East Texas Coalition for Mental Health Recovery

Program Evaluation Report:
Executive Summary
(2010-2014)

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EXECUTIVE SUMMARY

In the fall of 2010, the Hogg Foundation for Mental Health embarked on an initiative that focused on consumer, youth and family involvement in recovery and wellness in Texas. The foundation sought to develop a leadership network that would provide opportunities for professional development, networking, peer-to-peer support, and education and training on recovery, wellness, and consumer involvement to both consumers and mental health providers in the East Texas region. The East Texas Behavioral Healthcare Network (ETBHN), Burke Center, and the Stephen F. Austin State University School of Social Work responded to the foundation's request for proposals and ETBHN was subsequently awarded a two year grant of $701,499 to coordinate the efforts of East Texas Coalition for Mental Health Recovery (ETCMHR). The coalition was initially comprised of Rusk State Hospital (RSH) and five local mental health authorities (LHMAs) in East Texas. In the fall of 2012, ETBHN was granted funding to support six additional LMHAs as part of the coalition. By the fall of 2014, the Hogg Foundation had granted $1,939,844 in awards to support the work of the organizations within ETCMHR.

The primary goal of this initiative was to provide peer partners who are skilled, knowledgeable, and trained in recovery, in hopes of assisting the mental health system in East Texas with improving its outcomes and understanding of recovery and wellness. ETCMHR has spent the past four years focusing on the development of a learning community in which consumers and their families can share their experiences, learn from one another, and come together to strengthen recovery and wellness resources in the region. More importantly, ETCMHR has and continues to recruit and train consumers to become advocates and peer specialists[1], thus adding an important component to mental health services in the East Texas region.

Becoming a Peer Specialist

The process of becoming a peer specialist through ETCMHR consists of two phases: addressing personal recovery and preparing to support the recovery of peers. During the first phase, or year one, the consumers attended the three-day Wellness Recovery Action Plan (WRAP) training, which is focused on their own recovery. The importance of the WRAP training lies in its focus on teaching participants coping mechanisms that build upon their personal strengths and can be used to address life challenges. These skills are helpful to their personal recovery process and their efforts to assist others with recovery.

After WRAP training, the consumers spent the first year focusing on their own recovery plan, making adjustments to the plan, and engaging in a variety of related activities. In addition to being assigned a mentor and a WRAP pal, they participated in monthly conference calls and quarterly face-to-face visits. The mentors coached consumers about using their WRAP plans to address triggers that occurred in the previous week. The WRAP pal was another peer who was involved in the same process and could serve as a source of support. The quarterly face-to-face meetings typically included a half-day of WRAP related activities and a day of activities centered on the

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[1] The following terms are used interchangeably across the United States: peer specialists, peer support specialists, peer providers and peer support providers. In the State of Texas, the term "peer specialists" refers to consumers of mental health services who provide formal support services to other consumers. Certified peer specialists differ from peer specialists in that they have completed training and testing that results in certification.

development of ETCMHR, as well as addressing challenges to providing peer support services within the LMHAs and larger region. Finally, the consumers participated in monthly conference calls and ongoing voluntary activities such as attending conferences and trainings (e.g., three day WRAP training and Respect Institute) and speaking at relevant conferences.

During the second phase, or year two, the peers were able to attend WRAP facilitator training and/or Certified Peer Specialist (CPS) training. The individuals who went through the WRAP facilitator training committed to leading three trainings in their community; the first two were supervised by one of the WRAP facilitators. Peers who were interested in becoming a CPS attended peer specialist training and took a certification test four months post-training. It is important to note that becoming a WRAP facilitator is not a pre-requisite for the CPS certification. During year two, the peers continued to engage in regular voluntary activities including trainings and conferences.

Methodology

In order to assist ETCMHR in evaluating its efforts, the evaluators worked closely with ETBHN and the Hogg Foundation to design a comprehensive evaluation plan that would examine ETCMHR's impact on consumers, peer specialists, and the larger mental health system in East Texas.

Development Process of the East Texas Coalition for Mental Health Recovery

The first component employed a cross-sectional design[2] to examine the collaborative process utilized in the development of ETCMHR. Specifically, a modified version of the *Working Together: A Profile of*

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[2] A cross-sectional research design examines participants at a single point in time rather than multiple points over time (longitudinal design).

Collaboration instrument was used to identify members' perceptions about the collaborative process (Chrislip & Lasron, 1994; Omni Institute, 1992; Streeter & Rivaux, 2002; Streeter, Rivaux, & Lee, 2002). The instrument was administered to ETBHN's Regional Oversight Committee (ROC) during the first, second and third funding years. The ROC consists of the CEOs of member LMHAs, a representative from Rusk State Hospital, and one at large member who represents consumers of mental health services.

Recovery Orientation of the East Texas Coalition for Mental Health Recovery

During years two and three of the grant, a cross-sectional design was used to develop an understanding of the peer specialists' perceptions of the member LMHAs' orientation to recovery and the Hogg Foundation's role in the delivery of peer support services in the region. The AACP-ROSE (American Association of Community Psychiatrists Recovery Oriented Services Evaluation) was used during year two of the grant and the RSA-R (Recovery Self-Assessment - Revised) was used during the third year of the grant (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009; O'Connell, Tondora, Croog, Evans, & Davidson, 2005). Both instruments were employed to assess the LMHAs' orientation to recovery and they were accompanied by four narrative questions that examined the Hogg Foundation's role in ETCMHR. Participants consisted of the peer specialists who were recruited during the first and second grant years (Group 1 Peers and Group 2 Peers, respectively).

A Snapshot of the Peer Specialists

During year one, a cross-sectional design was utilized to examine the job functions and social support provided to peer

specialists. Specifically, Group 1 Peers were asked to complete a job description questionnaire designed to identify the primary functions, duties, and responsibilities attached to the position of peer specialist. They were also asked to complete a social support scale that was based on the Interpersonal Support Evaluation List (ISEL). The focus changed in years two and three to understanding where the peer specialists were in the recovery process. A cross-sectional design was employed to collect this information via the MHRM (Mental Health Recovery Measure), a 30 item self-report measure that assesses the recovery process in adults who have serious chronic mental health issues (Bullock, 2005, 2009). Participants consisted of the Group 1 Peers (grant years two and three) and Group 2 Peers (grant year three).

Recovery Experiences

Group 1 Peers (grant year two) and Group 2 Peers (grant year three) participated in individual qualitative interviews designed to help ETCMHR develop an understanding of the recovery experiences of the peer specialists. Group 1 peers also participated in follow-up interviews during year three of the grant.

Recruiting Peer Support Providers

Focus groups were conducted with Group 1 Peers during year two of the grant for the purpose of identifying elements that would be important to the process of identifying and recruiting peer specialists.

Outcomes for Consumers

In years one and two of the grant, ETBHN and the LMHAs were expected to collect output data that would offer insight about the nature of the peer support services provided via ETCMHR. However, the data was not provided, which was mostly due to challenges to collection and reporting. The focus changed in year three of the grant to identifying potential outcome measures for consumers who receive peer support services. An exploratory design was employed to examine a data set provided by one of the LMHAs, which consisted of TRAG (Texas Recommended Assessment Guidelines) data collected over a two year time period. The TRAG is administered by a QMHP-CS (Qualified Mental Health Professional-Community Services) during a face-to-face visit with a consumer of mental health services for the purposes of assessment and determining mental health services (Texas Department of State Health Services, 2007). It examines the following nine domains: risk of harm, support needs, psychiatric-related hospitalizations, level of functioning, employment, housing, co-occurring substance abuse, criminal justice involvement, and depressive symptomatology.

Findings

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ETCMHR has fostered a sense of hope and purpose among the peer specialists through the provision of support, knowledge and skills that are imperative to successful recovery. It also offers the peer specialists opportunities to help others or *"pay it forward."* They attribute their success with recovery and subsequent improvements in their quality of life to their experiences with ETCMHR. Along these lines, there is a deep sense of appreciation for the Hogg Foundation and their support of ETCMHR.

In terms of the collaboration profile, the results suggest that the collaborative process is healthy, stable and functioning. Strengths of the collaboration include the members' shared history and relationships, which appear to foster an environment that encourages progress. The results also indicate the presence of elements necessary for building and maintaining trust, ownership, commitment and accountability. Potential challenges to collaborative efforts include self-

interest, willingness to engage in collective decision-making, and the ability to commit resources necessary for growth.

Local Mental Health Authorities

The results from across the evaluation components have implications for the LMHAs. Several concerns were identified regarding the degree to which the LMHAs are oriented to peer support services and mental health recovery. For example, evidence suggests that more often than not, peer specialists were not included in treatment team meetings, treatment planning, assessment, and/or evaluation. Concerns were also raised about the degree of autonomy afforded to peer specialists and the degree to which they are valued by staff and the LMHAs.

The results of the AACP ROSE and RSA-R support the presence of the aforementioned concerns. The overall average score on the AACP ROSE bordered on the cut point for "needs significant improvement" and "fair." In examining the subscales, the concerns appear to be related to the following domains: administrative, treatment and supports. The results for the RSA-R are consistent with those of the AACP ROSE in that they raise concerns around involvement of consumers and peer specialists in decision-making, service delivery, mentoring and evaluation. Individual item scores also suggest a need for improving the holistic nature of treatment, especially in terms of personal needs and growth.

Understanding Recovery

The peer specialists' pre-recovery experiences included isolation, a fear of not getting better, difficulty managing their mental health symptoms, self-medication, misdiagnosis, poor life choices and unhappiness. All of these contributed to thoughts of helplessness, hopelessness and, in some cases, suicide.

Active involvement in recovery provided the knowledge, skills and confidence necessary to address these challenges and improve their overall quality of life. The results of recovery include hope, confidence, personal responsibility, independence, self-direction and empowerment. Simply, all of the participants went from believing that their lives would never improve to realizing that recovery is possible.

WRAP was identified as the most important factor in their ability to manage life challenges and maintain an active recovery. In fact, the importance of WRAP was echoed across all aspects and years of the evaluation. It is important to note that maintaining an active recovery allowed them to "*pay it forward*" or help others through the recovery process.

The importance of ETCMHR in the development of relationships, including friendships, was obvious. These relationships served as a source of encouragement, support and sense of belonging. Many participants noted that their success with recovery would not have been possible without these relationships.

Finally, the idea that "*recovery is personal*" was common across many of the responses. Specifically, every individual starts his/her journey from a different place with a different set of strengths and needs. And, each will take a different path to recovery at a different pace.

Recruiting Peer Specialists

Participants felt that the most important characteristic of a peer support provider was to be in active recovery marked by stability and independence. Additional characteristics include a commitment to one's own wellness, a genuine interest in the health and recovery of others, the ability to serve as a role model, an empowerment orientation, and

the ability to transition from being supported by others to being supportive of others.

In terms of barriers to becoming a peer specialist, the most common challenge mentioned was financial compensation. For example, most of the providers are either part-time employees or volunteers (unpaid). Whereas this situation works for those who have another source of income (e.g., retirees), that is typically not the case for those who need employment related income and/or benefits. Employment could render one ineligible for social insurance (i.e., Social Security and disability benefits) or public assistance, in which case compensation and benefits from employment would have to cover the loss of eligibility. This is further complicated by the LMHAs' limited ability to capture reimbursement for peer support services. Specially, reimbursement for peer support services is limited to Certified Peer Specialists.

Outcomes for Peer Specialists

The results of the MHRM suggest that the peer specialists are "*recovery savvy*" or have a fairly high level of self-reported recovery. However, the domain and individual scores raised questions about related aspects (e.g., health and finances) that are worthy of additional investigation.

Outputs and Outcomes for Consumers

Since output data was not available for analysis, the findings are limited to the outcome data. An exploratory analysis of the TRAG data found that consumers experienced an increase in their ability to function over the course of treatment. Reported rates of substance abuse were also slightly higher at the end of treatment. Change over the course of treatment for the following measures was

not statistically significant: risk of harm, support needs, psychiatric hospitalizations, level of functioning, employment, housing, criminal justice involvement and GAF (Global Assessment of Functioning)[3] score. Regression analyses indicate that the number of peer interactions and facility visits were not reliable predictors of mean changes for the aforementioned variables.

An analysis of symptoms related to the primary diagnosis revealed no mean changes for Schizoaffective Disorder. Those with a primary diagnosis of Bipolar Disorder or Major Depressive Disorder experienced a significant decrease in symptoms, suggesting that the services they received are related to their improvement. Regression analyses indicate that the number of peer interactions and facility visits were not reliable predictors of mean changes in symptoms for those who were diagnosed with Schizoaffective, Bipolar, or Major Depressive Disorders.

A regression analysis of consumers falling in the top 25% for number of peer visits showed that the number of facility visits was a predictor of change for support needs, hospitalizations, and GAF score. In other words, increases in the number of times a consumer visited a facility were associated with increases in the degree of positive change experienced by the consumer. For example, consumers who had more facility visits, tended to have higher GAF scores. For the same group, a regression analysis found that number of peer interactions was a predictor of scores for housing (more peer interactions was associated with an improvement in housing stability).

Given that the aforementioned results are based on a secondary analysis of data collected outside of a structured research

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[3] The GAF scale ranges from 0 to 100 and the score represents an individual's ability to function. For example, a sore of 0-10 would be assigned to a person whose functional impairment(s) results in a substantial risk of harm to himself/herself and/or others. A score of 100 indicates an absence of impairments in functioning and daily living. The GAF was assigned on Axis V under the DSM-IV, but was deleted from the DSM-V.

protocol for purposes other than this evaluation, one should be cautious in his/her interpretation of the results. Furthermore, there is not enough information available to draw specific conclusions. For example, the increase in reported rates of substance abuse may not indicate an actual increase in substance use. Rather, it could indicate that participants developed trust and rapport with their service providers over the course of treatment and were more forthcoming with information as treatment progressed.

Recommendations

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General recommendations that should be considered when planning for ETCMHR's future include taking actions to:

- Maintain the current level of participation of all the members
- Increase and diversify the representation of stakeholder groups in the coalition's membership
- Reduce travel time for peer coordinators
- Involve peer specialists and LMHA staff in planning and decision-making
- Evaluate and enhance access to peer support services within the region
- Develop a public awareness campaign that focuses on ETCMHR's impact on mental health services in the region
- Build the capacity of mental health systems for including consumers in the process of mental health recovery
- Advocate for changes in state policies that interfere with the transition of mental health services to a recovery orientation.

Given that support from the Hogg Foundation is not indefinite, it is imperative that ETCMHR implement a sustainability plan that supports the current peer support provider network.

Local Mental Health Authorities

Given the importance of ETCMHR's orientation to recovery and inclusion of peer specialists in appropriate aspects of service delivery, this element should be attended to in future evaluation efforts. The ability to examine the culture and recovery orientation of each LMHA would be especially beneficial. Employing the RSA-R for this purpose would allow for the creation of a recovery profile for each LMHA. The profile could provide a baseline measure for gauging progress toward a recovery orientation and effectiveness of related organizational interventions. It could also provide a basis for comparisons with other LMHAs and the overall system (ETCMHR).

Understanding Recovery

In planning for initiatives, ETCMHR should consider the following:

- WRAP training is one of the most important elements of the recovery process and, as such, it should be included in future endeavors
- WRAP training may be helpful in teaching staff about the recovery process and should be part of efforts to shift the LMHAs' orientation toward recovery
- Opportunities to *"pay it forward"* and to develop healthy relationships should be incorporated into activities
- Activities should include opportunities to assist peers and consumers in the development of relationships with family, friends, social groups and community
- Recovery is personal. Service planning and delivery should be personalized and holistic.

Recruiting Peer Specialists

Recommendations for the recruitment of peer specialists include:

- Development of a uniform method to identify potential peer specialists and assess their progress toward recovery

- Conduct research to identify the skills and knowledge that are imperative to the provision of peer support services.

Recommendations regarding training peer specialists include:

- Schedule activities and conferences once a month so that the peer specialists are active, but not overwhelmed
- First year activities should focus on individual development
- Second year activities should provide the content and instruction needed to become a successful peer specialist
- Offer WRAP or similar trainings to all consumers, but limit WRAP Facilitator and CPS trainings to those who actually want to engage in facilitation
- Provide basic facilitation skills training for individuals who are planning to attend WRAP Facilitator and/or CPS training
- After completing these trainings, they should participate in communication and leadership trainings to hone facilitation and professional skills
- Develop a training to educate peer specialists about the practical and legal implications associated with their role as a peer specialist
- Develop a training to educate peer specialists about the formal and informal guidelines for service delivery and fulfillment of their job responsibilities.

Additional recommendations include the following:

- Identify the knowledge and skills necessary for delivery of effective peer support services
- ETCMHR and LMHAs should examine the issues related to compensation of the peer specialists.

Outcomes for Peer Specialists

The domain and individual scores on the MHRM raised questions that are worthy of additional investigation. For instance, the importance of eating nutritious meals to overall health would lead one to question why the peer specialists scored lower on this item for years two and three of the grant. Given the importance of physical, social and recreational activities to recovery, the reasons for the reported lack of money for such activities are also of interest. Both of these questions could be addressed by the addition of narrative questions to future studies using the MHRM. In fact, annual administration of the MHRM to peer specialists would allow for assessment of their progress with recovery. Depending on the design employed, it could also allow conclusions to be drawn about factors that impact the recovery process of peer specialists.

Outputs and Outcomes for Consumers

Outputs. Given the importance of output information to evaluating efficiency, decision-making regarding service delivery and future attempts to replicate the coalition in other regions of Texas, ETBHN and the LMHA's should work together to implement a uniform process for collecting and evaluating outputs. Suggested outputs include:

- Consumer and peer led activities
- Consumer satisfaction with peer support services
- Number of new peer specialists identified, trained, and active in service delivery
- Amount of service provided by peer specialists
- Amount of reimbursable services provided by Certified Peer Specialists.

Outcomes. Whereas the TRAG data yielded interesting results, replacement of the TRAG by the ANSA (Adult Needs and Strengths Assessment) limits their utility for informing recommendations for future efforts related to outcome research. ETBHN and the LMHAs should develop a uniform process for

collecting and evaluating outcome data. Recommendations for the process include:

- Identification of the indicators of mental health and functioning and a process for collecting the related data that can be implemented by all of the LMHAs
- Indicators should relate to the four major dimensions of recovery: health, home, purpose, and community
- Include the following variables, which would improve the utility of the results: primary DSM diagnosis; number of crisis contacts (per month, quarter or year); the type, frequency, and duration of contacts with peer specialists; and type frequency and duration of other treatment interventions
- Inclusion of the MHRM as an indicator of the consumer's perception of his/her progress toward recovery
- Data should be collected for all consumers who receive peer support services
- Consider collecting data for all consumers of mental health services, which would allow for greater control of threats to internal validity. It could also lead to conclusions about effectiveness.

Given the scope of this endeavor, a reasonable starting point would be a pilot project involving one to three LMHAs.

Conclusion

The evaluation provided information about mental health recovery from the peer specialists' perspective, elements to consider when recruiting peer specialists, the status of the peer specialists' recovery, the recovery orientation of the LMHAs, and ETCMHR's overall collaborative process. In addition to implications for ETCMHR and the LMHAs, the results are important to efforts to replicate the coalition in other regions. However, before engaging in such endeavors, there are several concerns to address. Overall, the results suggest that ETCMHR is positively impacting consumers and progressing toward its desired outcomes, but there are still steps to be taken in order to ensure a bright future.

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