Recovery Institute Leadership Academy Summary Report August, 2015

TIEMH
Texas Institute for Excellence in Mental Health

viaHOPE
TEXAS MENTAL HEALTH RESOURCE

Texas Institute for Excellence in Mental Health
Center for Social Work Research
School of Social Work
University of Texas at Austin
1717 West 6th Street, Suite 335
Austin, Texas 78703
Phone: (512) 232-0600
Fax: (512) 232-0617
http://blogs.utexas.edu/mental-health-institute/

Jillian Bellinger, PhD
Stacey Stevens-Manser, PhD

Suggested Citation:
Bellinger, J. M., Stevens-Manser, S. (2015). *Recovery Institute Leadership Academy Summary Report: August 2015.* Unpublished report. Texas Institute for Excellence in Mental Health, Center for Social Work Research, School of Social Work, University of Texas at Austin.

Please contact Jillian Bellinger by phone (512) 232-8219 or email jbellinger@austin.utexas.edu for additional information about this report.

Recovery Institute Leadership Academy

In 2009 Via Hope, Texas Mental Health Resource was funded by the Department of State Health Services. Via Hope promotes mental health wellness to Texans by providing training and technical assistance resources and collaborative learning opportunities to consumers, youth, family members, and mental health providers (www.viahope.org).

Via Hope Recovery Institute

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

In 2014-2015, Via Hope provided three "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 the RI.

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

The Recovery Institute Leadership Academy (RILA)

This report focuses specifically on the content and outcomes of Level 3, the Recovery Institute Leadership Academy (RILA). The Recovery Institute Leadership Academy (RILA) is a foundational project intended to promote shared leadership, recovery oriented change, and increased community tenure. The project requires a significant level of commitment: Participation from an Executive Sponsor, creation of a Core Leadership Team to execute the project, and commitment to required project activities.

Goals of the Project:

Participating organizations were encouraged to focus their efforts on promoting shared leadership and were given the opportunity to work on at least two of the following four practice domains: (1) Access and engagement; (2) Community mapping and development; (3) Continuity of care; (4) and Addressing barriers to recovery. As a means of obtaining a broader impact, most sites chose to target activities in each of the aforementioned practice areas, as opposed to limiting their work to just two. The aforementioned recovery-oriented domains were specifically developed for this project as research indicates that they are particularly relevant to increased community inclusion, tenure, and reduced psychiatric rehospitalization, which was the original focus of the RILA project.

Mid-way through the project (December, 2014) sites expressed a need for technical assistance regarding peer specialist integration. Via Hope responded to this need by eliciting group discussion among participating sites, providing webinars on this area, and conducting an on-site training focused on demystifying peer support. Due to participating sites' needs and interests the project shifted its focus from reducing psychiatric rehospitalizations to a broader goal of promoting recovery oriented care and peer specialist support.

Goals of the Evaluation:

The focus of this evaluation was quality improvement. Data collection for the Leadership Academy was intended to determine if organizational teams mobilized to develop a plan for implementing recovery oriented change in their organizations, engaged in recovery-oriented activities, and increased community tenure.

The following research/evaluation questions will be examined:

1. Does the recovery orientation of the organizations change from project start to end?
2. Do organizations demonstrate successes (movement) in the 5 key areas of recovery oriented care and community engagement (i.e., access and engagement, community mapping and development, continuity of care, and addressing barriers to recovery) from project start to end?
3. Do clients report increases in recovery markers and/or better quality of care from project start to end?
4. Does the number of peer specialists employed increase from project site to end?

Information included in this report was gathered by The Texas Institute for Excellence in Mental Health (TIEMH) evaluation team and the Via Hope facilitation team through staff and client surveys, group discussions, interviews, and observation. This report presents recommendations for organizational strategies to promote recovery oriented culture change and increased community tenure. This information may be used to shape future Recovery Institute initiatives by refining training and technical assistance as well as improving understanding of the needs specific to Texas public mental health agencies.

Method

Participants:

Following a competitive application process, Via Hope selected five organizations to participate in the RILA project: (1) Denton County MHMR, (2) Community Healthcore, (3) Emergence Health Network, (4) Harris County MHMRA, and (5) San Antonio State Hospital. However, Community Healthcore graduated to another Recovery Institute initiative: the Peer Specialist Integration Project in April 2014. Participating organizations were required to select a 'change unit' where they would pilot new practices and approaches. Staff on the change unit were encouraged to participate in a number of recovery oriented activities, led by their organization's RILA leadership team. In addition, clients being served on the change unit were invited to complete an evaluation survey at project start and midpoint to share their perception of the organization's practices as well as attitudes and beliefs about their recovery.

Project activities:

The RILA activities were designed to build on each other in a staged learning process. The project began with an application process that required organizations to form a core leadership team and agree to participate in a number of key training and technical assistance activities. Bi-monthly webinars focused on critical change concepts (e.g., asset based community development, person centered recovery planning, shared leadership, and integration of peer specialists). Bi-monthly all team calls focused on the targeted practice areas described previously. Individualized technical assistance was also provided through monthly calls with each participating site. In-person gatherings and onsite visits were also held throughout the project. Cross site collaboration was fostered to encourage and promote continued recovery oriented work. Each of these activities are further described below.

Activity	Strategic Purpose
Project Application (December, 2013)	• Assess and select candidate sites for project • Collect RILA data from sites state wide
Orientation Phone Call (January, 2014)	• Clarification of expectations • Finalization of change unit and core leadership team • Preparation for initial site visit
Initial Site Visit and Report (February, 2014)	• Orient Core Leadership Team and Executive Sponsor to project • Share facilitation activities to begin collaborative process • Gather critical information about site to target project content and consultation • Provision of a report reflecting observations by the Via Hope consultants
Transforming Texas Cross-Project Conference (April, 2014)	• Brings together all organizations participating in the Recovery Institute initiatives (PCRP, PSI, RILA, and Peer-Run organization) • Provides a foundation for the work to come • Initiates cross-site collaborations
Development of Recovery Project Plan (April, 2014)	• Invite staff in change unit to prioritize targeted goals and action steps to achieve those goals • Identify key players to achieve goals • Although plans were designed to be developed and updated by the teams on a monthly basis, only a few teams were able to provide monthly updates to their plans.
Organizational Asset Mapping 1-day On Site Visit (June, 2014)	• Mapping assets which relate to supporting people in the community and reducing psychiatric readmission • Mobilizing team work and engagement in the project • Celebrating strengths and addressing barriers
Recovery in Practice Training 2-day On Site Visit (October, 2014)	• Explored principles, attitudes, and skills that facilitate the provision of exceptional recovery support • Participants created a plan for implementing individual practice changes to embrace recovery oriented care
Wellness Visit 1-day Onsite (April, 2015)	• Reflect with core leadership team the achievements of the project on site • Provide consultation for ongoing or potential challenges • Provide consultation for next steps to sustain and further develop recovery oriented organizational culture

Monthly Webinars – Presentations Related to Practice Domains	• Invite sites to engage in learning and interaction • Presentation of tailored material to assist organizations with meeting challenges emerging during the project
Monthly Individual Site Calls	• Track progress, celebrate successes, address barriers, and highlight learning and development • Keep sites engaged in process and aware of progress • Provide consultation to address challenges
Technical Assistance	• Ongoing technical support, guidance, and assistance to Leadership Academy team members was provided by the project facilitator and Via Hope staff, as well as consultants from outside Texas when required • Partnerships at the local, regional, and state level were fostered – an essential method to create knowledge across a learning community

Recovery Webinars and All Team Calls:

Bi-monthly webinars and process calls were hosted over the course of the RILA. Webinars focused on the key organizational practice areas with the goal of increasing knowledge on recovery-oriented care and promoting community tenure.

The process calls were used to deepen understanding of specific recovery practices, provide support for making recovery change, and address questions, concerns, and experiences of team members. These calls provided a forum for cross site collaboration among participating organizations. In addition, active participation and engagement during the calls was fostered through the use of Liberating Structures. Information regarding each of the team calls are presented below.

Date	Topic
1.13.2014	Initial All Teams Call
3.05.2014	Effective Recovery Support: Sorting out roles and transforming agencies with the assistance of people in recovery
5.07.2014	Asset Based Community Development
7.02.2014	Process Call: Teams sharing/collaborating
8.13.2014	Participative Leadership and Change
9.02.2014	Organizational Recovery Plans
11.05.2014	Attracting Powerful Peer Support Team Members
1.07.2015	Process Call: Reviewing purpose and recovery plans
2.11.2015	Introduction to Trauma Informed Care
3.04.2015	Self-expression as a Tool in Recovery
4.27.2015	Introduction to Emotional CPR
5.19.2015	Process Call: Teams sharing/collaborating

Evaluation Results

The evaluation included several components and focused on information gathered from the RILA team members and clients. The number of individuals participating in the evaluation was small and is not

considered representative of the organization. Because of this, evaluation results are limited but they do offer insight into how a collaborative like the leadership academy can facilitate recovery change using a leadership team. Graphs are included within the context of the report to highlight significant findings. Tables depicting detailed staff and client results can be found in Appendix A and B, respectively.

Organizational Background

Organization	Change Unit	Total clients seen per month on change unit	Number of clients who withdraw from services each month	Average length of client stay	Staff turnover
Denton County MHMR	Mental Health Case Management	1,800	50	3-5 years	45%
Emergence Health Network	Central Outpatient Clinic	310	16	4 months	2%
Harris County MHMRA	Adult Mental Health Clinic at Southwest Location	1,900	70	12 months	6%
San Antonio State Hospital	Crockett Hall	30	20	54 days	34%

Staff and Client Feedback:

Staff completed online surveys at project start (February, 2014), middle (October, 2014), and end (June, 2015) via an online or paper based form[1]. Online surveys were administered through Qualtrics, a secure, online survey administration tool, to facilitate data entry and analyses. Staff who did not have access to a computer completed the survey via a paper form. Clients being served at the change unit of each participating organization were invited to complete an evaluation survey at the beginning (February, 2014) and mid-point (October, 2014) of the project.[2] Clients completed the paper-based survey and returned in a provided envelope to the TIEMH evaluation team.
The following data was collected:

Staff:

- Organizational structure
- Recovery orientation and readiness
- Practice areas
- Recovery change team activities
- Barriers encountered
- Recovery accomplishments

[1] Emergence Health Network did not participate in the end of year staff survey.
[2] Due to the change in the scope and direction of the RILA project, Via Hope, TIEMH, and participating sites determined that an end of year survey with clients was not warranted.

Clients:

- Recovery orientation and practice
- Recovery markers
- Quality of life
- Attitudes and beliefs about health and wellness
- Engagement with peer specialists

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

Staff Participants

Four hundred seventy nine individuals, from four organizations, participated in the Leadership Academy. Organizations were located across Texas in urban, suburban, and rural areas. The number of respondents gradually decreased from Time 1 (N = 191) to Time 3 (N = 125). However, the demographic information for participants was relatively consistent across time points. The majority of respondents were White, female, and between the ages of 25 to 44 years. Results from Pearson Chi-Square analyses indicated that survey respondents were not significantly different in ethnicity, sex, or age among time points ($p > .05$). This suggests that participation throughout the RILA was consistent and that differences in outcomes are not attributable to individual differences among respondents at project beginning and end. Demographic information of Leadership Academy staff survey respondents is presented below.

Age, Sex, and Ethnicity of RILA Respondents - Staff

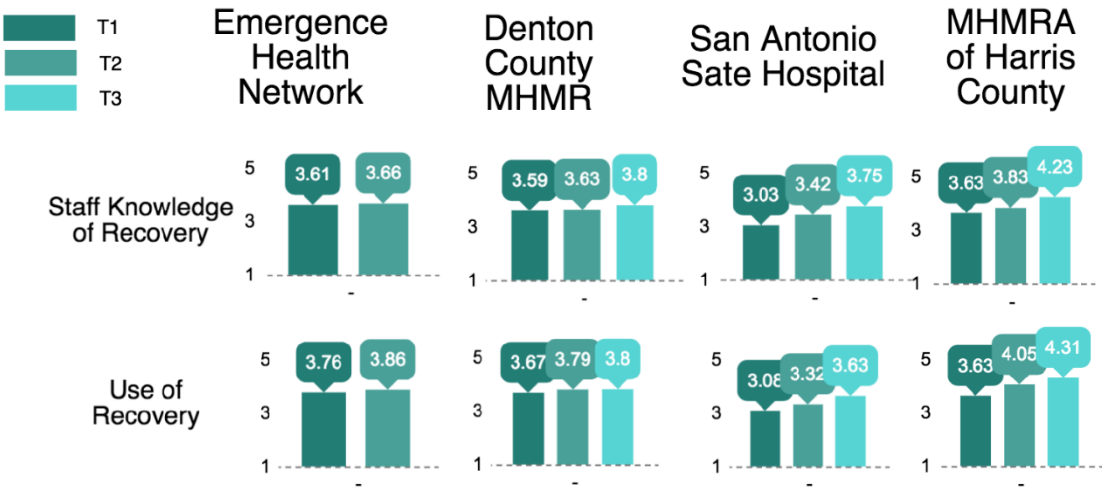
Demographic		Percentage of Respondents		
		Time 1 (N =191)	Time 2 (N =163)	Time 3 (N =125)
Ethnicity	Hispanic	29	26	33
	American Indian/Alaska Native	1	3	2
	Asian	1	3	2
	Black or African American	17	22	27
	Native Hawaiian or Other Pacific Islander	0	1	0
	White	55	49	36
	Other/Not Disclosed	26	22	33
Sex	Male	21	20	28
	Female	79	80	72
Age	18 – 24	6	3	4
	25 – 34	28	34	30
	34 – 44	30	29	22
	45 – 54	16	16	26
	55 – 64	16	12	12
	65 or older	4	6	6

Staff Knowledge and Use of Recovery:

Staff knowledge and use of recovery was assessed via two items:

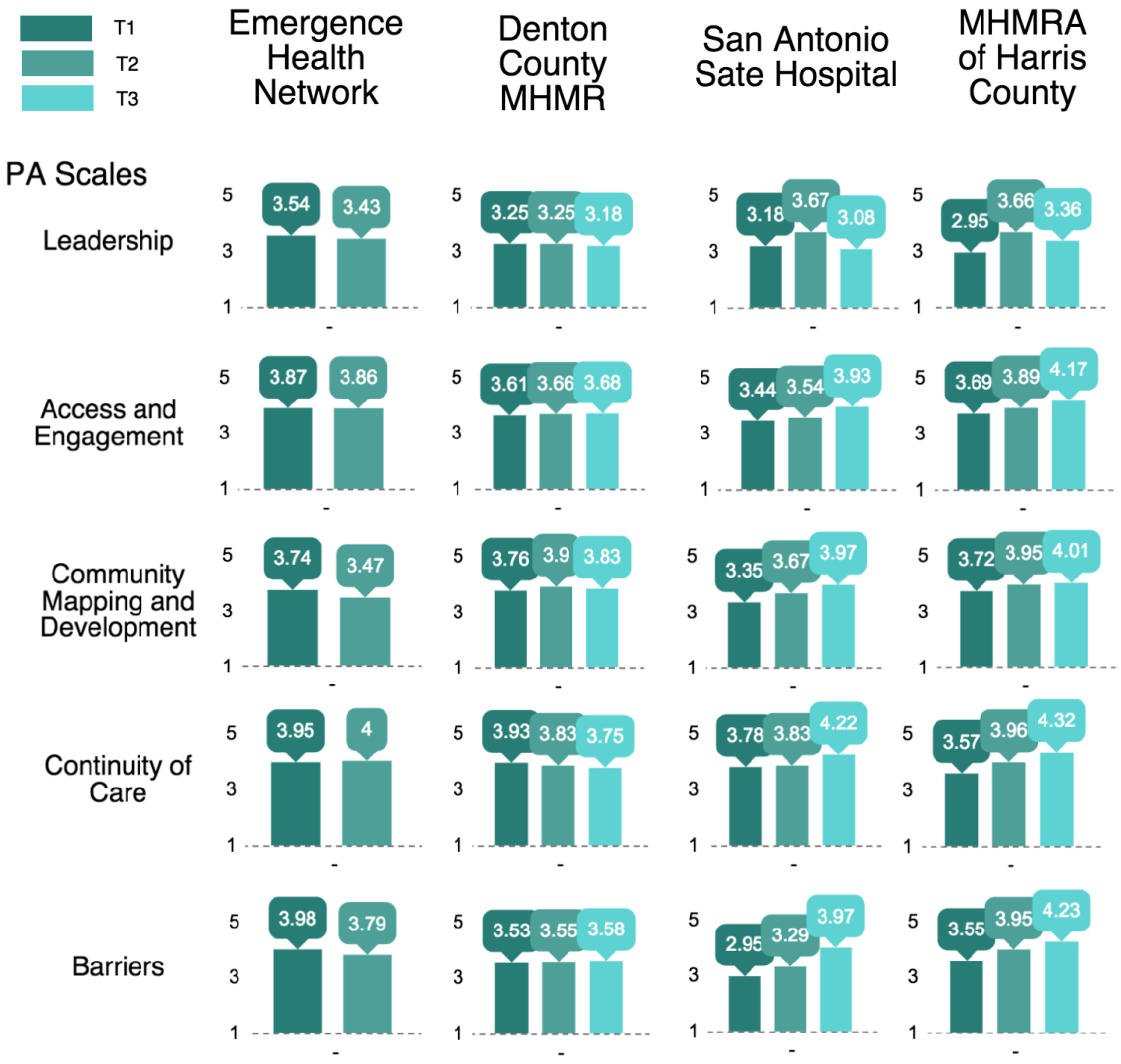
- "Presently, my organization's staff are knowledgeable about recovery concepts and practices."

- "Presently, my organization's staff use recovery oriented practices with the individuals we serve." Responses were rated on a 5-point frequency scale ranging from *Never* to *Always.* All of the organizations demonstrated increases in staff knowledge and use of recovery from project baseline to end and two of the organizations, ***Harris County MHMRA and San Antonio State Hospital, made significant gains in both of these areas*** ($p < .05$).



Recovery-Oriented Domains:

Progress in the recovery-oriented domains was assessed via staff responses on the 26-item RILA Practice scale and the 31-item Recovery Self-Assessment (RSA). Items were categorized into eight recovery oriented domains: Leadership; Access and Engagement; Continuity of Care; Community Mapping and Development; Life Goals; Involvement; Choice; and Addressing Barriers to Recovery. Responses were rated on a 5-point frequency scale ranging from *Never* to *Always****. Across all organizations, the greatest gains were made in the five domains of Access and Engagement, Continuity of Care, Community Mapping and Development, Life Goals, and Barriers***. Harris County MHMRA and San Antonio State Hospital made significant gains across multiple areas, while Denton and Emergence reported scores that were relatively consistent across time points. This may be attributed to a number of reasons including motivation and engagement of the change team, organizational branding of recovery and the RILA project, leadership and staff changes/turnover, resources available within each of the organizations. Specific results in each of the recovery oriented domains is further explained below.


T1
T2
T3
Emergence Health Network
Denton County MHMR
San Antonio Sate Hospital
MHMRA of Harris County
PA Scales
Leadership
3.54
3.43
3.25
3.25
3.18
3.18
3.67
3.08
2.95
3.66
3.36
Access and Engagement
3.87
3.86
3.61
3.66
3.68
3.44
3.54
3.93
3.69
3.89
4.17
Community Mapping and Development
3.74
3.47
3.76
3.9
3.83
3.35
3.67
3.97
3.72
3.95
4.01
Continuity of Care
3.95
4
3.93
3.83
3.75
3.78
3.83
4.22
3.57
3.96
4.32
Barriers
3.98
3.79
3.53
3.55
3.58
2.95
3.29
3.97
3.55
3.95
4.23

Leadership:

This domain evaluates how leadership is distributed within the organization and examines the level of respect among executive leadership and staff. This scale was assessed via ratings on the RILA Practice composite. ***The greatest gains in leadership were observed between Time 1 and Time 2; however, the level of change was not statistically significant***. A slight regression in scores was noted at Time 3. This may be a result of the project winding down and/or the lower response rate. In general, staff reported that their organization *Sometimes* to *Often* engages in activities consistent with shared leadership.

Example items:

- "Staff share ideas and/or explore ways to promote recovery" (Practice Scale, #4)
- "There is mutual respect among executive leadership and staff" (Practice Scale, #2)

Accomplishments:

- One page profiles created and displayed by staff
- Emotional CPR training provided to staff
- Use of recovery-oriented language encouraged
- Recovery tree filled with recovery quotes and stories

- Recognizing recovery oriented staff
- Discussing RILA webinar presentations with the broader change unit staff
- Recovery oriented mission statement

Access and Engagement:

This domain focuses on promoting swift and uncomplicated entry to services, removing barriers to receiving care, engaging the person rather than the diagnosis, building trust by attending to the person's goals and needs, and providing a range of services in addition to clinical care. This domain was assessed via ratings on the RILA Practice scale and Recovery Self-Assessment (RSA). ***Two of the organizations, Harris County and San Antonio State Hospital, made significant gains in access and engagement over the course of project*** ($p < .01$). The remaining organizations (Denton and Emergence) remained relatively consistent in this area.

Example items:

- "This organization provides options for clients to choose from to include in their recovery/treatment plan" (RSA, #2)
- "Staff use person-first language" (Practice Scale, #6)

Accomplishments:

- Reduced wait time for services and renovated waiting room in response to client feedback
- Administered consumer feedback forms to gain information regarding the acceptability and utility of services provided
- Implemented recovery branding campaign throughout change unit
- Invited clients to include family and other natural supports at meetings
- Posted recovery stories

Continuity of Care:

This domain evaluates continuity of care procedures currently in place at the organization, the valued outcomes of the organization, and the handoff process between two or more points of care. This domain is closely linked with psychiatric readmission, which was the original focus of the RILA project. Progress in Continuity of Care was assessed via the RILA Practice scale. ***Two of the organizations, Harris County and San Antonio State Hospital, made significant gains in continuity of care*** ($p < .05$). One organization remained relatively consistent (Emergence), while one organization slightly decreased (Denton).

Example items:

- "When clients are leaving our care, they partner with staff to create discharge plans" (Practice Scale, # 19)
- "Staff match clients to appropriate mental health providers for follow-up care when discharged from services" (Practice Scale, #21)

Accomplishments:

- Increased PNA wages to cut down on the high turnover rate
- Meetings and focus groups to identify discharge needs and gaps in service provision
- Partnered with the criminal justice department to provide mental health training to police
- Hired additional peer specialists to engage and support clients

Community Mapping and Development:

This area examines social connections and other assets within the organization, creates and shares knowledge about the value that people in recovery bring to a sustainable community/team, and enhances community relationships and collaborative efforts. It also examines the degree to which services are customized to individual needs, cultures, and interests. Practices related to community mapping were evaluated via ratings on the RILA Practice scale and Recovery Self-Assessment (RSA). ***Two of the organizations, Harris County and San Antonio State Hospital, made significant gains in Community Mapping*** ($p < .05$). One of the sites stayed relatively consistent (Denton), and one slightly decreased (Emergence).

Example items:

- "This organization does not duplicate services that are available in the community" (Practice Scale, #14)
- "Staff ask clients about their interests or the things they would like to do in the community" (RSA, #28)

Accomplishments:

- Hosted a health and human resource fair to provide information regarding local service providers. Over 60 community agencies attended.
- Recovery Movie Night. Staff, clients, and community stakeholders attended and a follow up discussion to the movie was led.
- Mapping of staff and community resources
- Reducing duplication of services within the organization

Life Goals:

This scale evaluates the extent that staff promote the development and pursuit of individually-defined objectives. Practices related to Life Goals were evaluated via ratings on the RSA. ***Two of the organizations, Harris County and San Antonio State Hospital, made significant gains in Life Goals*** ($p < .05$), while the remaining two sites, Denton and Emergence, remained relatively consistent.

Example items:

- "Staff believe in the ability of clients to recovery" (RSA, #10)
- "The primary role of staff is to assist a person with fulfilling his/her recovery goals" (RSA, #21)

Accomplishments:

- Collaborative treatment plans
- Use of recovery oriented language when creating plans
- Involving significant others in the creation of treatment plans

Involvement:

This domain examines the degree to which consumers participate in the development and provision of programs/services, staff training, and advisory board/management meetings. Practices related to Involvement were evaluated via ratings on the RSA. ***Ratings on the Involvement scale were consistent across organizations, with no significant gains being made.*** Client Involvement was noted as being a barrier during practice calls and this domain has historically resulted in low to moderate ratings across Recovery Institute evaluations (see RILA FY 2013 and PSI FY 2013 report).

Example items:

- "Clients help staff with the development of new groups, programs or services" (RSA #26)
- "Peer specialists or advocates are involved with facilitating staff trainings or education at this organization" (RSA, #31)

Accomplishments:

- Peer specialist network gathering. A group of 27 Peer Support Specialists and a number of professional staff attended.
- Eliciting client and staff feedback on organizational practices

Choice:

This scale evaluates the extent to which staff abstain from using coercive measures, provide clients with access to treatment records, and have clear discharge criteria. Practices related to Choice were evaluated via ratings on the RSA. ***Two of the organizations, Harris County and San Antonio State Hospital, made significant gains in Choice*** ($p < .05$), while the remaining two sites, Denton and Emergence, decreased.

Example items:

- "Clients can change their service provider(s) when they wish" (RSA, #12)
- "Staff respect the decisions that clients make about their care" (RSA, #30)

Accomplishments:

- Educating staff on the importance of respecting client choice
- Meeting clients where they are

Addressing Barriers to Recovery:

This area focused on specific barriers to recovery faced by people in the community, both external to and within the organization. None of the sites chose to focus on this area specifically. However, barriers to accomplishing the aforementioned practice domains were discussed and addressed with each of the sites via collaborative and individual site calls. ***Two of the organizations, Harris County and San Antonio State Hospital, made significant gains in addressing Barriers*** ($p < .05$). One of the sites slightly increased (Denton), and one slightly decreased (Emergence).

Example items:

- "This organization is focused on promoting recovery rather than managing illness" (Practice Scale, # 23)
- "Recovery is embraced by staff at all levels of this organization" (Practice Scale, #26)

Accomplishments:

- Encouraging staff involvement in onsite recovery trainings
- Promoted staff knowledge of person centered treatment planning

Usefulness of RILA Activities and Resources

Staff were asked to rate the usefulness of each of the RILA activities and resources. Respondents rated each of the items on a scale from 1 to 5, where *1 = not at all helpful* and *5 = very helpful*. ***The cross site 2 day training and bi-monthly RILA practice calls received the highest ratings for usefulness***. Teams

reported that individualized contact and feedback (via the site visits and individual practice calls) helped to mobilize efforts and further promote recovery oriented change. Formal training opportunities were also noted as beneficial methods for generating excitement and sharing information. These tools were reported to be successful modalities of change.

Activity/Resource	Mean
Cross Site 2 day training	4.4
Bi-monthly RILA practice calls	4.3
Bi-monthly RILA webinars	4.2
Demystifying training	4.2
RILA listserv	3.9
Organizational asset mapping	3.9

Client Participants

Three hundred thirty eight clients participated in the Leadership Academy evaluation across the baseline and midpoint survey collection. The number of respondents decreased somewhat from Time 1 (N = 193) to Time 2 (N = 145). The demographic information for participants was relatively consistent across time points. The majority of respondents for both time points were White and between the ages of 45 to 54 years. A greater percentage of males participated in the survey at Time 1 than Time 2, 54% and 42%, respectively. Results from Pearson Chi-Square analyses indicated that survey respondents were not significantly different in ethnicity, sex, or age among time points ($p > .05$). This suggests that client participation throughout the RILA was consistent, and that differences in outcomes are not attributable to individual differences among respondents at project beginning and end. Demographic information of Leadership Academy staff survey respondents is presented below.

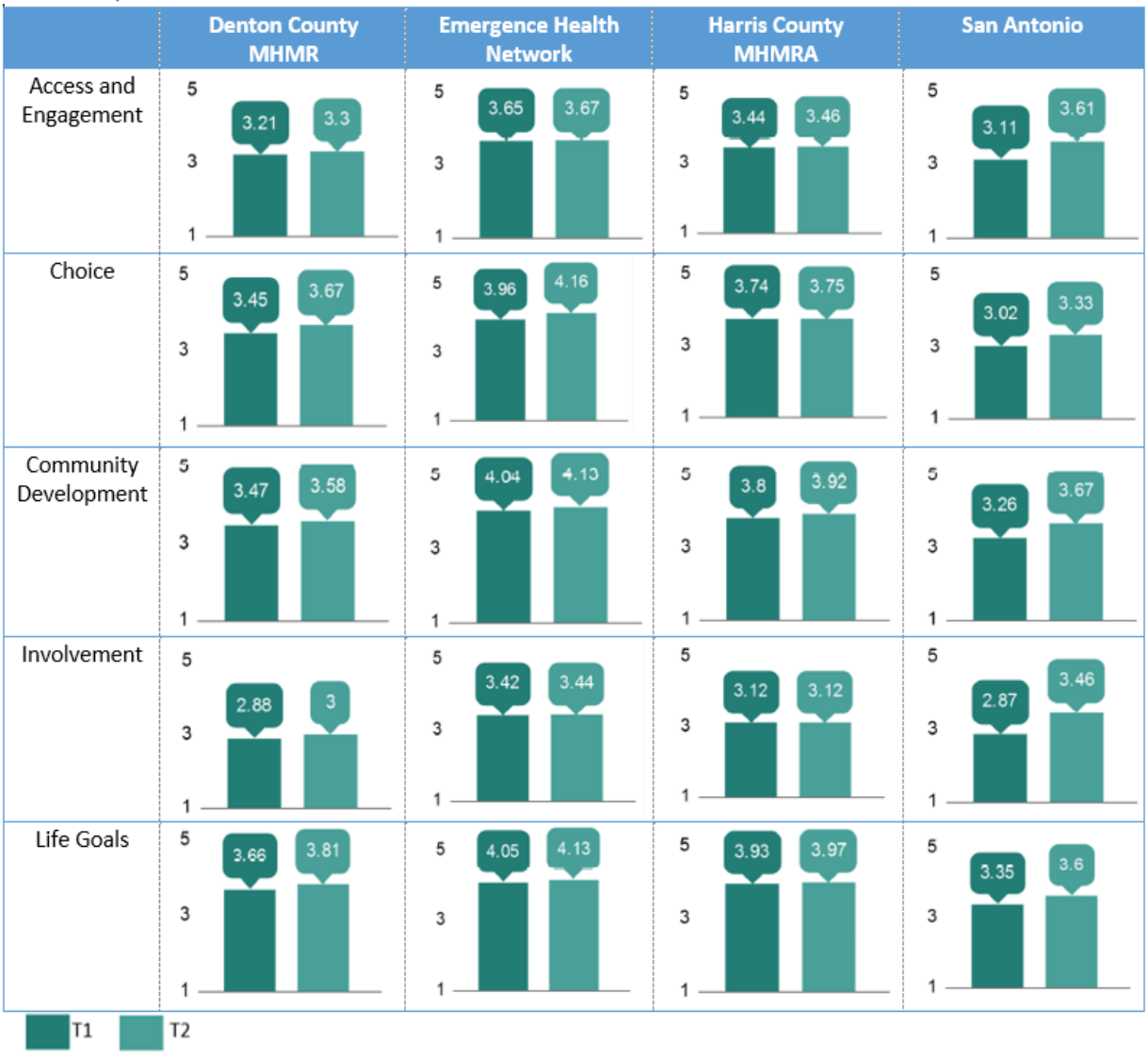
Age, Sex, and Ethnicity of RILA Respondents – Clients

Demographic		Percentage of Respondents	
		Time 1 (N =193)	Time 2 (N =145)
Ethnicity	Hispanic	37	40
	American Indian/Alaska Native	5	1
	Asian	1	5
	Black or African American	23	22
	Native Hawaiian or Other Pacific Islander	1	1
	White	49	44
	Other/Not Disclosed	21	27
Sex	Male	54	42
	Female	46	58
Age	18 – 24	11	9
	25 – 34	20	12
	34 – 44	20	21
	45 – 54	26	29
	55 – 64	17	14
	65 or older	5	7

Recovery-Oriented Domains:

Client perceptions of organizational practices in targeted recovery-oriented domains was assessed via the 30-item Recovery Self-Assessment (RSA). Items were categorized into five recovery oriented domains: Access and Engagement; Community Development; Choice; Life Goals; and Involvement. Responses were rated on a 5-point frequency scale ranging from *Never* to *Always.* Consistent with staff results, the greatest gains were noted in Access and Engagement, Community Development, and Involvement. Clients at each of the organizations reported gains in these domains, and ***statistically significant gains were noted at San Antonio State Hospital***. Information describing each of the recovery oriented domains is further explained below.

Recovery Self-Assessment – Client



Access and Engagement:

This domain focuses on promoting swift and uncomplicated entry to services, removing barriers to receiving care, engaging the person rather than the diagnosis, building trust by attending to the person's

goals and needs, and providing a range of services in addition to clinical care. ***Small gains in this area were noted at each of the organizations, and a statistically significant gain was reported at San Antonio*** ($p < .05$).

Example items:

- "This organization provides options for me to choose from to include in my recovery/treatment plan." (RSA, #2)
- "Some groups, meetings, and other services are scheduled in the evenings or on weekends to accommodate my schedule." (RSA, #9)

Community Development and Inclusion:

This area examines social connections and other assets within the organization, shares knowledge about the value that people in recovery bring to a sustainable community/team, and enhances community relationships and collaborative efforts. It also examines the degree to which services are customized to individual needs, cultures, and interests***. Small gains in this area were noted at each of the organizations, and a statistically significant gain was reported at San Antonio*** ($p < .05$).

Example items:

- "Staff are knowledgeable about special interest groups or activities in the community." (RSA, #3)
- "This organization offers services that align with my interests, culture, or life experience." (RSA, #19)

Choice:

This scale evaluates the extent to which staff abstain from using coercive measures, provide clients with access to treatment records, and have clear discharge criteria. ***Small gains in this domain were reported at each of the organizations; however, gains did not reach the threshold for statistical significance*** ($p > .05$).

Example items:

- "I can change my service provider(s) when I wish." (RSA, #12)
- "Staff respect the decisions that I make about my care." (RSA, #30)

Life Goals:

This scale evaluates the extent that staff promote the development and pursuit of individually defined objectives. ***Small gains in Life Goals were reported at each of the organizations; however, gains did not reach the threshold for statistical significance*** ($p > .05$).

Example items:

- "Staff partner with me to assess progress toward my recovery goals." (RSA, #5)
- "Staff encourage me to have hope and high expectations for my recovery." (RSA, #24)

Involvement:

This domain examines the degree to which consumers participate in the development and provision of programs/services, staff training, and advisory board/management meetings. ***Ratings on the involvement scale were relatively consistent at Emergence, Denton, and Harris County. San Antonio reported statistically significant gains in Involvement***.

Example items:

- "I am involved in the evaluation of this organization's programs, services, or service providers." (RSA #16)
- "I attend organization advisory boards or management meetings." (RSA, #8)

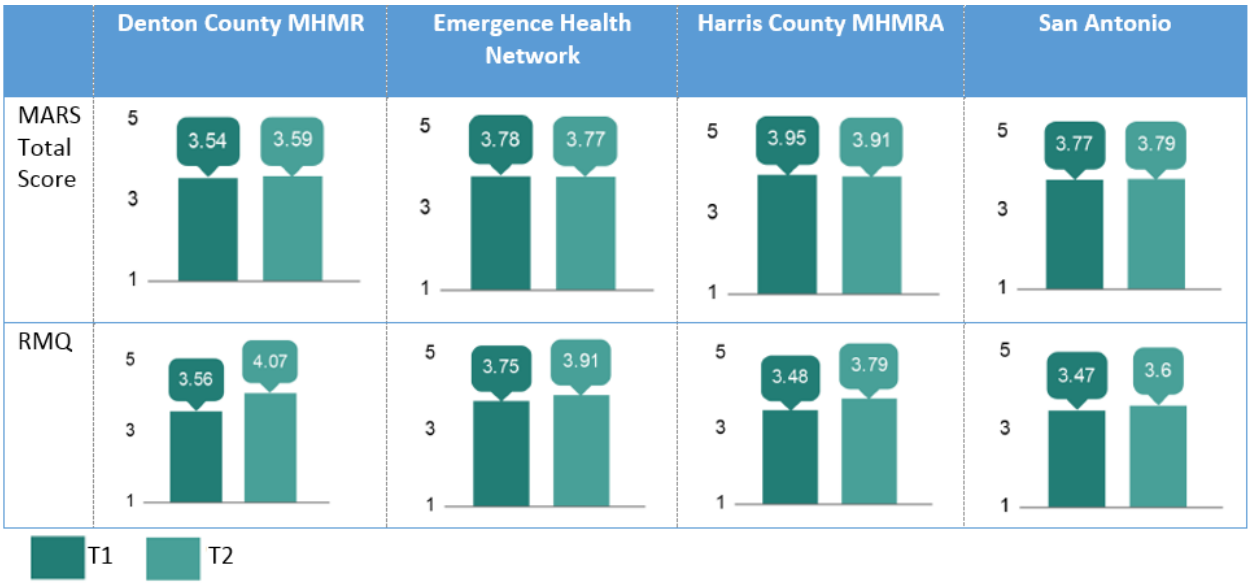
Recovery and Wellness:

Maryland Assessment of Recovery

The Maryland Assessment of Recovery (MARS) was used to assess client attitudes and beliefs about health and wellness. Scores are rated on a 5-point scale, where higher scores indicate more agreement with recovery health and wellness. Clients at each organizations reported slight increases on the MARS from Time 1 to Time 2. ***Across all organizations, the highest scored item on the MARS was "I am responsible for taking care of my physical health". The lowest scored item was "I feel good about myself even when others look down on my illness."***

Involvement in the Recovery Process

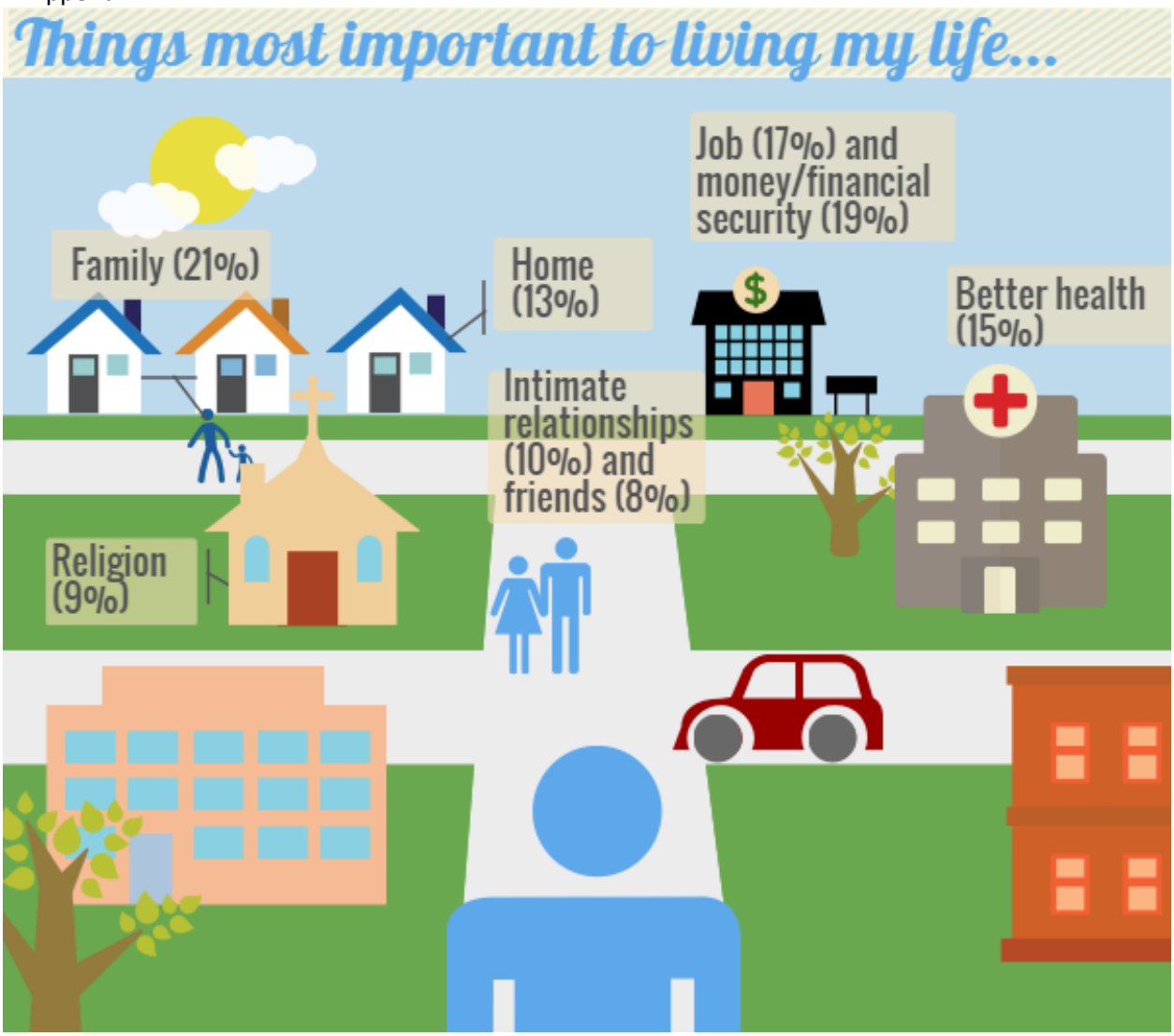
Involvement in the Recovery Process was assessed via an item on the Recovery Marker's Questionnaire, where *1 = I have never heard of, or thought about, my recovery; 2 = I've been thinking about my recovery, but haven't decided yet; 3 = I am committed to my recovery, and am making plans to take action very soon; 4 = I am actively involved in the process of my recovery; 5 = I am not working on my recovery; 6 = I feel that I am fully recovered, I just have to maintain my gains****. Scores on the RMQ increased from Time 1 to Time 2, with the majority of respondents indicating that they are 'actively involved in the process of recovery.'***



Things most important to living my life

Clients were asked to respond to the following open-choice item: "The things that I would find important to living the kind of life I would like to have are…" Narrative responses from this item were categorized and evaluated. Top responses reported by clients are depicted below, along with the

percentage of clients indicating each response. The full list of responses and percentages can be found in Appendix B.



Peer Specialists

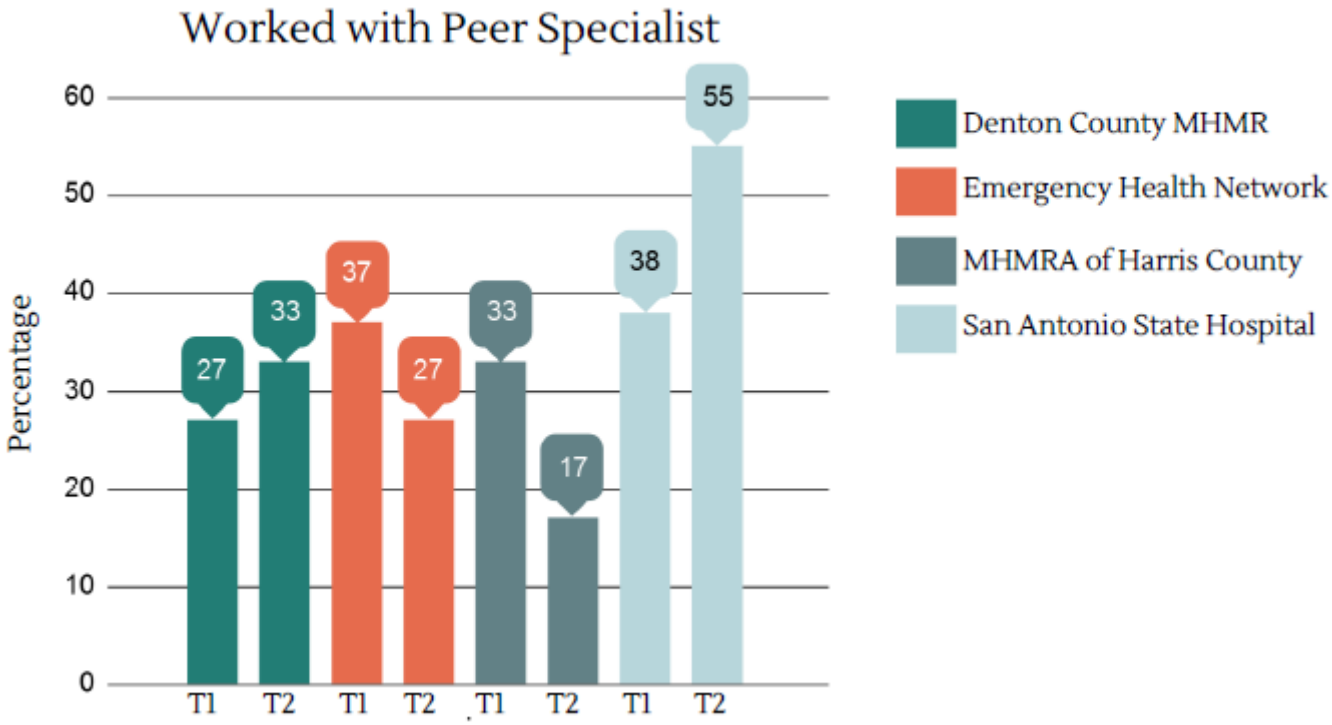
Number of Peer Specialists Employed

The number of peer specialists employed at each organization from project baseline to end is depicted in the graph below. ***The number of peers employed remained consistent at three of the organizations and greatly increased at one organization, Harris County MHMRA***. In line with these results, Harris County was also observed to have made the most significant gains across recovery oriented domains on the staff survey. Although Emergence does not have any peer specialists employed at present, they have made great gains in pursuing peer specialist involvement and after extensive TA with the RILA coordinator they have successfully established and posted a peer specialist position. They hope to recruit a peer specialist soon. Similarly, San Antonio hopes to hire another peer specialist in the near future.

Organization	Baseline	Time 2	Time 3
Denton County MHMR	2	1	2
Emergence Health Network	0	0	0 Peer specialist position posted in August 2015
Harris County MHMRA	11	16	19
San Antonio State Hospital	3	2	1 Hope to post another position soon

Peer Specialist Services

The number of clients working with a peer specialist increased at Denton County and San Antonio. It is important to clarify that although Emergence does not employ a peer specialist, many clients noted that they have worked with a peer. Upon further examination of these results, it appears that clients may have interpreted 'peer specialist' as a fellow client in services, as opposed to an individual trained and employed by the organization to deliver peer services. This information was valuable for the evaluation team and efforts were made to clarify this item on the survey. The reduction in clients working with a peer specialist from Time 1 to Time 2 may be reflective of these efforts.



Limitations

It is important to emphasis that the original focus of the RILA project was to reduce psychiatric rehospitalizations; however, mid-way through the project (December, 2014), the focus shifted to a

broader goal of promoting recovery oriented care and peer specialist integration. This shift occurred due to the overwhelming demand from sites regarding resources and technical assistance on peer specialist integration. Via Hope responded to this need by eliciting group discussion among participating sites, providing webinars on peer specialist integration, and conducting an on-site training focused on demystifying peer support. In line with this shift, evaluation results suggest that some of the sites made the greatest gains in practice area domains from Time 1 to Time 2. In terms of broader impact, the provision of recovery oriented care and progress in each of the practice area domains was primarily measured through staff and client completion of the project survey and self-reported data collected during practice calls and onsite visits. While adequate reliability and validity evidence exists for RSA total and subscale scores, the sensitivity of this measure has not been evaluated. Therefore, changes in the recovery orientation of participating organizations may not have been detected by this measure and the level of implementation of self-reported recovery practices could not be adequately measured. Additionally, feasibility, accessibility, and convenience of the survey completion may have reduced the response rates. There was a decline in response rates from Time 1 to Time 3, which may be reflective of participant engagement in the project. Future data collection efforts should include interviews or focus groups with staff and clients to further examine the quality of recovery practices being provided. These efforts could be supported by local peer specialists.

Policy Implications

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

Recommendations

- Via Hope should continue to offer recovery learning experiences using formats similar to the RILA.
    - The stepped learning structure was helpful to organizational teams that were beginning to learn about recovery and wanted to explore recovery oriented practices.
    - The targeted practice areas structured the recovery project plans and provided ideas for recovery oriented work, while allowing for flexibility and creativity.
- Identify a specific outcome for sites to focus on/rally around. This may increase site motivation and engagement.
- Responding to site needs and TA requests is crucial. Having the flexibility to change the focus of the project was beneficial and enabled sites to make gains in areas that they deemed to be most important for their organization.

    - Consider obtaining site feedback regarding targeted practice areas at project start.
    - Reduce the number of targeted practice areas from 5 to 3 in order to encourage gains in specific areas. This may increase site progress and reduce confusion.
- Focusing on a measurable client outcome related to the RILA activities might additionally focus the work of organizational change teams.
- Continue to increase opportunities for collaboration among participating organizations and develop more user-friendly ways of increasing communication across teams.
    - The onsite visits were seen as extremely valuable by most participants and were where much of the team learning and next steps development occurred.
    - The conferences provided a shared experience for the team, guidance from national experts in the field of recovery, and collaboration among participating organizations. Team members noted that the collaboration among participating teams was particularly useful.
- Teams should receive individual coaching calls on at least a monthly basis.
    - Sites noted the importance of the individualized calls. These calls enabled the project facilitator to monitor each team's adherence to their recovery project plan as well as provide teams with individualized assistance regarding barriers, next steps, and recovery oriented changes within their organization.
- Continue to obtain feedback from sites regarding ideas for bimonthly webinars and calls.
- Develop a list of frequently asked questions regarding peer specialist integration that can be posted to the Via Hope website and/or provided to participating sites via email.
- Continue to explore methods for tracking site progress. Sites continued to have difficulty completing and submitting recovery oriented project plans. This has been noted as a difficulty on other evaluations of RI initiatives (see RILA FY 2013 and PSI FY 2013 report).
    - Sites reported that the project were helpful at project start; however, it was cumbersome to update them each month.
    - Consider having sites submit a recovery project plan at project start, midpoint, and end.

Summary

Increasing community engagement and social inclusion of persons in recovery can make extraordinary contributions to the healing of each individual, and additionally, increase the health and sustainability of the local communities (and economies) in which they live. People in recovery have lives to live and gifts to give.

In order to maximize this beneficial change, leadership must pursue a mission to provide excellent recovery support services which value experiential knowledge of recovery, honor self-determination, and consider empowerment an essential aspect of a meaningful life. It is the responsibility of all staff to promote this reality through their rock-solid belief in recovery. People in recovery can be invaluable resources in the creation of hope and the initiation of self-managed recovery.

Appendix A:

Staff Data: Baseline, Midpoint, Final

Denton	T1 (N=46)	T2 (N=19)	T3 (N=10)
Knowledge of Recovery	3.59	3.63	3.80
Use of Recovery	3.67	3.79	3.80
Practice Domains			
Leadership	3.25	3.25	3.18
Access and Engagement	3.61	3.66	3.68
Community Mapping Development	3.76	3.90	3.83
Continuity of care	3.93	3.83	3.75
Barriers	3.53	3.55	3.58
Recovery Self-Assessment			
Access and Engagement	3.58	3.68	3.75
Choice	3.89	3.70	3.81
Community Development Inclusion	3.75	3.70	3.78
Involvement	3.38	3.33	2.83
Life Goals	3.91	3.92	3.86

Emergence	T1 (N=33)	T2 (N=29)
Knowledge of Recovery	3.61	3.66
Use of Recovery	3.76	3.86
Practice Domains		
Leadership	3.54	3.43

Access and Engagement	3.87	3.86
Community Mapping Development	3.74	3.47
Continuity of care	3.95	4.00
Barriers	3.98	3.79
Recovery Self-Assessment		
Access and Engagement	3.54	3.50
Choice	4.02	3.83
Community Development Inclusion	4.13	3.90
Involvement	3.66	3.33
Life Goals	4.07	3.92

*Emergence did not participate in the final (T3) evaluation.

Harris County MHMRA	T1 (N=24)	T2 (N=81)	T3 (N=67)
Knowledge of Recovery	3.63	3.83	4.23*
Use of Recovery	3.63	4.05*	4.31*
Practice Domains			
Leadership	2.95	3.66**	3.36
Access and Engagement	3.69	3.89	4.17*
Community Mapping Development	3.72	3.95	4.01
Continuity of care	3.57	3.96*	4.32**
Barriers	3.55	3.95*	4.23**
Recovery Self-Assessment			
Access and Engagement	3.23	3.68*	3.95**
Choice	3.38	3.93**	4.13**

Community Development Inclusion	3.40	3.97*	4.18**
Involvement	3.23	3.68*	3.32
Life Goals	3.54	4.05**	4.31**

San Antonio State Hospital	T1 (N=38)	T2 (N=25)	T3 (N=43)
Knowledge of Recovery	3.03	3.42	3.75**
Use of Recovery	3.08	3.32	3.63*
Practice Domains			
Leadership	3.18	3.67*	3.08
Access and Engagement	3.44	3.54	3.93*
Community Mapping Development	3.35	3.67	3.97**
Continuity of care	3.78	3.83	4.22*
Barriers	2.95	3.29	3.97**
Recovery Self-Assessment			
Access and Engagement	3.53	3.76	3.65
Choice	3.15	3.36	3.72*
Community Development Inclusion	3.53	3.64	3.94*
Involvement	3.41	3.60	3.18
Life Goals	3.21	3.45	3.75*

Appendix B:

Client Data: Baseline and Midpoint

Denton County MHMR	T1	T2
Worked with PS	27% Yes	33% Yes
MARS Total Score	3.54	3.59
RMQ Item	3.56	4.07*
Recovery Self-Assessment		
Access and Engagement	3.21	3.30
Choice	3.45	3.67
Community Development Inclusion	3.47	3.58
Involvement	2.88	3.00
Life Goals	3.66	3.81

Emergence Health Network	T1	T2
Worked with PS	33% Yes	17%
MARS Total Score	3.78	3.77
RMQ Item	3.75	3.91
Recovery Self-Assessment		
Access and Engagement	3.65	3.67
Choice	3.96	4.16
Community Development Inclusion	4.04	4.13
Involvement	3.42	3.44
Life Goals	4.05	4.13

Harris County MHMRA	T1	T2
Worked with PS	31% Yes	27% Yes
MARS Total Score	3.95	3.91
RMQ Item	3.48	3.79
Recovery Self-Assessment		
Access and Engagement	3.44	3.46
Choice	3.74	3.75
Community Development Inclusion	3.80	3.92
Involvement	3.12	3.12
Life Goals	3.93	3.97

San Antonio State Hospital	T1	T2
Worked with PS	38%	55%
MARS Total Score	3.77	3.79
RMQ Item	3.47	3.60
Recovery Self-Assessment		
Access and Engagement	3.11	3.61*
Choice	3.02	3.33
Community Development Inclusion	3.26	3.67*
Involvement	2.87	3.46***
Life Goals	3.35	3.60

Things most important to living my life

Response (N = 145)	Percentage at Time 2
Family	21%
Financial security/money	19%
Job/career	17%
Recovery/better mental health	15%
Home	13%
Intimate relationships	10%
Children/grandchildren	10%
Religion	9%
Free from stress, fear, and worry	9%
Friends	8%