expectations and hope for recovery should be adjusted according to the severity of a person's illness/condition.**
• **The more a person complies with treatment the more he/she is to recovery.**
• **Symptom reduction is an essential component of recovery.**
• **There is little that professionals can do to help a person recover if he/she is not ready to accept his/her illness/condition or need for treatment.**
• **Symptom management is the first step toward recovery from mental illness/substance abuse.**

FY2012 Via Hope Initiatives

Recovery Institute (RI): 4 Levels

Action

Person Centered Recovery Planning (PCRP)
Focus on the **practice**
Organizational culture and processes are identified and addressed during implementation

Preparation

Recovery Oriented Change Initiative (ROCI)
Focus on **organizational culture and processes**
Implement practices in recovery plans that are informed by organizational strengths and needs

Contemplation

Leadership Academy
Build readiness and plan for recovery concepts & practices
Assess recovery orientation/knowledge of leadership, identify strengths and needs, build urgency and coalition for change

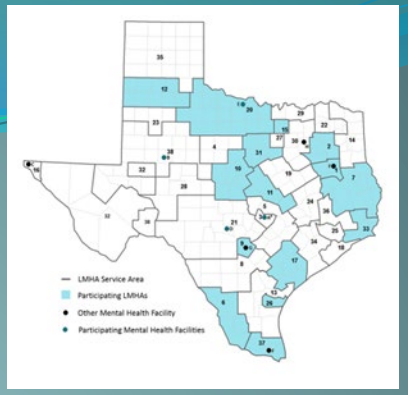
Precontemplation

Recovery Awareness
Build **awareness of and introduce to** recovery concepts
Engage new leaders and organizations

RI: Awareness

- Began activities in May
- 239 individuals signed up to participate
- 20 LMHA staff represented
- Recovery Reads:
  - Participation primarily peer specialists and staff working with peer specialists

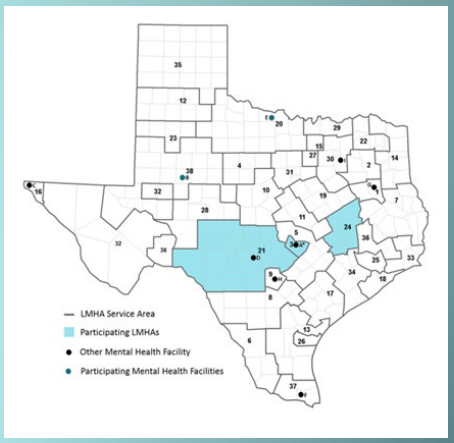
RI: Leadership Academy



- 19 participating organizations
- Webinars, Leadership Conference, Regional Meetings
- Data collected from Leadership Team (pre-post):
  - Consumer/Family Involvement, RSA, RKI
  - Used to plan for change at regional conferences
  - Time 1 Results:
    - Differing responses from team members (e.g. mission/involvement)
    - RKI similar to other organizations …

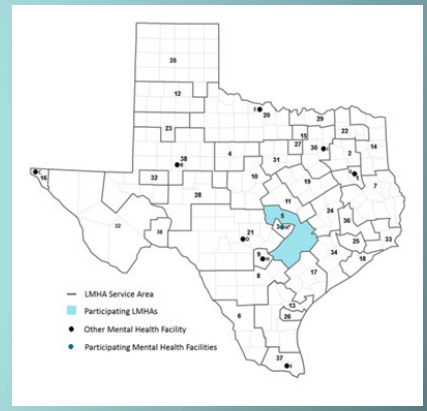
RI: Recovery Oriented Change Initiative

- 5 organizations (3 Centers, 2 Hospitals)
- Initial site visit, 2-day training, group and individual monthly calls
- Recovery Plans
- Quality Improvement Measurement:
  - Staff RSA
  - Staff RKI
  - Consumer RSA
  - Ongoing online surveys
  - Track Recovery Plan activities and progress over time



RI: Person Centered Recovery Planning

- 2 organizations: 1 Center, 1 Hospital
- Interventions:
  - 1-day PCRP overview; 2-day intensive PCRP training; refresher
  - Peer specialist training
  - PCRP TA calls (1-recovery plans, 1-leadership)
  - Between sites: continuity of care (peer specialists)
  - Recovery launch events
  - Quality Improvement Measurement:
    - Staff Person Centered Care Questionnaire (PCCQ)
    - Staff Recovery Knowledge Inventory (RKI)
    - Consumer PCCQ
    - Improvements in Person Centered Recovery Plans
    - Identification and remediation of system barriers



RI: Person Centered Recovery Planning

- Challenges Identified to Date:
  - Time- and resource-intensive
  - Communication – internal and external
  - Resistance to change
  - Electronic Health Record
  - Implementing the Recovery Model vs Traditional Model
  - Medicaid
  - Translation of concepts to concrete implementation strategies
  - Transition of traditional "problem-oriented" plans to "goal-oriented" plans
  - Staff focus from directive/parental to collaborative
  - Developing "team" approach to writing narrative
  - Focus of one Unit/Service Package
  - On-going development Peer Support Specialist Role
  - Maintaining momentum and sense of urgency to change.

RI: Person Centered Recovery Planning

- Success Strategies Identified to Date:
  - Peer Support Specialists!!
  - Training related to Peer Support Specialist role (Lyn Legere)
  - Involve leaders at every level – formal and informal
  - Willingness to have honest, open dialogue about the current system and to take risks
  - Availability of Information/Resources
  - Role-modeling on unit
  - Modify environment
  - Launch Events
  - Flexibility/Delegation/Collaboration
  - Celebrate and share success

"When we heard about recovery and the de-emphasis on medication maintenance and symptom management, into person-centered plans and what the client wants and what's meaningful to them… it was like, WOW! And anyone who has been working in mental health for a number of years, they were repeating the same old litany of "make sure you take your meds if you have problems or symptoms here's what you do" and writing the same old treatment plans … wow. We're going to stop doing that. Let's stop doing that."

- RFLC Change Team Member

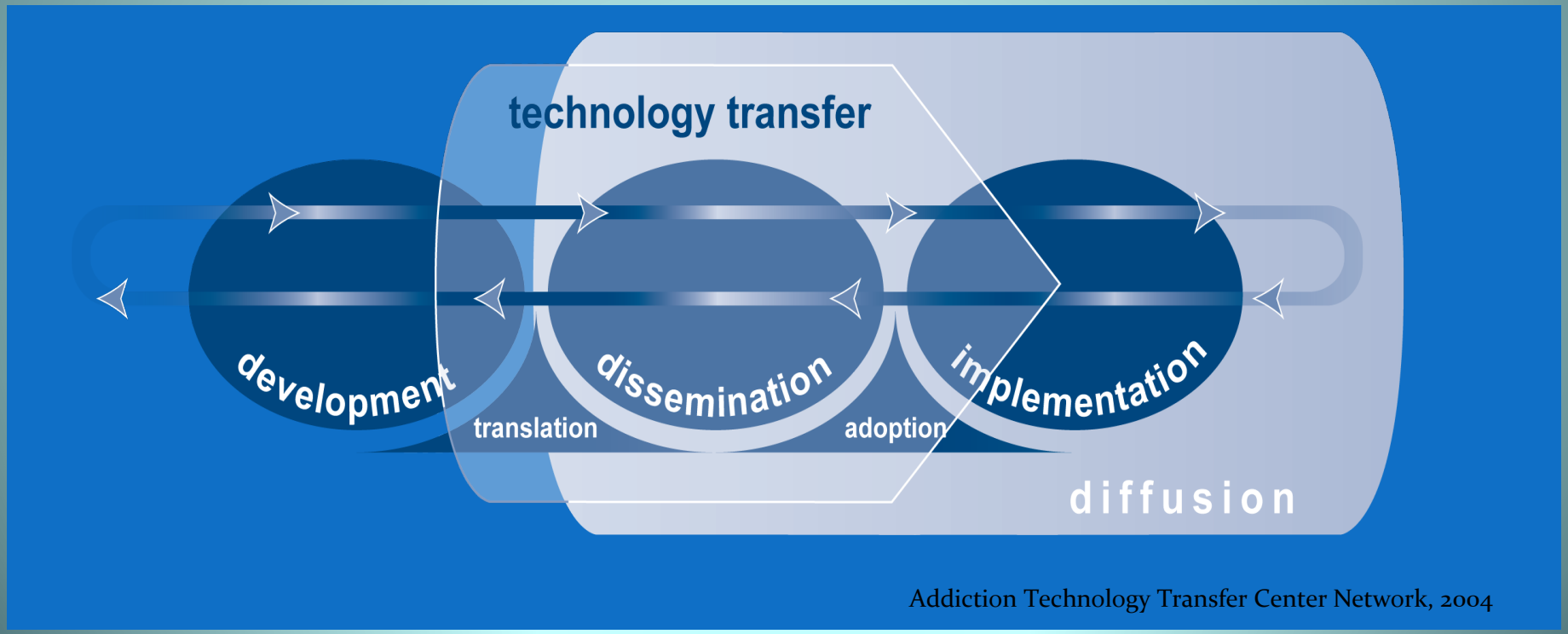
2. Framework or Context to View Results

"… I hear the patients and clients and hear the words 'how will you know when you no longer need us' and they're not used to being asked that."

- RFLC Change Team Member

Technology Transfer Model

- A model to view the process of research to practice
- IOM (2001) reported the lag for evidence to reach practice; "patients" receive best practices just 55% of the time (Texas?)



Addiction Technology Transfer Center Network, 2004

Effective Implementation

TRAINING COMPONENTS	OUTCOMES		
	Knowledge	Skill Demonstration	Use in Classroom
Theory and Discussion	10%	5%	0%
plus Demonstration in Training	30%	20%	0%
plus Practice & Feedback in Training	60%	60%	5%
plus Coaching during Practice	95%	95%	95%

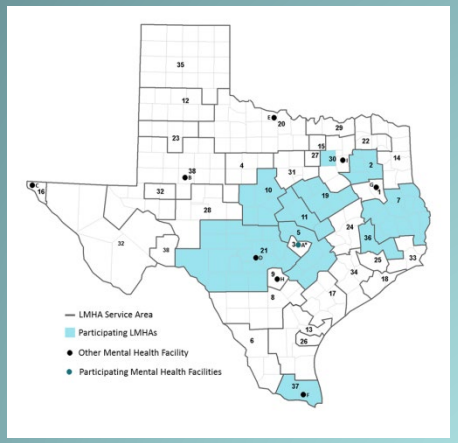
OUTCOMES =
% of participants who demonstrate knowledge, demonstrate new skills in a training setting, and use new skills in practice setting

Joyce & Showers (2002) in Dean L. Fixsen, Karen A. Blase, Leah Bartley, Michelle Duda, Sandra Naoom, Allison Metz, Barbara Sims & Melissa Van Dyke. 2012. Evidence-based programs: A failed experiment or the future of human services? National Implementation Research Network.

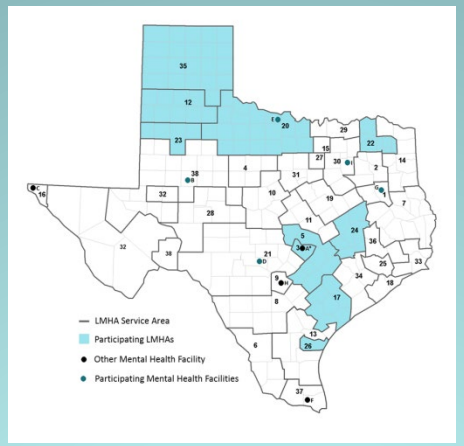
Effective Implementation of an Intervention	
Team	No Team
80%, 3 yrs	14%, 17 yrs
Effective use of implementation science & *practice*	Letting it happen
Fixsen, Blase, Timbers & Wolf, 2001	Balas & Boren, 2000

Recovery Innovation Participation …

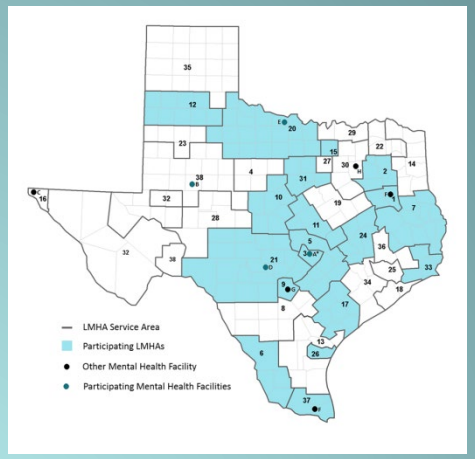
PSLC



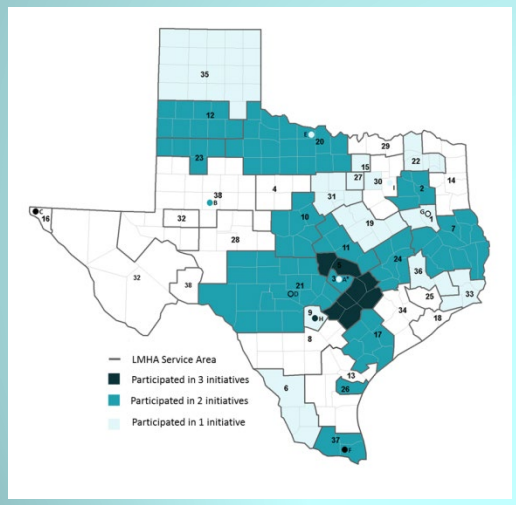
RFLC



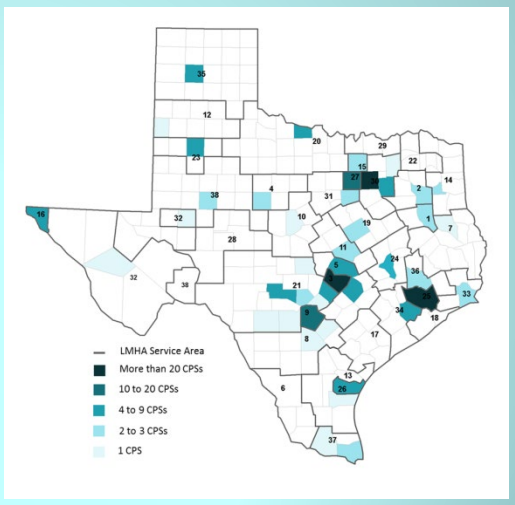
Recovery Institute



All Initiatives



CPSs

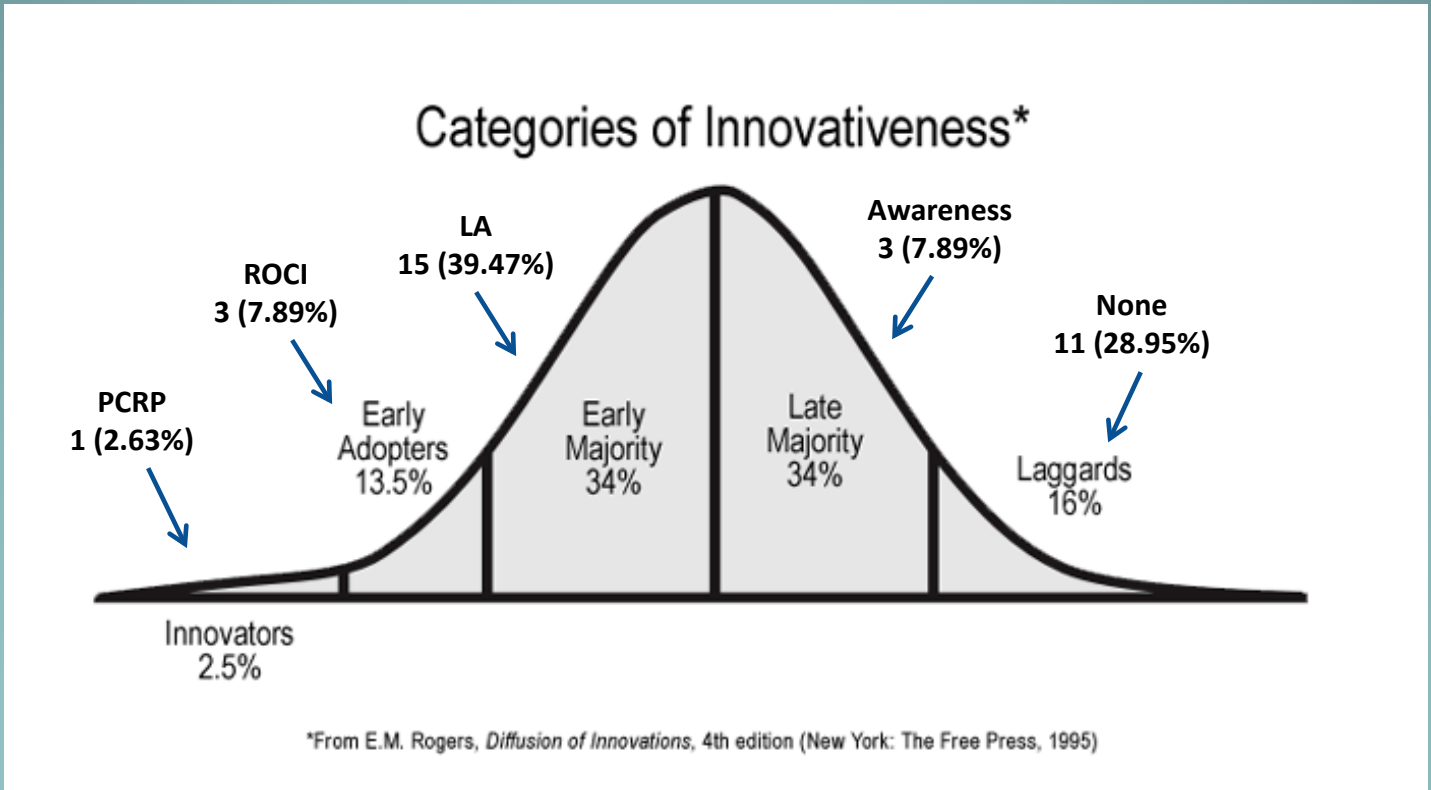


Participation …

ID	LMHA	ID	LMHA	ID	LMHA
5	Bluebonnet Trails Community Services	9	Center for Healthcare Services	4	Betty Hardwick Center
6	Border Region MHMR Community Center	15	Denton County MHMR Center	8	Camino Real Community Services
7	Burke Center	19	Heart of Texas Region MHMR Center	13	Coastal Plains Community Center
2	Andrews Center	22	Lakes Regional MHMR Center	14	Community HealthCore
3	Austin Travis County Integral Care	27	MHMR of Tarrant County	16	El Paso MHMR
10	Center for Life Resources	30	North Texas Behavioral Health Authority	18	Gulf Coast Center
11	Central Counties Center	31	Pecan Valley Centers	25	MHMR Authority of Harris County
12	Central Plains Center	33	Spindletop Center	28	MHMR Services for the Concho Valley
17	Gulf Bend Center	35	Texas Panhandle Centers	29	Texoma Community Center
20	Helen Farabee Centers	36	Tri-County Services	32	Permian Basin Community Centers
21	Hill Country MHDD Centers			34	Texana Center
23	Lubbock Regional MHMR Center			38	West Texas Centers
24	MHMR Authority of Brazos Valley				
26	MHMR of Nueces County				
37	Tropical Texas Behavioral Health				
15 participated in 2 or 3 VH initiatives		*10 Participated in 1 VH initiative*		*11 Participated in 0 VH initiatives*	

11 LMHAs have not participated; but some of these have PS and 2 participate in Hogg East TX Recovery Initiative

Diffusion of Innovation - LMHAs



Where is DSHS MHSA on this curve?

LMHA	PSLC	RFLC	RI-Aware Only[1]	RI-LA	RI-ROCI	RI-PCRP
Participation Totals	11	11	3	15	3	1
Participation Rates	28.95%	28.95%	7.89%	39.47%	7.89%	2.63%

Recovery Planning

Let person do what he/she wants regardless of our concerns. This is not being person-centered; this is

Neglect

Get the person to do what WE want regardless of their viewpoint. This is not acting in their best interest; this is

Control

http://www.patdeegan.com/AboutCommonGround.html

3. Continuing the Recovery Movement

"Sometimes you see these great new ideas and they're the flavor of the month. [Then you just] wait for them to fade. But this one isn't fading."

- RFLC change team member

DSHS Vision

- Hope, Resilience, and Recovery for Everyone

DSHS Mission

- To improve health and well-being in Texas by providing leadership and services that promote hope, build resilience, and foster recovery.

Related Block Grant Objectives
Recovery Support:
• Develop plans and resources for implementation of person-centered recovery planning.
• Develop tools and processes to facilitate movement towards recovery-oriented organizations and services.
• Establish scope of practice for Peer Specialists and Family Partners based on evidence-based and promising practices for peer provided services.

Thank you.

- Questions?

For additional information, please contact Stacey Stevens Manser: stacey.manser@austin.utexas.edu