viaHOPE
TEXAS MENTAL HEALTH RESOURCE

Recovery Focused Learning Community
Summary Report: December 2011

CENTER FOR SOCIAL WORK RESEARCH

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Executive Summary

Background Information

MHT SIG Grant

In late 2005, Texas was awarded a Mental Health Transformation State Incentive Grant (MHT-SIG) from the Substance Abuse and Mental Health Services Administration SAMHSA. The President's 2003 New Freedom Commission Report on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* served as the impetus for a growing emphasis on resiliency and recovery in the public mental health system, and eventually, the dissemination of MHT-SIG grants. Texas proposed to transform its mental health services by "building a solid foundation for delivering evidence-based mental health and related services, fostering recovery, improving quality of life, and meeting the multiple needs of mental health consumers across the lifespan" (Texas Department of State Health Services, n.d.-b).

Via Hope

Via Hope, a Texas Mental Health Resource was created through the Texas MHT Project, in collaboration with the Department of State Health Services (DSHS), Mental Health America of Texas (MHAT), and the National Alliance on Mental Illness Texas (NAMI).

> "Via Hope is a training and technical assistance resource for mental health consumers, their family members, youth consumers, and professionals." Specifically, Via Hope provides classroom and on-line training courses in a wide variety of mental health subject areas. In an important statewide initiative, Via Hope provides training and certification for peer specialists and has facilitated two learning communities in order to help mental health agencies provide recovery-oriented services and integrate peer specialists into their care teams (Via Hope Texas Mental Health Resource, n.d.).

Peer Specialist Training and Certification

To increase the number of trained peer specialists across Texas, in FY 2010, Via Hope developed a new training and certification program for peer specialists. The University of Texas Center for Social Work Research (UT-CSWR) provided evaluation of the peer specialist training and certification process the initial year (Steinley-Bumgarner, Kaufman, & Stevens-Manser, 2010).

Peer Specialist Learning Community

Initially conceived as a marketing tool for the new peer specialist certification training, in November of 2010, Via Hope offered Consumer-Operated Service Providers (COSPs), Local Mental Health Authorities (LMHAs) and Community Mental Health Centers (CMHCs) an opportunity to participate in a Peer Specialist Learning Community (PSLC). The PSLC was designed to ensure employment opportunities for peer specialists by helping providers: understand the benefits of hiring and utilizing Certified Peer Specialists (CPSs), identify changes in recovery orientation necessary to successfully incorporate CPSs into the workplace, and acquire additional supports in order for both CPSs and providers to be successful.

The team from UT-CSWR also collected process data and reported on the experiences of stakeholders in the PSLC (Kaufman, Steinley-Bumgarner, Stevens-Manser, & Murphy-Smith, 2010). Most significantly, the team was able to make recommendations for a learning community model that focused on creating a recovery-oriented environment in which peer specialists, and other staff members could successfully contribute to each client's recovery journey.

The Recovery Focused Learning Community

In response to lessons learned in the PSLC and recommendations from the UT-CSWR report, a new learning community was created for the 2011 fiscal year. The learning community retained a strong emphasis on peer support services as a vehicle for needed change, but asked the participating teams to look at their organization's culture and to re-design services so that they provide recovery support services in an environment of hope and respect.

In November of 2010, Via Hope and DSHS requested applications for the RFLC. Applications were received from nine LMHAs, five state mental hospitals, and one LMHA/COSP team. All applicants were invited to participate. Each organization was required to put together a team of *at least* four members, including an executive sponsor. Teams were also required to attend two RFLC conferences (one at the beginning of the learning community process and one at the end), support a change team and its activities, administer recovery orientation surveys to staff members as well as consumers at two time points, participate in 8 monthly conference phone calls and 7 individual site consulting phone calls. In addition, all participating sites scheduled and hosted an on-site Recovery 101 training to support the work of the change team with its local stakeholders.

Outcomes, Conclusion, and Recommendations

The purpose of the Recovery Focused Learning Community was: 1) that individuals and systems develop a deeper understanding of recovery orientation and experiment with recovery-oriented practices, and 2) to increase in the number of peer specialist positions in the Texas public mental health system. The RFLC benefitted from the enthusiastic participation of fifteen change teams from across Texas. Change team members were carefully chosen by executive sponsors who provided leadership, fiscal support, and, at times, active participation.

Teams experiment and develop understanding of recovery

- Tools were adapted, change activities shared, connections made, and faculty support provided as requested or as needs became apparent to the RFLC Coordinating Team. The majority of the RFLC activities revolved around expanding peer support services, increasing numbers and integration of peer specialists, and supporting clinical staff to provide recovery support services.

- Over the eight-month period, measured recovery orientation of the sites showed statistically significant changes in one to three subscales of the Recovery Self Assessment (RSA) for twelve of the fifteen participating agencies. Two participating sites had no statistically significant changes and one site did not collect sufficient data for analyses. The major area of improvement was recovery education and consumer involvement (for six of the 12 sites with significant changes). In general, consumers gave higher ratings for recovery orientation than did staff members via the RSA surveys.

Sites increase the number of peer support specialists

- The number of peer specialists serving the sites increased from 22 to 45 and all the participant change teams expanded their peer support service offerings.

Conclusion

The learning community model is a resource-rich method for supporting organizational learning in participating agencies and for building the transformational systems change that will be necessary to "promote hope, build resilience, and foster recovery" (Texas Department of State Health Services, n.d.-a) throughout the Texas public behavioral health system. There were lessons learned and recommendations shared by participants, which should be considered in future efforts at transformation of the public mental health system in Texas.

Recommendations:

Lessons about Learning Communities

Consideration: The Kick-Off Conference was seen as extremely valuable by most of the participants. The conference provided a shared experience for the team, motivating speakers, visions of success, and hopefully the initiation of the "community" aspect of "learning community." During the RFLC, Psychiatric Nurse Assistants (PNAs) and patients did not participate in the Kick-Off Conference. In addition, over the course of the RFLC, at some hospitals, patients indicated an interest in training as peer specialists and providing volunteer peer support services to others.

> **Recommendation:** For hospitals to access the change team contributions which could be made by PNAs and long-stay patients, another model for on-site learning community initiation could be considered. In addition, on-site peer specialist training could be considered for an innovative hospital with motivated staff and patients.

Consideration: Teams (and individuals) had different levels of comfort with experimentation and with asking for help. Some teams requested extra on-site trainings, and received them. In contrast, one Change Team Leader reported at the end of the project "I wish my executive sponsor had been able to sit in on the Individual Site Calls.". Other teams heard the message that was allowed, if not encouraged.

> **Recommendation:** In the future send repeated messages about partnership and the necessity of two-way giving of feedback. It is assumed that a longer term learning community would build the level of trust for these messages to be received and acted upon. In any case, ensure this message is sent early and often.

Consideration: One of the deficiencies of the application process for hospitals was neglecting to include a recommendation to have a direct care staff team member. Psychiatric Nurse Assistants (PNAs) provide daily care to patients, and are therefore considered essential to successful culture change across hospitals.

> **Recommendation:** Considering the potential for daily recovery coaching which could be provided by PNAs to hospital patients, they should be included as required change team members for the team's application.

Consideration: As part of the RFLC process, the teams created their own AIM statements, and goals. Upon creation of these organizing devices, the change activities of the team became more focused and easier to track. Eight of the fifteen RFLC change teams found it helpful to plan and track change activities using a form of the Change Tool. The UT facilitator also found it easier to track activities and progress for those teams that were actively using a Change Tool.

> **Recommendation:** Include the intention to create useful tools as an expectation of participation in future learning communities. Obtain assistance from LC members in their creation and use.

Consideration: Change teams across the RFLC indicated that they would benefit from communication and technical assistance from members of change teams from other locations.

> **Recommendation:** Create more user-friendly ways to increase opportunities for communication among learning community members and request assistance of specific members to share their success stories and areas of expertise.

Consideration: Consumers on hospital change teams cannot attend conferences with other team members.

> **Recommendation:** Allow consumers to participate to the greatest extent possible. For hospitals, this may require the use of technology or possibly an on-site visit, or an increase in the number of on-site visits.

Consideration: Organizations have their own unique culture and leadership styles, which at times are not as comfortable with the participatory nature of change team activities as promoted by the learning community model.

Recommendation: Emphasize the non-traditional nature of team learning used with the learning community model and check for understanding with executive sponsors prior to final participant decisions.

Consideration: Change teams across the RFLC indicated that they would like more time to work together in a facilitated fashion at the Kick-Off Conference.

Recommendation 1: Create time, space, and support at the Kick-Off Conference (or other type of Initial Activity) for teams to accomplish work together.
Recommendation 2: Increase interaction/experiential activities at Kick-Off conference.

Consideration: One participant at the Kick-Off Conference noted the lack of activities set aside particularly for the peer specialists attending.

Recommendation: At every meeting opportunity planners should include peer-focused meetings and activities. This would serve to emphasize the importance of the role, as well as provide peer support to those attendees. A statewide network of peer-to-peer connections would also support further system change.

Staff Resources

Consideration: The RFLC's 15 teams required a consistently high level of attention and care. Although all teams expressed satisfaction with their participation in the RFLC, the teams were not all able to sustain the same level of change team activity within the planned schedule. The RFLC had 2 full time staff members, a large faculty, and 4-5 part time staff. Although the required work was accomplished, the initiative required workloads that went beyond a reasonable capacity of the individuals directly involved. Five to eight teams might have been more appropriate for the existing staff resources.

Recommendation: For a highly-resourced model of a learning community such as the one used for the RFLC, the number of teams should be kept to a number that corresponds to the staff support coverage. Future decisions on team applications should be made with an understanding that the number of teams accepted can be realistically supported by the capacity of the expected staff team.

Collection of Data Measuring Quality of Recovery Support Services

**Consideration*:* The executive sponsors assisted with planning the staff data collection. Wherever possible, online surveys were used. However, in rural areas, and especially in large hospitals, many staff members do not have adequate access to computers, so paper surveys were used. The process was more onerous and took longer for paper surveys. The change teams assisted in the collection of data from consumers and used peer specialists' assistance wherever possible. The change teams made data collection plans that focused on comfort, privacy, and choice, and plans were adjusted to resources, physical layout, schedule, clients' needs, and availability of peers.

**Recommendation*:* Online surveys should be used whenever possible to save resources and work for both change teams and researchers. In rural areas, and especially in large hospitals, however, many staff members do not have adequate access to computers. The assistance of change teams in planning and implementing site-appropriate data collection was valuable and is recommended for future data collection whenever possible.

Consideration: Use of the Persons in Recovery version of the Recovery Self Assessment was greatly assisted when peer specialists helped with distribution and collection. With an increasing number of peer specialists serving in public mental health service providers, this should improve data collection and increase comfort of clients with this type of data. However, consumers and community members alike are powerfully affected by the sharing of recovery stories.

Recommendation: Future data collection efforts should include interviews or focus groups with clients to allow this type of data to be considered when assessing the quality of recovery support services being provided. Again, these efforts could be supported by local peer specialists.

Consideration: Most of the high quality, data-driven learning collaboratives required that the teams collect data to guide their own change activities and show outcomes (Ayers et al., 2005). However, considering the short timeline and the depth of data collection desired, the RFLC coordinating team had UT-CSWR collect data to assist the teams. Following the provision of mid-point reports to all 15 teams, only one CTL requested a phone call with UT-CSWR to discuss the findings.

Recommendation: Continue to include team needs in planning of data collection. Perhaps include an All Teams Call presentation, or module for change teams presenting examples of teams using data to achieve results. Another possibility is to coach Change Team Leaders and Executive Sponsors on ways to use data in support of change efforts.

Continuing Systems Change in the Texas Public Mental Health System

Learning Communities offer a way for participating organizations to become more nimble

Consideration: The RFLC Executive Sponsors' greatest concerns were listed as: 1) clients/outcomes/quality of services, 2) staff retention and development, 3) availability of peer specialists/recovery orientation of agency, 4) funding cuts/lack of financial support, 5) organizational efficiency and compliance, 6) capacity, and 7) stigma/justice system. The most frequently mentioned challenges related to staff retention and development and this is likely to remain a challenge for the foreseeable future.

Recommendation: Learning communities are an effective way to deal with multiple needs that are affected by or related to inadequate resources. The engagement of a diverse team of employees to solve problems, increase quality, and create recovery outcomes for persons they serve also can be related to the development of locally relevant new knowledge and to improved staff morale. Learning communities should be considered an important element in planning for long term system change, as well as responding to sudden environmental changes.

Consideration: Most of the high quality, data-driven learning collaboratives had timelines covering several years (Ayers et al., 2005) and had a focus on sustainability in the final years. The funding timelines and a desire to be successful within the funding cycle drove the RFLC schedule, and also supported the decision to provide extensive support for the RFLC members. Although proud of their accomplishments, many change team leaders regretted the short timeline.

Recommendation 1: A long term plan is needed to support mental health providers in transforming the system to one that is recovery oriented.
Recommendation 2: The natural pace of building trust and learning in a learning community should not be rushed if the desire is to create deep and sustainable change. Consideration by the State of longer-term learning community projects is encouraged.
Recommendation 3: In addition, to build on the momentum of the participating RFLC agencies, it is recommended to provide the RFLC teams with different avenues (and levels of intensity) for participation in the future system change efforts across Texas. Each team will be able to provide unique leadership in local and statewide efforts. They are likely to consider different levels of commitment as they learn more about the statewide drive to create systems change.

Consideration: The CTLs reported that the most valued RFLC resources were the Kick-Off Conference, followed by on-site technical assistance, the individual site calls, and Via Hope resources. For many teams, the All Teams Calls were not as valued. The literature on collaborative learning supports the importance of cross-team learning and sharing. However, it also acknowledges the need for more face-to-face meetings in the interests of building necessary trust. Considering the resources available for further system work, an increase in face-to-face meetings is not likely. Also, some RFLC members requested the opportunity to communicate with each other following the end of the project.

Recommendation: Create a way to test multiple models of 'learning communities' for Texas. Considering the inability for all of the hospital change team members (patients) to attend out of town meetings, assess the effectiveness of a more local approach: building local learning networks around the topic of recovery. Also consider increasing the use of conference calls and webinars for a widespread learning community. Test models with more or less face-to-face time for the development of trust within the learning community members.

Leadership

Consideration: The most common need or plan identified was training (including CPS, peer supervisor, and recovery skills). The second most requested support was consultation, and, specifically, consultation provided on-site. The respondents then cited: continued communication with other RFLC members, continuation of all or part of the RFLC program, DSHS leadership and policy support, and finally, money. All the teams anticipated continuing the work.

Recommendation: As the State continues its efforts to transform the mental health system, the plans should include continuing development of the current RFLC teams in ways that fit with their needs. The RFLC teams exhibited leadership and continue to learn about recovery services. They comprise a pool of potential leaders for the State of Texas in its recovery diffusion efforts.

Learning Communities provide new ways to train staff across the state as 'participants in change work'

Consideration: Via Hope provided a travel / lodging stipend to offset most of the costs for the teams to attend both the Kick-Off and Wrap-Up conferences in Austin. The most frequently mentioned challenge of the Executive Sponsors of the RFLC teams was "staff retention and development", and there is a question whether any of the teams could have participated without the financial support enabling all RFLC activities, especially the face-to-face meetings.

Recommendation: There will be a need for further financial support to enable the local change teams from LMHAs and hospitals to fully participate in any future learning communities. One possibility is that as DSHS moves further towards its vision of recovery and resiliency for all, they could encourage LMHAs and hospitals to use their training budgets to support participating in these types of initiative as opposed to 'training as usual'. DSHS could also act as a role model in pursuing learning community models to create powerful changes within its own system.

Consideration: DSHS is not always in a position to react quickly to unique issues arising from the field in learning community projects.

Recommendation: Assemble a DSHS work group to do parallel work to the learning communities, and provide responses to requests for advice or support coming from these types of projects within one week.

Need for statewide recovery diffusion efforts (and selected pilot projects)

Consideration: All the RFLC change teams began the process of creating documentation for recovery planning. They see this as an essential tool in the provision and documentation of recovery support services by their clinicians. Many participants requested additional consultation for this work.

Recommendation: Creation of recovery planning processes and documentation for behavioral health providers across the State would add impetus to the system changes necessary to provide recovery support services in a consistent manner. A recommended next step for this system change should include a pilot project through which intensive training and coaching on person-centered recovery planning could be provided to sites in a learning project. Upon completion of this pilot, lessons would be used to create a next cohort of learning organizations.

Consideration: In 2006, the Committee on Crossing the Quality Chasm: Adaptation to Mental Health Addictive Disorders recommended that the Chronic Care Model be used in agencies caring for persons in recovery with mental illness and addiction in order to improve coordination of their care, in addition to other aspects of quality assurance.

Recommendation: A recommended next step for this system change should include a pilot project within an innovative center or a small group of innovative centers to use the Chronic Care Model as an organizing guide for process improvement efforts relating to recovery support services.

Consideration: On reflection, many Change Team Leaders shared that they still had opportunities to increase the influence of consumers in the day-to-day life of their organizations. The voices of clients and family members who are not volunteers or employees are essential to achieve the vision of recovery-oriented services.

Recommendation: The RFLC teams and others in the State could learn more about how to increase the voices and influence of clients and family members on all aspects of the care provided by an organization.   This remains an area for learning with these teams and for the State as it moves forward to achieve the vision of recovery and resilience for all. One possibility is to create a theme-based, short-term project, supporting existing RFLC members in some way so they can continue to work on this aspect of care or include it as a major focus of a future learning community.

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Background Information

Via Hope, Texas Mental Health Resource

In October 2005, Texas was one of seven states to be awarded a Mental Health Transformation State Incentive Grant (MHT-SIG) from the Substance Abuse and Mental Health Services Administration (SAMHSA). The MHT-SIG originated from the President's 2003 New Freedom Commission Report on Mental Health, Achieving the Promise: Transforming Mental Health Care in America. The funds were designed to support states in identifying any problems with or gaps in the mental health care system and, furthermore, to make recommendations to improve upon the current system. Through this grant, Texas was charged with transforming mental health services in the state by

> "building a solid foundation for delivering evidence-based mental health and related services, fostering recovery, improving quality of life, and meeting the multiple needs of mental health consumers across the lifespan" (Texas Department of State Health Services, n.d.-b).

A transformed system will provide consumers with the knowledge and resources that facilitate active participation with service providers in creating their own recovery plans, as well as designing and developing the systems of care in which they are involved.

Via Hope, Texas Mental Health Resource was created through the Texas MHT Project, in collaboration with the Department of State Health Services (DSHS), Mental Health America of Texas (MHAT), and the National Alliance on Mental Illness Texas (NAMI). Via Hope promotes mental health wellness to Texans by providing training and technical assistance resources to consumers, providers, and youth and family members. In addition to providing classroom and on-line training courses in a wide variety of mental health subject areas, Via Hope also provides training and certification for peer specialists and has facilitated learning communities in order to help mental health agencies integrate peer specialists into their Centers (Via Hope Texas Mental Health Resource, n.d.).

Recovery in Mental Health

As previously stated, the President's New Freedom Commission Report identified multiple problems with the mental health system. It also presented a vision of a 'recovery oriented system' with early detection, improved access, decreased stigma, increased involvement of consumers and families in decision-making at all levels and coordination of care to provide "a life in the community for everyone" (United States. President's New Freedom Commission on Mental Health., 2003). The origins of the recovery movement with consumer advocacy and its' strong civil rights foundation require that the definition of 'recovery in mental health' is one constructed by persons with the lived experience of mental illness. Indeed, each person in recovery is to craft his/her own recovery plan and, through the giving and receiving of help, make progress on his/her own unique recovery journey.

There are multiple definitions of 'recovery in mental health', with some experts presenting it as both a process and an outcome (Torrey, Rapp, Van Tosh, McNabb, & Ralph, 2005). In a review of the meanings of recovery accorded by three different perspectives (substance use, physical illness, and traumatic experiences), and considering a disability model, Davidson and his colleagues (2005) created a concept for recovery with mental illness that includes nine elements included in a comprehensive definition of recovery in mental illness. The essential elements for a person in recovery with mental illness include: "1) renewing hope and commitment; 2) redefining self, 3) incorporating illness, 4) being involved in meaningful activities, 5) overcoming stigma, 6) assuming control, 7) becoming empowered and exercising citizenship, 8) managing symptoms, and 9) being supported by others." (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005, p. 484). These elements can be integrated in a definition that provides a vision for consumers and mental health clinicians alike. For instance, the definition ultimately adopted by the state of

Connecticut's transformation group was ""a process of restoring a meaningful sense of belonging to one's community and positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition"(Davidson et al., 2007, p. 25). The authors pointed out that this definition is "consistent with the recovery core values and principles articulated by the state's consumer community and with the disability and civil rights model of addiction and mental illness which had been promoted by people in recovery across the country" (p. 25). For the RFLC, several definitions were shared by Via Hope and participation in an ongoing dialogue was encouraged.

Peer Specialists

Individuals often report feeling powerless, demoralized and socially isolated throughout their experience participating in treatment through the public mental health system (Chinman, Young, Hassell, & Davidson, 2006). Advocates have, and continue to, demand inclusion of consumer and family voice and choice in all aspects of the mental health treatment process. Recently the peer specialist workforce is gaining attention for providing peer support and for making significant contributions toward making the mental health system more recovery-oriented. Peer specialists are individuals who have lived experience with mental illness, are in recovery and are willing to assist others in earlier stages of recovery and serve as employed staff of the public mental health system in a variety of settings, (Davidson, Chinman, Sells, & Rowe, 2006; Hebert, Rosenheck, Drebing, Young, & Armstrong, 2008). The success of peer specialists with clients have opened the eyes of an increasing number of policy makers that people with serious mental illnesses can, in partnership with mental health and peer providers, create their own paths to recovery (Campbell, 1996). Specifically, a Certified Peer Specialist (CPS) provides peer support services that are related to the consumer's individualized treatment needs (i.e., helping consumers develop skills for coping and managing psychiatric symptoms or providing consumers an opportunity to support each other) and are often based on the concept of mutuality (Via Hope Texas Mental Health Resource, n.d.). Certified Peer Specialists are increasingly employed by mental health care agencies to offer peer support services and some agencies and states are developing processes to enable reimbursement through Medicaid (Eiken & Campbell, 2008).

Learning Communities

Collaborative quality improvement efforts are gaining respect as the way to enable groups of people to work in complex systems, to influence people within the system to strive towards a common goal, and ultimately, to create unique, creative, and local ways of achieving their goals. Initial improvement efforts in primary care by the Institute for Healthcare Improvement, have further developed a model and outcomes. For example, IHI's Breakthrough Improvement Series, initially introduced in 1995, has been employed by over 50 collaborative groups, and has resulted in the training of over 650 people in this methodology, with consequential 'spread' across the healthcare world (Institute for Healthcare Improvement, 2003). Other, specific projects with partners like the Health Services Research Bureau (HRSA) (in the Health Disparities Collaborative (Landon et al., 2007)), or the Bureau of Primary Care (with the National Diabetes Collaborative (Chin et al., 2004)) provided greater exposure for the ideas and success of the learning collaborative (or learning communities) model. Essentially, healthcare teams were provided research-based content from national experts (for example, cutting edge treatment for specific conditions, systems concepts, and the chronic disease model), were trained in the breakthrough model, began to collect and use their own data, planned change strategies, learned from rapid cycle change processes, shared ideas, outcomes, tools, and lessons-learned. In the process, they created new knowledge relevant and valuable to each team in their organizational setting (Chin et al., 2004; Institute for Healthcare Improvement, 2003; Landon et al., 2007).

Although the initial IHI work was focused (and is still focused) on primary care in the community setting, or acute care in hospital settings (or both), other fields are looking to the learning collaboratives (LC) model (Institute for Healthcare Improvement, n.d.). With its solid foundation in adult learning principles, and the addition of a complex systems perspective, service organizations are finding the principles useful in reacting to a rapidly changing environment (such as that created by healthcare reform or a plunging economy).

In 2003 the Network for the Improvement of Addiction Treatment (NIATx), a component of the University of Wisconsin-Madison's Center for Health Enhancement Systems Studies, was founded to provide technical assistance to two three-year learning collaboratives for addiction treatment providers. The sponsors were RW Johnson and SAMSHA and the participants achieved "dramatic improvements in reducing no-shows and wait times and increasing admissions and continuation in treatment."Subsequent learning collaboratives led by NIATx increased the experience of providers and expanded areas of innovation (a state/payer focused improvement project, a project promoting evidence based practices, another on using emerging communications technology and one improving financial health as well as customer service). Following this, NIATx changed its name to simply "NIATx" as they report "[T]his reflects our growth and expansion into fields other than addiction treatment" (Niatx, n.d.). The evaluators for a 2006 New York county NIATx project concluded that other community-based organizations might find the local learning collaborative model useful and effective in improving addiction treatment (Roosa, Scripa, Zastowny, & Ford, 2011).

Behavioral health providers have only recently shown interest in the learning collaborative model (LC), and early adopters were providers in children's mental health (Cavaleri et al., 2006; Roosa et al., 2011). In 2009, the National Child Traumatic Stress Network (NCTSN), responding to a perceived gap in the use of trauma informed treatments across all relevant community settings, instituted a large LC project. This group described their approach which "focuses on spreading, adopting, and adapting best practices across multiple settings and on creating changes in organizations that promote the delivery of effective interventions and services". They provided learning collaboratives and learning communities both, and distinguished the learning community as a model that "does not include all of the elements of the learning collaborative" but includes in-person contact, and sharing of experiences and lessons among members (National Child Traumatic Stress Network, n.d.).

Chronic Disease Model

An example of a lesson learned from these many learning collaborative projects was the adoption of the Chronic Care Model (CCM) for the IHI-McColl Institute partnership with the Chronic Care Breakthrough Series Collaboratives (Wagner, 1998). This ensured a systems perspective for the quality improvement activities of the change teams (Appendix A presents the expanded version of the Chronic Care Model and basic definitions (Wagner et al., 2001)). In addition, a secular trend which was slowly changing the view of many conditions from acute to chronic (for example, HIV, addiction, and mental illness) fed into increased attention on the learning community model and the chronic care model by professionals in different fields.

In 2006, the Committee on Crossing the Quality Chasm: Adaptation to Mental Health Addictive Disorders performed a thorough examination of quality of care provided by the mental health and addiction treatment systems. They also examined the differences, similarities, and gaps between medical and behavioral healthcare. One recommendation was greater care integration so that "patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients" (Shortell SM, 2000, p. 129). The Committee went further to identify the Chronic Care Model as one that should be assessed for usefulness in behavioral healthcare.

The Chronic Care Model (CCM) "emphasizes the use of certain organizational structures and processes, including interdisciplinary practices in which a clear division of the roles and responsibilities of the various team members fosters their collaboration. Instituting such arrangements may necessitate new roles and divisions of labor among clinicians with differing training and expertise" (p. 241). The organizational structures and processes of the CCM may be useful in the clarification and

changes of roles that are inherent in the transformation from "usual care" to recovery-supportive care, and especially in the integration of peer specialists into the clinical recovery support teams. Citing its successful use in practices treating various chronic diseases, as well as treatment of depression and addiction disorders in primary care settings, the Committee recommended that the Chronic Care Model be "developed for use in the care of individuals with chronic M/SU illnesses as a mechanism for improving coordination of care, as well as other dimensions of quality" (p. 241).

Peer Specialist Learning Community

In 2010, in an effort to increase the number of peer specialists in Texas, Via Hope developed a program to provide training and certification for peer specialists. Initially seen as a marketing activity, Via Hope also offered Local Mental Health Authorities (LMHAs), Community Mental Health Centers (CMHCs), and Consumer-Operated Service Providers (COSPs) an opportunity to participate in a Peer Specialist Learning Community (PSLC). Ultimately, however, the main goal of the PSLC was to ensure employment opportunities for peer specialists by helping providers understand the benefits of hiring and utilizing Certified Peer Specialists (CPSs). Additionally, the teams were to identify any organizational barriers and strengths and to create implementation plans to be used in order to successfully integrate CPSs into the workplace. Experiences of this learning community were to be shared in order to continue to improve employment opportunities for CPSs across the State (Kaufman et al., 2010).

A formal evaluation of the PSLC was not conducted; however, The University of Texas Center for Social Work Research (UT-CSWR) assisted with collecting data, documenting, and reporting on outcomes of the PSLC activities. This report provided a description of the Via Hope experience, documented the creation, enhancement, or expansion of peer specialist positions, and summarized lessons learned about the potential of the learning community for the integration of certified peer specialists into the public mental health system in Texas (Table 1).

Table 1: Recommendations from the UT-CSWR PSLC Report

	Recommendations and Future Directions
1	Enhance future learning community marketing and/or visibility strategies.
2	Market the PSLC to state hospitals in addition to the LMHAs as these organizations have shown an interest in integrating peer specialists into their organizations by sending individuals to Via Hope's Peer Specialist Training and Certification program.
3	Due to the very different nature of the organizations, consider facilitating a separate learning community specific to the needs of COSPs.
4	The Executive Director or an individual in a leadership position should attend the Learning Community Kick-Off Conference and participate more fully in the PSLC to demonstrate organizational buy-in.
5	Prior to calls, send a reminder of the date and time of the call and an agenda to help teams prepare for discussion topics.
6	Future learning communities should attempt to accommodate schedules for higher participation on group calls.
7	Build rapport and tailor the provision of training and technical assistance to the needs of individual Centers by increasing the frequency of individual calls.
8	Facilitate regionalized phone calls among Centers so that the teams could assist one another in addressing certain issues that may be particular to the region, for example, issues specific to South Texas or veterans issues in regions with military facilities.
9	Enhance marketing strategies for the on-line forum (MHTonline.org) to increase the number of communication

	channels available to teams.
10	Offer site visits within the first few months of the learning community to serve as the basis for increasing recovery culture throughout the Center.
11	Clarify details of site visit (i.e., which staff members to invite to attend) before the site visit.
12	Change the emphasis of next year's learning to be recovery focused with the integration of peer specialists included as part of that change rather than the focus of the change.
13	Work in conjunction with Recovery Innovations (or another training organization) to provide training tailored to the needs of each Center.

The PSLC resulted in more peer specialists in the mental health workforce and the experience showed participants that the Certified Peer Specialist workforce has great potential to positively influence the Texas mental health system. However, truly recovery-supportive cultures and processes were needed in each organization in order to support their work. In addition, other staff members needed to gain an understanding of their roles in the provision of recovery support services. Therefore, the focus of the 2011 learning community was to promote recovery orientation in participating organizations. This culture change, together with professional skills training on recovery support services would provide a recovery-oriented environment in which clients, clinical staff, and peer specialists could thrive. The new learning community retained a strong emphasis on peer support services as a vehicle for the needed culture change, but asked change teams to look at their organization's culture and to re-design services so that they would be supportive of recovery.

The Recovery Focused Learning Community (RFLC) Model

RFLC Coordinating Team

Adopting most of the recommendations of the UT-CSWR report, a RFLC Coordinating Team was formed to plan and create a more fully-supported learning community. Six colleagues from DSHS, Via Hope, and UT-CSWR met weekly beginning in September of 2011 to plan the RFLC process. Some team members had prior experience with the Institute for Healthcare Improvement (IHI) learning collaboratives and much of the planning was based on experience with, and literature relating to, this highly successful group. Additionally, a team from UT-CSWR planned an evaluation around the developing RFLC model.

In alignment with the learning collaborative model to be followed by the RFLC participants, the RFLC Coordinating Team created the following AIM and goals for their process.

RFLC AIM and Goals

AIM: To build a recovery orientation that fosters, and is supported by, the use of peer support services in the Texas public mental health system.

What are we trying to accomplish?

- Individuals and systems develop a deeper understanding of recovery orientation and experiment with recovery-oriented practices; and

- There is an increase in the number of peer specialist positions in the Texas public mental health system.

How will we know that change is an improvement?

- Organizations that participate in the Recovery-Focused Learning Community increase the number of peer specialist positions;
- There is an increase in the recovery orientation of the change units of participating organizations, as measured by the Recovery Self Assessment data provided by staff and consumers;
- There is an increase in the knowledge of recovery principles of the staff in participating organizations, as demonstrated by a change in each organization's RKI scores; and
- Qualitative data collected throughout the project will identify and track whether incremental improvements toward the organizational goals are being made.

What changes will we make that will result in ongoing improvement?

- We will host kick-off and closing conferences for the RFLC to provide content and process-related information to participating organization;
- We will provide ongoing support and resources to participating organizations; and
- We will support the development of lasting partnerships at the local, regional and state level.

Learning Collaborative Considerations

Learning collaboratives, or learning communities, are increasingly used by leaders attempting to transform systems. A systems approach acknowledges that any change, simple, or "whole practice transformation, cannot be a carefully engineered, stepwise process, but rather will need to be the result of emergent properties, processes, and structures that evolve from a robust and resilient relationship system among agents" within the system (Crabtree et al., 2011, p. 6). Systems cannot be controlled, but they can be influenced using principles arising from the complex adaptive systems model. One powerful way to influence the changes is to empower and enroll the interdependent agents of that system to create a compelling vision of the future. The trick is to have a well-understood goal, and a few simple rules to act as boundaries. In this way experienced local agents use their understandings, communication, relationships and creativity to construct a unique, local approach to attaining this vision (Committee on Quality of Health Care in America, 2001, pp. 309-322; Zimmerman, Lindberg, & Plsek, 1998, pp. 23-44).

A leader in the use of learning collaboratives to improve patient outcomes was the Institute for Healthcare Improvement (IHI). Their breakthrough series model has been used by healthcare professionals, nationally and internationally, to increase effectiveness of systems and improve patient outcomes (Ayers et al., 2005; Berwick, 2003; Craig, 2011; Institute for Healthcare Improvement, 2003). One of the essential elements of the IHI model is a clearly defined AIM, and steps or goals, which utilize measurable outcomes in 'mini experiments' (rapid cycle change) from which the teams learn. In a learning collaborative the teams share their lessons and 'learn to learn' together. This model was used very successfully with well defined outcomes (for example, clinical markers of diabetes, hypertension, and other easily measured markers (Bricker et al., 2010; Cole et al., 2006). As described previously, the learning collaborative model should also be very useful for creating less well-defined outcomes, such as the recovery orientation of an organization. The synergy comes from persons with the on-the-ground experience becoming invested and empowered in reaching for a goal that is highly valued by all, and lacking detailed steps and structures.

The definition of "learning collaborative" or "learning community" is not universal. In fact, Wilson, Berwick, and Cleary (2003) set out to identify essential components of learning collaborative by interviewing leaders from seven countries. This study identified seven key features, which determined eventual success of the collaborative: sponsorship, topic, ideas for improvement, participants, senior leadership, preliminary work, and learning about and making improvements. Specifically,

Sponsorship – This is seen as an important factor in the ultimate success of a learning collaborative. The respondents found professional organizations often to be seen as very positive sponsors. In contrast, government agencies sometimes received a more cynical response.

Topic – Broad topics were thought to promote more freedom and creativity in the change teams, and relevant topics (for instance those responding to national healthcare priorities) were essential. Early in the learning collaborative process they observed that those topics that were more familiar and simple were attractive to the change teams. Once the members became proficient in the change process, they would tend to move on to the full range of topics.

Ideas for Improvement – Having a nationally recognized faculty share ideas and provide legitimacy was important. In some cases the experts were seen as being "too different" and not 'in tune' with the local scene. When participants generated their own ideas there was an increased amount of commitment, however it required more time as the change was slower.

Participants – There was great variation in how participants were chosen. The majority of respondents depended on volunteers, rather than creating a change team composed of designated employees. Those that used participation criteria included characteristics such as "previous experience in quality improvement, commitment to the collaborative and topic, and participation of a senior executive" (p. 87).

Senior Leadership Support – Most respondents reported that visible support from senior leaders was imperative to the eventual success of the change teams.

Preliminary Work – All the respondents described pre-work (consisting of data collection, system analyses, or some type of audit) helped prepare the change teams prior to initiation of the learning collaborative. The teams needed to start thinking about their organizations, understanding their baseline, especially in respect to the topic of interest. Some respondents mentioned having additional early sessions to establish a baseline understanding of the processes that would be used by the change team to agree on an AIM and to experiment with change activities.

All these features identified by Wilson and his colleagues were considered by the RFLC Coordination Group when planning the program.

Lea Ayers and colleagues conducted a similar study with ten organizations in three countries to compile a list of essential elements for a successful quality improvement learning collaborative. These elements included: "cultivating trust, attendance to the human dimension, nonlinear development, attendance to organizational culture, integrated philosophy of quality improvement, and a focus on process and outcome measurement to drive change" (2005, p. 234). These issues were also considered by the RFLC Coordination Group when planning, and throughout the program, but the group may have been less successful in promoting all these characteristics than the more concrete features identified by Wilson and his colleagues (2003). As expected, the RFLC participants also had suggestions to refine some of these elements throughout the learning community process.

The Final RFLC Model

The final RFLC model that emerged from the collaborative planning group had the following core components:
- The application process;
- Creation of a change team;
- Pre-work for the change team;

- Kick-Off Conference;
- Monthly All Teams Conference Calls;
- Monthly Individual Site Coaching Calls;
- Scheduled on-site Recovery 101 trainings;
- MHT Online communication link;
- Additional resources, TA, and connections, as requested by the change teams; and
- Wrap-Up Conference.

The timeline that emerged from the planning process had the announcement being sent out at almost one year following the announcement of the Peer Specialist Learning Community (PSLC) This required a time period of only nine months for the entire learning community process due to grant funding restrictions. The RFLC Coordinating Team did not feel that such a short timeline would be ideal for the creation of relationships, development of skills, assembling of change teams, support for their experimentation, and fostering of free flowing information sharing across the learning community. However, they hoped that the teams would be to be able to show some progress towards their goals with the assistance of the other teams and the RFLC faculty.

RFLC Timeline

Figure 1 presents the timeline that developed within the constraints discussed previously. It was acknowledged from the first communication with the teams the RFLC would be an intense process, but it would also be exciting and satisfying work for change team members and other staff. Ultimately, it was hoped that clients would see transformative changes in the support they receive for their recovery journeys.

Figure 1: 2011 RFLC Time Line
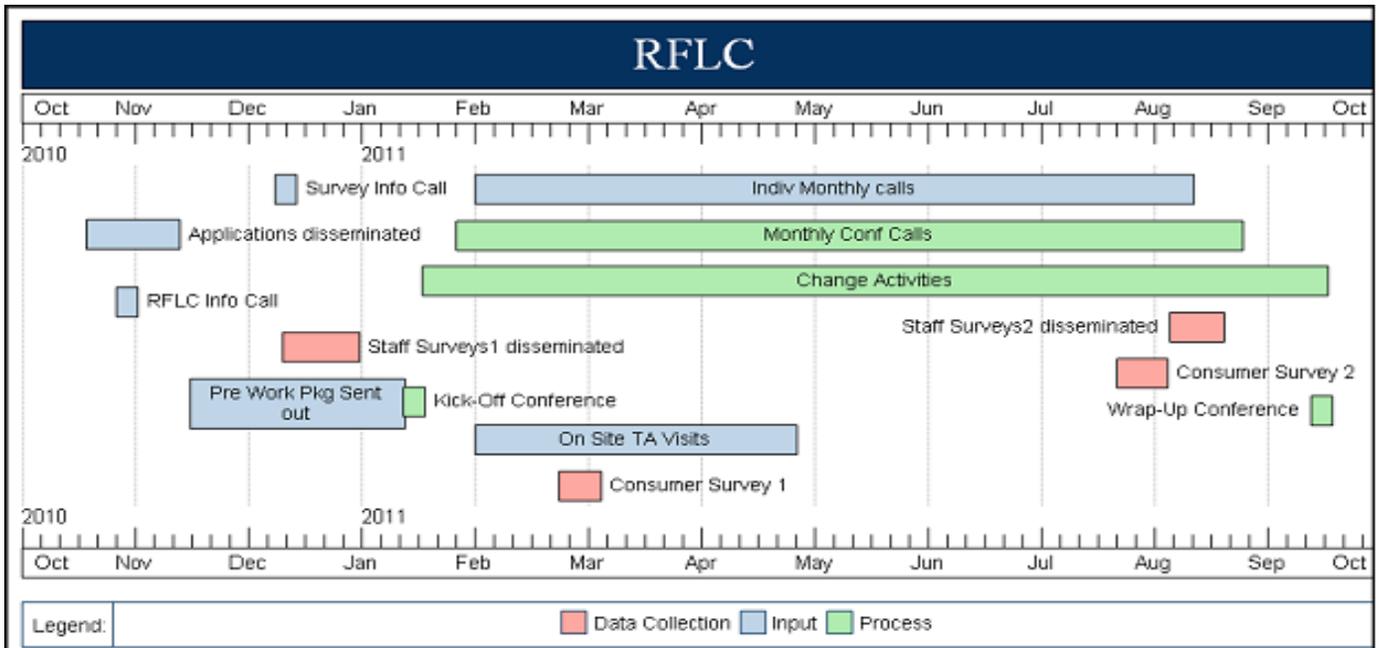
RFLC Invitation

In the invitation to participate, the 2011 RFLC was described:

> "This year, Via Hope is partnering with the Center for Social Work Research at the University of Texas at Austin (UT-CSWR), to provide a richer and more broadly focused collaborative learning experience with a focus on building a recovery orientation that supports, and is supported by, the use of peer specialists. State hospitals and community mental health centers are invited to apply."(Maples, 2010).

The suggested benefits of participating included:

- a conference featuring an exceptional group of nationally recognized leaders in recovery,
- an opportunity to creatively examine your agency's operations and recovery culture,
- time dedicated to plan, implement, experiment with, and receive support for specific changes you would like to make in your organization,
- priority enrollment for your agency's peer specialists in Via Hope's peer specialist training and certification program,
- on-site training on recovery concepts for your organization's staff,
- ongoing technical support and assistance, including twice monthly calls related to your change process—individual calls that are focused on your organization, and community calls that address common themes and provide time to share experiences, and
- data collection and analysis to measure the impact of the RFLC and your Change Team's efforts (Maples, 2010).

Members of the RFLC

Between 4-11 November 2011, 15 applicant organizations applied online. The application process asked executives to define their expectations, guided them through the choosing a change team and a change unit, and specifically listed responsibilities of the participating teams. The responsibilities to which executive sponsors agreed on behalf of the change teams included:

- Attendance of Change Team at the Kick-Off Conference in January;

- Attendance of Executive Sponsor at the Kick-Off Conference;

- Initial on-site staff training on recovery-oriented practices and culture change to be hosted by Executive Sponsor;

- Attendance by Change Team Leader on 2 regularly scheduled conference calls per month;

- Attendance of Change Team members at Wrap-Up Conference in September 2011; and

- An estimated 3 to 6 hours of RFLC-related (self-regulated) activities per month for the Change Team.

Following review, and a phone call with forensic hospital applicants (acknowledging necessary adaptations to the approach for their setting) all 15 applicants were accepted as members of the RFLC.

Table 2: Members of the RFLC

Participating Agency/Hospital	Executive Sponsor	Change Unit
MHMR of Nueces Count	Jeanne Wallace, MH Adult Services Director	Psychosocial Rehabilitation Unit providing Service Package 3 level services
Bluebonnet Trails Community Services	Leo De La Garza, LMSW-AP, Director of Special Programs	Initially San Gabriel Respite Center, then Bastrop Center
Big Spring State Hospital	Olivia Flournoy, Assistant Superintendent for Programs	Acute Psychiatric Service for Females (APSF) Unit
Helen Farabee Regional MHMR Center	Gianna Harris LCSW, Associate Executive Director of Operations	The Wichita Falls Adult Mental Health Clinic Site
Kerrville State Hospital Texas DSHS	Stephen Anfinson, Superintendent	Vocational Services Dept.
MHMR Authority of Brazos Valley	Robert Reed, Director of Mental Health Services	Brazos Mental Health Center
North Texas State Hospital (NTSH)	James E. Smith, Superintendent	The Behavior Management and Treatment Program (BMTP) Unit
Lakes Regional MHMR Center	James W. Williams, Behavioral Health Director	Mount Pleasant Mental Health Center
Rusk State Hospital	Ted Debbs, Superintendent	Short term treatment units.
Austin Travis County Integral Care	Reese Carroll, Manager Psychiatric and Counseling Services	Psychiatric and Counseling Services (PCS)
Lubbock Regional Mental Health Mental Retardation Center (LRMHMRC)	JoAnne Harwood, Director of Mental Health Services	Assertive Community Treatment (ACT) team
Terrell State Hospital	Dr. Joe M. Finch, PsyD Superintendent	Adult Acute Unit 7
Gulf Bend MHMR Center	Lane Johnson, M.Div., LPC Director of Clinical Programs and Services	Adult Mental Health Unit. (SP3/SP1)
Texas Panhandle MHMR (TPMHMR)	Libby Moore, Executive Manager of MH Services	Adult Amarillo Psychosocial Rehabilitation Program
Central Plains Center	Ron Trusler, CEO	Main clinic in Plainview, TX

Core Components

With the time constraints, the RFLC Coordinating Group attempted to be thoughtful about each step of the process, and hoped that even completion of, for example the application, would provide value to the potential participant. The following section describes in detail the core components of the RFLC model.

The Application Process

At the end of October, 2010, an invitation was issued by DSHS to eligible organizations regarding participation in the RFLC. The newest learning community was presented as a way to apply lessons learned from the PSLC.

> "Through the 2010 Learning Community [PSLC], we recognized that organizations that embrace recovery in their culture and practices are more successful when they bring peer support services to their organizations, and peer specialists believe their work is more meaningful when their work setting is recovery-oriented. This year, the RFLC will focus on

recovery orientation with the understanding that peer support services are critical to the effort of creating recovery culture" (Maples, 2010).

The Executive Director, or a key staff member with delegated authority, was required to complete the application online. (Appendix B). Applications were accepted through 12 November, 2010.

Some data from this application were used to design the Kick-Off Conference and to guide further development of the model. For instance, Executive Directors were asked to include their greatest challenges (or 'what keeps them up at nights') for their organizations. These were shared with the attendees and the RFLC process was discussed as one way to deal with some of the nightmares. The categories of their concerns included: 1) clients/outcomes/quality of services, 2) staff retention and development, 3) availability of peer specialists/recovery orientation of agency, 4) funding cuts/lack of financial support, 5) organizational efficiency and compliance, 6) capacity, and 7) stigma/justice system. The most frequently mentioned challenges related to staff retention and development. Appendix C presents the specific concerns of the Executive Sponsors organized by category.

Via Hope and DSHS received applications from 15 LMHAs, state hospitals, and mental health centers. Of the 15 applicants, ten had paid or volunteer peer specialists providing peer support services to clients. The remaining five applicants were either actively recruiting peer specialists or were in the planning phase of the process.

The Change Team

In order to participate in the PSLC, each organization was required to put together a team of at least four members. Because executive sponsorship is considered a critical component of the program's success, one of the team members had to be either the Executive Director or a key staff person with delegated authority to implement the necessary changes. The team also had to include at least one consumer, who was either currently working as a peer specialist or had aspirations to become a peer specialist. In addition to these two required team members, other departments within the organization could be represented on the team, but were not required. At the Kick-Off Conference, there was variation in the number of team members from each site, with teams ranging in size from the minimum requirement of four members up to seven members. Team members were reminded at the Conference that change team membership should be flexible to ensure appropriate representation that reflects the focus of change activities at any point in time.

Pre-Work

On December 1st, a congratulatory letter was sent to participants of the RFLC. The letter contained information about the upcoming RFLC Kick-Off Conference, a contact information form, change team stipends, the organizational staff surveys which they would need to distribute and collect prior to the conference, the pre-work packet, details of the first All Teams conference call, communication formats and methods for sharing documents.

As part of the RFLC Pre-Work, all change team members were asked to complete their registration for MHT Online (the online platform chosen for team communication), retrieve specific documents prior to the kick-off conference, and check in with Via Hope using that communication platform (http://www.mhtonline/).

On 15 December, 2010, Via Hope sent the Change Team Leaders a Pre-Work Packet (Appendix D). This Pre-Work Packet provided information about the change process, peer specialist implementation, recovery orientation, specifics about the upcoming conference, and guidance about pre-work that the change teams were expected to complete prior to attending the kick-off conference. On December 20th, the first All Teams' informational conference call was held to review essential information and discuss any remaining questions.

Data Collection – Initial Staff Surveys

A significant portion of the pre-work for the change teams was data collection with staff members of their organizations. Through telephone conversations with the UT-CSWR facilitator, each Executive Sponsor decided on the extent of the survey sample (essentially, whether to sample only the change unit or to have a much larger organization sample that would include the change unit). Because most of the Executive Sponsors did want a larger sample, a unique variable was required for each survey by which the respondent confirmed whether or not s/he was an employee at the specifically named change unit. This necessitated 15 different surveys. Originally the surveys were to be provided online using the Survey Monkey application. After conversations with some of the larger and rural organizations, it was decided to also provide paper surveys for those teams that requested that format. All five hospital teams required paper surveys for their large numbers of psychiatric nurse assistants. Additionally, one center requested paper surveys. Therefore, the initial data collection comprised 21 different surveys. All the surveys were fundamentally the same (except for the wording of the 'change unit variable'), but provided through individual paper surveys, separate links for each organization, and in many cases, via both formats. Copies of a generic hospital and center online survey are provided in Appendices E and F. Staff at UT-CSWR printed and copied the requested surveys, sent them via Fedex, and provided paid, pre-addressed and paid labels for their return. Following return of the paper surveys, data were entered by a UT-contracted research assistant and ultimately combined with the online data.

The paper and online data were compiled and analyzed in the first weeks of January, 2011. At the Kick-Off Conference, each team was provided a Recovery Profile to use with their planning processes. See Appendix G for an example of a center profile. The sample sizes ranged from 5 to 423 and response rates ranged from 38% to 136%, with a total of 2,067 respondents for the initial staff survey (See Appendix H for details).

The Learning Community Kick-Off Conference

All 15 teams attended the 2011 Via Hope Recovery Focused Learning Community Kick-Off Conference on January 12-14th at the Omni South Park in Austin, Texas. The conference was formatted as a track of the annual United State Psychiatric Rehabilitation Association (USPRA) "Windows to Wellness" conference.

At this 3-day conference, nationally recognized leaders in the recovery movement shared their insights and knowledge about the types of system changes that have been utilized to build recovery support services throughout public mental health systems. Texas faculty provided local context and DSHS leaders shared the strategic vision of the MHSA division in promoting "resiliency and recovery for everyone".

The conference was a game-changer for us. It was a delightful blend of expert presentations and cheerleading…Our staff felt special because they were chosen to attend… it showed them that they are considered leaders.

The goal of the Kick-Off Conference was to provide participants with an in-depth understanding of the origins, civil rights foundation, and lessons-learned from some of the leaders of the recovery movement. The intention was to follow the learning collaborative model in providing teams with time and opportunity to apply what they had learned to develop their own AIM and goal statements. Each team also received an individualized "Agency Recovery Profile" based on RSA and RKI responses. Please see Appendix I for a copy of the 2010 Conference Schedule and Appendix J for a description of the Conference Manual provided to each participating agency. Via Hope provided a travel / lodging stipend to offset most of the costs for the teams to attend both the Kick-Off and Wrap-Up conferences in Austin.

Evaluations of the Kick-Off Conference confirmed that many participants found it extremely valuable. The change team leaders identified it as the most valuable resource in a later survey (details of this survey follow – see Table 3). Some individuals reported being overwhelmed with information, had critiques of the room comfort, the long days, and the lack of time set aside for actual work by change team members at the table. During one of the sessions a participant pointed out that no meetings had been set aside particularly for peer specialists, who could appreciate a session for information sharing and peer support. At that point, a Via Hope staff member arranged to facilitate a meeting at the end of one day. Due to inclement weather, three of the faculty members were unable to attend as planned. Through the use of Skype technology, Drs. Larry Davidson and Peggy Swarbrick were able to present from their home locations. However, Larry Fricks was unable to participate. The RFLC Coordinating Group agreed that valid and important critiques were the lack of time for team change planning, and the lack of any session specifically for peer specialists. They also agreed that the use of Skype, although not ideal, was an excellent way to deal with the unexpected absence of essential faculty on-site.

All Teams Conference Calls

Over the course of RFLC, Via Hope facilitated nine monthly conference calls among the participating teams (copy of monthly schedule and participation rates in Appendix K). These conference calls took place from December to August. Participation rates were very high. Nine teams had representatives on all nine All Teams Calls. Three teams missed one call and one team missed two calls. There were two types of calls: participative and didactic. When a common need was identified through the Individual Site Calls (or other dialogue with teams), Via Hope arranged for an appropriate faculty member to provide a webinar (with split groups when necessary – for example, the March call on peer providers was split into separate calls for hospitals and centers).

Individual Site Coaching Calls

Each month on a set schedule, the UT-CSWR facilitator, along with Michele Bibby of Via Hope, and sometimes other members of the UT-CSWR team spoke to each team's Change Team Leader (CTL) or their representative(s). Notes were taken of the conversation and provided to the CTL, along with any requested resources, and referrals. Initial calls focused on the team's AIM statement and goals and how they related to the site's RSA and RKI survey results.

> *And me, like anybody else, when you gave me good positive feedback on things it helped me to take a larger look at what we're doing and say 'yeah yeah that's right this is working, even though there's challenges week to week… don't worry … [It helped by] boosting my feelings about it and then [I] transfer those feelings to staff, and that moves [things forward].*

Based on the conversations, the facilitators provided various versions of a Change Tool in an attempt to create a version that would be helpful to each CTL. The Change Tools were meant to perform as the organization's "recovery plan" and intended to help plan and track change activities of the team. By March, most teams (9 of 15) had created change tools which they found useful for tracking plans and activities. With the creation of a clear AIM and relevant goals, and the addition of a useful change tool, the change team's activities began to easily align around relevant goals. It was also easier for CTLs to discuss plans and report on change activities being used to make progress towards the team's AIM when they used a change tool. See Appendix L for a generic example of a Change Tool.

Requiring the Executive Sponsor's commitment to monthly calls, establishing a monthly schedule, and providing reminders and agendas prior to each set of calls ensured more consistent communication with the teams than in the Peer Specialist Learning Community. Five change teams were able to participate in all seven scheduled calls. Four teams missed only one monthly call, and one team missed two calls. The month of June was the least consistent (reportedly due to vacations, maternity leave, and staff turnover) with four change teams missing the individual site call that month (Appendix M).

Scheduled On-Site TA

As suggested by the experience of the participants in the Peer Specialist Learning Community, on-site Recovery 101 training was scheduled as quickly as possible following the Kick-Off Conference for each team of the RFLC.   The Recovery Profile for each agency was shared with the on-site trainers prior to the training. The first training was held on February 22nd and the final one was held April 21st (see final column Appendix K). All Recovery 101 trainings were provided by Recovery Opportunities' staff members (Dr. Lori Ashcraft, Chris Martin, and Chris Flanagan), except for

After the Focus for Life training what we saw was patients making plans for themselves and their lives. We also saw several patients who said they were interested in serving as peer specialists.

the training at Kerrville State Hospital. This team requested consulting around their goal of creating a clubhouse on campus. Dr. David Stayner provided this training on the 4th and 5th of April.

Other TA and Trainings

Some change teams were able to access additional on-site trainings, such as   Focus for Life (FFL) and Wellness Recovery Action Planning (WRAP). Others had specific resource needs (phone calls with faculty members, connection with a RFLC member who had specific experience to share, copies of recovery plans, examples of job descriptions, specific topics suggested for All Teams Calls, etc.) that were provided by relevant faculty through Via Hope referrals. In addition, many peer specialists from participating teams enrolled in the Via Hope Certified Peer Specialist training, the Advanced Peer Specialist training, or the Wellness Coaching module. Though some of the individual coaching calls, a need for attendance by at least one staff member in the Via Hope peer specialist supervision training was identified. The reports from attendees, or their Change Team Leaders, were extremely positive. Attendees reported an improved understanding of the role and value of peer specialists, as well as an improved understanding of their own role in integration of, and support for, peer specialist employees.

I didn't think that Via Hope would give this as much support as they did. As far as resources and conference calls and all the different trainings offered and that sort of thing. I was just surprised by how much support they actually provided.

Value of Support and Resources

Through an online survey of Change Team Leaders (CTLs) in June of 2011, their perception of the usefulness of the various forms of support and TA provided up to that point of the RFLC process was requested. The data suggest that for the sites that hosted a Focus for Life training, this was seen as having an important positive impact on their staff and clients. Because not all sites had access to this TA, the analyses were separated into two groups: those that hosted FFL Trainings and those that did not host FFL trainings. It should be noted that these data share the perspectives of the CTLs only, and that other change team members may have had different priorities.

Although some change team members were critical of some aspects of the Kick-Off Conference in the evaluations, and some CTLs would have preferred to initiate the RFLC process with the on-site training, overall, it was valued as the most helpful resource by all respondents. There were some general trends for both groups. The onsite TA was felt to the second most valuable resource (this analysis includes Focus for Life in the category of "onsite TA"), followed by the monthly individual site calls. Priorities diverged after that, with some teams availing themselves of individual support from Via Hope more than others. When considering the All Teams Calls, both groups found the didactic conference call type more valuable than the participative conference calls type. MHT online was seen to have the least value overall. The RFLC Coordinating Team consistently sought to increase ownership and dialogue on the participative calls, but these results show that more work could be done in this area.

Table 3: Order of value of RFLC resources by CTLs hosting FFL and not hosting FFL

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	21.0	Focus for Life	20.0
Individual Site Calls	14.2	Onsite TA	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

Consumer Surveys – Time 1

As part of the application process, the Executive Sponsors agreed that the Change Teams would assist with data collection for their clients at the appropriate times. The agreed upon goal was to have peer specialists or other consumers assist with the data collection to make clients more comfortable. If it was not possible to have consumers distribute the surveys, then staff members with an understanding of the importance of privacy and confidentiality were recruited to distribute the surveys, continually reinforcing the volunteer nature of participation.

The clients were first surveyed in April (April 22 to May 6, 2011) using the Person-in-Recovery version of the Recovery Self Assessment (O'Connell, Tondora, Croog, Evans, & Davidson, 2005), to obtain their perception of the recovery orientation at the change unit. As the RFLC change model uses a specific change unit for experimentation (change activities) by a change team, it was expected that any increase in recovery orientation might first be experienced by the clients receiving those services. It was also seen to be a 'reality check' for the change team as they worked to increase recovery support services and recovery expectations among staff members on the change unit.

Consumers at centers (sample size 438) and hospitals (sample size 121) provided different perspectives, with the most similar subscales for the two groups being "Diversity of Treatment Options". The lowest scores for both centers and hospitals occurred with the subscale "Consumer Involvement and Recovery Education". For the clients at the centers, the most recovery oriented scores were those for "Choice -- Rights and Respect" and "Individually-tailored Services". For hospital patients, the most recovery oriented scores were those for "Individually-tailored Services" and "Life Goals". Scores between the two groups were significantly different for "Choice -- Rights and Respect" and "Individually-tailored Services. See Appendix __ for more in-depth analyses of these results.

Individual Site Mid-Point Reports

In June 2011, individual site reports were produced by UT-CSWR and emailed to the Executive Sponsor and Change Team Leaders. These provided the Time 1 survey results for staff members and consumers, as well as providing some process data. An example of a mid-point report is presented as Appendix N. Each CTL was given an opportunity to discuss this report with UT-CSWR researcher in the following month's Individual Site Call. One CTL requested a follow-up telephone call to discuss the data in more depth.

Staff Surveys – Time 2

To determine if changes occurred over the course of the Learning Community, staff members at each of the organizations were asked to complete the same online survey administered at Time 1 (December 2010) for a second time during the period of August to September 2010 (Time 2). Response rates were more modest at Time 2 compared to Time 1, with 177 change unit staff and 274 other staff respondents for the centers and 228 change unit staff and 739 other staff member respondents for the hospitals. Appendix O provides in-depth analysis of these data.

Consumer Recovery Self-Assessment (RSA) – Time 2

Because the initial consumer survey was distributed in April, in order to collect the change unit consumer perspective at a second point in time, the UT-CSWR team delayed a second collection for as long as possible. The change teams assisted in planning for, distributing, and collecting the surveys. The Time 2 consumer survey data were collected from 29 August to 9 September, 2011. A total of 305 consumer respondents from the centers and 117 from the hospitals shared their perception of the recovery orientation of the change unit at which they were receiving services. It is assumed that some of the respondents were sampled at both Time 1 and Time 2, but identifying data were not collected and some change units had more frequent turnover than others. Therefore the surveys were considered to be two snapshots in time at the change unit, rather than an indication of consumers' change in perception over time. Appendix O provides in-depth analysis of these data.

The Learning Community Wrap-Up Conference

On September 12-13, 2011, all RFLC participants and many DSHS stakeholders were invited to participate in the RFLC Wrap-Up Conference as a way to close the 9-month learning community process. All teams had representation at the conference, including Bluebonnet Trails, which had just experienced wildfires that had displaced over 1,500 families from their homes, destroyed acres of forest, and closed multiple businesses. The agenda is attached as Appendix P.

Team members from each Center provided a PowerPoint presentation to the attendees on their process, lessons learned, accomplishments, and future plans. Teams were requested to cover the following topics: change team members, AIM and goals, accomplishments, how our work has changed, future plans, topics we would like to discuss with fellow RFLC members, and a 'free choice' topic. The UT-CSWR team provided a general look at the changes in recovery orientation represented by survey data over the course of the RFLC process. They compared Recovery Self Assessment data (description of the organization's recovery orientation practices) and the Recovery Knowledge Inventory (description of individual's knowledge and attitudes about recovery) for hospitals and centers as reported by staff members and consumers at the change unit.

Process Data

Models of Change

As described previously, each change team created its own AIM and goals. They chose change activities in order to experiment with ways to reach the goals, and make progress toward achieving their AIM. Each change team was scored on the number of change activities focused in each area: consumer voice and influence, staff recovery education and system support, and peer specialists and peer support services. Note was also made of the integration of planning and implementation within the change team for each site. All the teams had activities in more than one area, but for the most part, there was a particular focus to most of their work. The models of change that emerged were individually unique, although they could be categorized into four distinct types: Integrated (3 teams), Consumer-Focused (2 teams), Peer Specialist-Focused (5 teams), and Staff-Focused (3 teams). There were two teams that utilized hybrid model types: one that had a Dual Consumer and Peer Specialist Focus and one that had a Dual Peer Specialist and Staff Focus. Appendix Q provides a short description of each change team's model for change.

Change Activities

Many teams had similar goals and consequently developed similar change activities. Some change activities were complex and had multiple steps while others were easily-implemented. It was expected that change teams that implemented multiple activities at different levels would have a more comprehensive effect on the recovery orientation in their organizations. Further analyses of the process and outcome data may lead to a better understanding of the relationships among these data. A compilation of change activities from all the change teams is presented in Appendix R.

A RSA-based tool was created by the UT-CSWR team to assist teams to think about ways to deal with identified gaps or needs. This is attached as Appendix S. The change teams could focus on an area showing as weak in their RSA results and find a suitable goal on which to experiment with suggested change activities. Data were not collected to quantify the number of teams that used this particular tool, although it remains available for future change efforts.

> *I'm kinda more proud of the changes I've seen in [the staff] … they're getting better every day… It is exciting cuz you can get burned out real quick… I eavesdrop and I hear … the words 'how will you know when you no longer need us' and [our clients are] not used to being asked that. To hear that maybe you're going to make enough progress that you're going to be able to get out and get a job. As the caseworker supervisor that's what I'm most proud of to see the progress that they're both making – the consumers and our [staff].*

The change teams increased their number of change activities over time. As the team's AIM and goals became clarified soon after the Kick-Off Conference, the alignment of the activities with specified goals also became clear. When a team missed an individual site call, their change activity data were not collected. There is a decline in number of reported change activities in July, which would have been reported on the August call. The August call was a bit different in that it focused on obtaining answers to 'reflection questions'. It is possible that the reports of change activities may not therefore have been as complete as on previous calls. On the other hand, there were additional comments about the difficulty of dealing with staff absences in the summer; this may have also affected the total number of change activities reported. Ultimately, an aggregate of data from all the teams shows a crossover in March from random activities (which were 'felt' to be recovery-oriented) to change activities identified as supporting specific goals (Figure 2).

Change Activities Over Time
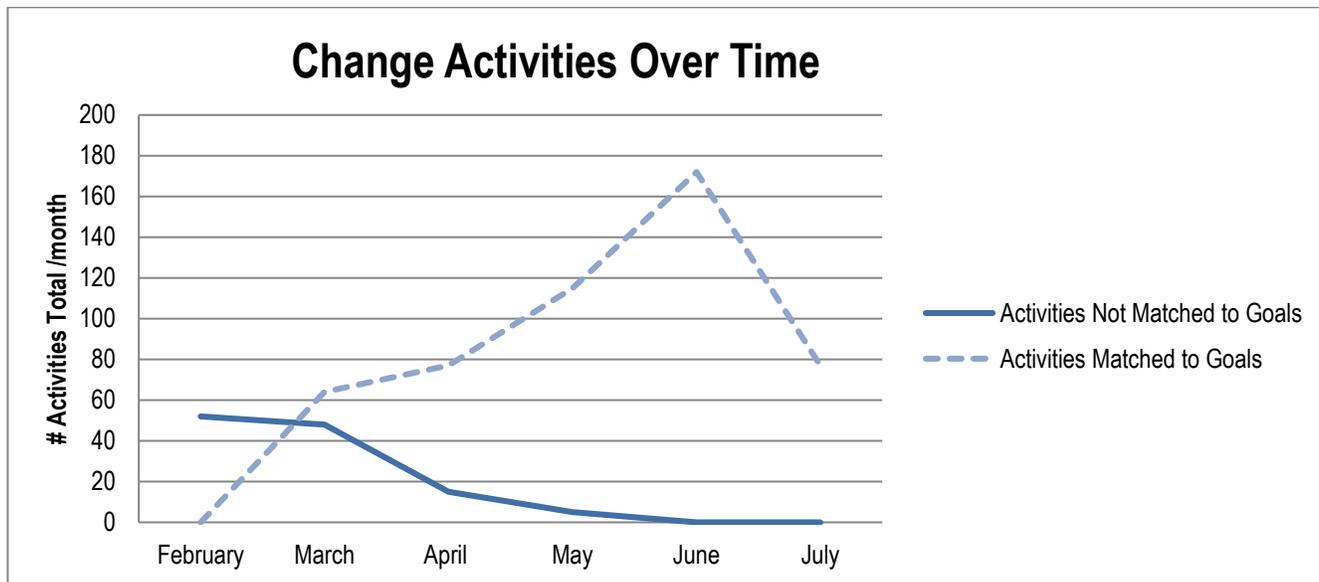
Peer Influence

There was a reported increase in peer influence across all sites and the RSA subscale "Consumer Involvement and Recovery Education" shows statistically significant improvement between Time 1 and Time 2 for all staff, except hospital staff (who showed only a slight improvement over time). There were two types of efforts in this regard: increasing the number of peer specialists in the organization, and increasing routes of influence for consumers on the day-to-day life of the organization.

> *Besides [the peer specialist's] personal traits, I think that's really opened the hospital up to becoming recovery-oriented. It has been great timing. It all happened at once. We had the academic support and then we had her to bring it to life.*

Peer Specialists

The total number of peer specialists (whether volunteer or paid, part-time or full-time) at RFLC member agencies increased from 22 to 45 in aggregate. The peer specialist(s), many times with the support of the change teams, expanded the peer support services in diversity, in number of services provided, and in number of participants.

Two change teams had a consumer focused change model, although many more than that had change activities designed to increase communication with clients and patients. These activities ranged from inviting clients to assist with creation of a new mission statement, to campaigning for increased peer representation on the local planning network, to creation of patient forums at one state hospital, and providing more employment opportunities (some off campus) at others. All sites participated in the consumer RSA surveys and were encouraged to initiate dialogues when provided with the results. Some of the RFLC members had on-site Focus for Life classes with a mixed audience of staff and clients. It was reported that this increased communication and understanding among all participants, with particularly appreciated results in those sites having mixed audiences. This approach might be one for future learning community members to consider.

Accomplishments

In the August Individual Site Calls the Change Team Leaders (CTLs) were asked a number of reflection questions, including one "what are you most proud of accomplishing in the RFLC process". The answers were powerful and the most frequently identified accomplishments were identified in two categories: peer specialists (and peer support services), or changes in staff and services provided. One thing to consider is that the CTLs may have been aware of other accomplishments of their team, but were perhaps proud of the more challenging successes.

At the Wrap-Up Conference, each change team presented their list of accomplishments. A summary list incorporating both lists of accomplishments from the CTLs and full teams was created by the UT CSWR team and then categorized by themes (Appendix T). In general, the accomplishments mentioned by the change teams and their leaders have distinct patterns for centers and hospitals.

For instance, the DSHS Frequent Users Report. F. has been involved with our program here I guess for about 4 or 5 years. In the last 2 years peers specialists [services] have really improved here. I pointed that out to DSHS. She hasn't been in the 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 the 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.

Centers

The most commonly mentioned accomplishments for centers were: (1) increased number of peer specialists and expansion of peer support services; (2) increase in recovery-focused care (including redesigned treatment plans, recovery-focused support groups, and staff provision of recovery support to clients); and (3) recovery education for staff and community (including new employee orientation).

Hospitals

The accomplishments of which the hospital teams were most proud included: (1) increase in patient choice; (2) expansion of peer support services and increase in patient voice; and (3) increased staff and patient interaction/engagement.

We used to have people burn out within 3 months. But it's not like that anymore. There are still times that things go bad but it's working.

Future Plans and Needs

Future plans were shared by the change teams at the Wrap-Up Conference on the storyboards. Additional information about future plans was collected in the 'reflection interviews' with the change team leaders. The Change Team Leaders or Executive Sponsors also responded to a question: considering your future plans beyond the RFLC Wrap-Up Conference, what do you foresee in the way of support or resources that you might need? The lists of future plans from the storyboards and anticipated needs often overlapped. Consequently these lists were consolidated by the UT-CSWR team and categorized by theme.

The most common need or plan identified was training (including CPS, peer supervisor, and recovery skills). The second most requested support was consultation, and consultation provided on-site. The respondents then cited: continued communication with other RFLC members, continuation of all or part of the RFLC program, DSHS leadership and policy support, and finally, money. Plans also ranged from "continue what we're doing" to specific objectives. All the teams anticipated continuing the work. No one reported being 'finished', and in fact a few CTLs asked about the possibility of continuing various aspects of the RFLC support (see Appendix U for details).

Quantitative Data

Demographics

As previously reported, survey data were collected at two time points for staff members and for consumers. Some of the larger organizations (most hospitals) included a wider sample than the change unit in order to have a baseline assessment of all their staff members. In order to ensure consistency in data interpretation, the change unit staff member and the change unit service recipient samples were used to assess for any changes for the purpose of the RFLC analysis. The demographics of these sample groups are presented in Tables 4 and 5 following:

Table 4: Demographics of RFLC Center Survey Respondents

Centers					
Demographics		**Change Unit Staff**		**Consumers**	
		Time 1 (n=236)	Time 2 (n=181)	Time 1 (n=433)	Time 2 (n=297)
Ethnicity	Hispanic	16.7%	15.7%	27.0%	24.7%
	American Indian/Alaska Native	5.0%	2.2%	2.3%	2.6%
	Asian	.8%	0%	.5%	1%
	Black or African American	10.5%	11.6%	19.2%	16.1%
	Native Hawaiian or Other Pacific Islander	.4%	0%	.7%	.3%
	White	76.6%	78.5%	61.6%	61.3%
	Other	0%	0%	13.7%	14.4%
Sex	Male	24.7%	22.2%	48.3%	50.3%
	Female	72.3%	73.9%	51.7%	49.7%
	Not disclosed	3.0%	3.9%	0%	0%
Age	18 – 24	5.5%	7.7%	9.7%	10.1%
	25 – 34	30.5%	29.3%	19.2%	19.9%
	34 – 44	20.3%	18.2%	24.7%	22.9%
	45 – 54	23.7%	22.1%	32.6%	32.0%
	55 – 64	16.5%	17.1%	12.5%	13.1%
	65 or older	.8%	1.7%	1.4%	2.0%
	Not disclosed	2.5%	3.9%	0%	0%

A comparison of the center change unit staff and consumer data shows a larger percentage of respondents who identify as White. There are higher percentages of Hispanic and African American consumers than staff members. The percentage of women staff members was over 70%, while the consumers show a more balanced distribution for sex. The percentages of consumers aged 18 to 54 are higher than those of the staff members. For the age group after age 55, there was a greater percentage of staff members than clients.

Table 5: Demographics of RFLC Hospital Survey Respondents

Demographics		Change Unit Staff		Patients	
		Time 1 (n = 302)	Time 2 (n=241)	Time 1 (n=121)	Time 2 (n=113)
Ethnicity	Hispanic	9.7%	14.1%	26.3%	25.5%
	American Indian/Alaska Native	1.3%	3.7%	3.3%	6.0%
	Asian	2.0%	3.3%	1.7%	1.7%
	Black or African American	24.7%	25.7%	28.9%	29.9%
	Native Hawaiian or Other Pacific Islander	1.0%	1.7%	.8%	0%
	White	61.5%	52.7%	43.8%	45.3%
	Other	0%	.4%	24.8%	16.2%
Sex	Male	31.4%	33.9%	51.2%	50.9%
	Female	65.2%	60.7%	48.8%	49.1%
	Not disclosed	3.3%	5.4%	0%	0%
Age	18 – 24	11.3%	9.5%	16.0%	12.4%
	25 – 34	15.6%	16.6%	28.6%	20.4%
	34 – 44	21.5%	19.5%	21.8%	28.3%
	45 – 54	26.8%	24.9%	24.4%	22.1%
	55 – 64	17.9%	19.5%	7.6%	12.4%
	65 or older	1.7%	2.9%	1.7%	4.4%
	Not disclosed	5.3%	7.1%	0%	0%

A comparison of the hospital change unit staff and patient data indicated that the largest percentage of respondents identified as White. There are higher percentages of Hispanic consumers than staff members, while the percentage of respondents (both staff and patients) identifying as African American is the most similar percentage of all the sub-samples. The percentage of women staff members is over 60%, while the consumers show a more balanced distribution for sex. The percentages of consumers aged 18 to 34 are higher than those of the staff members. There is a similar distribution of staff and patient respondents aged 35 to 54. In a similar pattern to centers, for ages 55 and older, there are greater percentages of staff members than clients.

Changes in Perceived Recovery Orientation, Knowledge, and Attitudes towards Recovery

As the change teams developed their plans, experimented with change activities, and adjusted these plans, they continued discussing perceived results and accomplishments. All the Change Team Leaders reported having made progress towards their AIM and many were interested to hear whether there had been any resulting change in their survey data over time. Individual Site Progress Reports (example in Appendix V) were provided to each team so that they could understand their results, as well as consider these in relation to future plans.

"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.'" [a doctor on the change team]

Recovery Self Assessment

The Recovery Self Assessment was considered by UT-CSWR to be the measurement of recovery orientation for the organization, as perceived by staff members (change unit staff and others) and clients. A detailed description of the constructs measured by this survey is included in Appendix W.

Staff Differences

Differences between Centers and Hospitals

A principal comparison is that of change unit staff RSA scores at Time 1 and Time 2. Due to the difference in hospitals and centers, they are compared by category and the RSA subscale mean scores are presented in Table 6.

Table 6: Change Unit Staff RSA Results Time 1 and Time 2 by Organization Type

RSA Subscales	C.CUST1 (n=217)	C.CUST2 (n=177)	T Score	H.CUS T1 (n = 277)	H.CUS T2 (n=228)	T Score
Life Goals	3.90	3.92	-.21	3.62	3.67	-.77
Consumer Involvement and Recovery Education	3.12	3.40**	-3.65	3.26	3.42*	-2.22
Diversity of Treatment Options	3.37	3.58**	-2.87	3.43	3.53	-1.53
Choice- Rights and Respect	3.69	3.96***	-4.36	3.54	2.93**	9.90
Individually-Tailored Services	3.63	3.71	-1.09	3.59	3.56	.35
RSA Total	3.57	3.73**	-2.67	3.50	3.55	-.96

Note: C=centers, H=hospitals, T1=Time 1 and T2=Time 2
*denotes statistical significance at p≤.05, ** statistical significance at p≤.01, and *** statistical significance at p≤.001

In a short period of time (9 months), the UT-CSWR evaluation team felt that any measurable change in scores could be related to change team participation in the learning community. For the centers, all subscale scores increased, and three were statistically significant increases, as was the total RSA score. The significant increases were in the subscales "Consumer Involvement and Recovery Education", "Diversity of Treatment Options", and "Choice
– Rights and Respect".

In the case of the five hospital participants, three of the five subscales increased, while two decreased. The statistically significant changes were an increase in "Consumer Involvement and Recovery Education" and a decrease in "Choice – Rights and Respect".

Differences between Forensic and Non-Forensic Hospitals

I think there some [of our] folks that wondered to what extent people in maximum security could effectively participate in their own recovery given the burdens of the court requirements and everything and I think … coming to terms with that and some of our patients being asked, challenged and expected to take some responsibility for their own recovery. Finding some unique ways to focus on patients' strengths was an important part of [what we accomplished].

Throughout the RFLC process, on the individual site, and other, calls, there was discussion about the appropriateness of the surveys for hospitals when they had been created for community

centers. There was special concern about the inappropriateness of some of the questions for the forensic hospitals. However, as one CTL responded "we don't want to suffer from terminal uniqueness. Recovery is appropriate for this setting; we just need to find out how and where we can increase choice for our patients within legal and safety parameters."

By separating the RSA results for forensic and non-forensic hospitals, t-test comparisons of the means showed some significant differences at both Time 1 and Time 2. Table 7 provides the results of these comparisons.

Table 7: RSA Results for Forensic and Non-Forensic Staff at Time 1 and Time 2

RSA Subscales	Forensic T1	Non Forensic T1	T Score T1	Forensic T2	Non Forensic T2	T Score T2
Life Goals	3.61	3.59	.53	3.78	3.64**	2.90
Consumer Involvement and Recovery Education	3.18	3.37	-4.67***	3.37	3.40	-.62
Diversity of Treatment Options	3.43	3.46	-.81	3.63	3.53*	1.93
Choice - Rights and Respect	3.49	3.57	-2.18	3.16	3.00***	3.36
Individually-tailored Services	3.54	3.62	-2.07*	3.57	3.64	-1.45
RSA Total	3.46	3.52	-1.82	3.60	3.56	1.01

Note: T1=Time 1 and T2=Time 2
*denotes statistical significance at p≤.05, ** statistical significance at p≤.01, and *** statistical significance at p≤.001

At the first administration, non-forensic hospital staff reported statistically significant higher subscale scores for "Consumer Involvement and Recovery Education," "Choice - Rights and Respect" and "Individually-tailored Services." However, at Time 2 two differences were more pronounced and in a different direction (higher for forensic) for the subscales "Choice – Rights and Respect" and "Life Goals". These results lend support to the position that forensic and non-forensic hospitals provide distinctly different contexts within which change teams were working to increase recovery orientation.

Some comments from staff members on the initial survey indicated that they found some questions not applicable in their setting. It is hoped that additional analyses of these data will shed some light on this question. If possible, work with the RFLC hospital teams could assist to further revise the RSA to create a more valid instrument for this environment.

Consumer Differences

As previously referenced, the samples of consumers from each change unit will have had more overlapping at some organizations than others. There were no identifying data collected, so the comparisons are simply two snapshots of consumer feedback at the same change unit at different points in time. Table 8 provides subscale scores and t-test results for significance at the two time points.

Table 8: Consumer RSA Results Time 1 and Time 2 by Organization Type

RSA Subscales	C. Cons T1 (n=438)	C. Cons T2 (n=267)	T Score	H. Cons T1 (n=121)	H. Cons T2 (n=95)	T Score
Life Goals	3.80	3.86	-.69	3.53	3.66	-.93
Consumer Involvement and Recovery Education	3.30	3.55**	-2.90	3.42	3.38	.27
Diversity of Treatment Options	3.45	3.63*	-2.40	3.46	3.59	-.92
Choice- Rights and Respect	4.00	4.08	-1.38	3.44	3.51	-.45
Individually-Tailored Services	3.96	4.01	-.75	3.55	3.67	-.82
RSA Total	3.81	3.89	-1.31	3.55	3.60	-.39

Note: C=centers, H=hospitals, T1=Time 1 and T2=Time 2
*denotes statistical significance at p≤.05, ** statistical significance at p≤.01, and *** statistical significance at p≤.001

In general, both center and hospital change unit clients rated recovery orientation higher at Time 2 than those consumers completing the survey at Time 1. Although all center scores were higher at Time 2, analyses reveal some statistically significant increases in report of "Consumer Involvement and Recovery Education" and "Diversity of Treatment Options." Hospital consumers, on the other hand, perceived higher recovery orientation subscale scores at Time 2 related to four of the five subscales, although none of the changes were statistically significant.

Invite Subscale

The Consumer RSA contains two unique questions, which could be described as "Invite" characteristics of the organization. The results for these questions at both points in time are presented in Table 9.

Table 9: Consumer RSA Invite Subscale Results Time 1 and Time 2

Invite Items	C. Cons T1 (n=438)	C. Cons T2 (n=267)	T Score	H. Cons T1 (n=121)	H. Cons T2 (n=95)	T Score
Staff welcome me and help me feel comfortable in this program.	4.33	4.26	.99	3.83	3.80	.22
The physical space of this program (e.g., the lobby, waiting rooms, etc.) feels inviting and dignified.	3.94	3.97	-.32	3.62	3.71	-.56

*C=Centers, H=Hospitals, T1 = Time 1, T2 = Time 2. No statistically significant differences found for these results.

Interestingly, both categories of sites had higher scores for the physical environment at the second administration, and a lower score for the perception of staff welcoming attitudes. However, none of the measured differences was statistically significant.

Comparison of Change Unit Staff and Consumer RSA Results at Time 2

The surveys of staff members and consumers were by necessity completed on different time schedules. Consequently the only surveys completed at a comparable point in time were the second surveys for both groups. Again, because the RFLC change activities were focused on each change unit, the consumers at the same unit were those recruited for the Person in Recovery RSA surveys (O'Connell et al., 2005).

Table 10 and Figure 3 present the mean subscale scores for Change Unit Staff and Change Unit Consumers for centers and hospitals at the Time 2 administrations.

> *It's something that's so new to a lot of PNAs and other staff. For years we focused on: "if you take all your meds, you will get better and be just fine". We all know that's not true so the idea of it being a continuous up and down – that is a very different direction in the time that I've been here. We've never really acknowledged the fact that recovery has all different stages. I think the more knowledgeable we are- the more our patients will be. So they don't just beat themselves up when they slip.*

Table 10: RFLC Change Unit Staff and Relevant Consumer RSA Subscales at Time 2

	C. CUS T2 (n=177)	C. Cons T2 (n=267)	T Score	H. CUS T2 (n=220)	H. Cons T2 (n=77)	T Score
Life Goals	3.92	3.86	.85	3.67	3.66	.05
Consumer Involvement and Recovery Education	3.40	3.55	-1.71	3.42	3.38	.28
Diversity of Treatment Options	3.58	3.63	-.517	3.53	3.59	-.48
Choice - Rights and Respect	3.96	4.08	-1.76	2.93	3.51	-4.69***
Individually-tailored Services	3.71	4.01***	-3.90	3.56	3.67	-.87
RSA Total	3.73	3.89**	-2.54	3.55	3.60	-.47

Note: C=centers, H=hospitals, T1=Time 1 and T2=Time 2
*denotes statistical significance at p≤.05, ** statistical significance at p≤.01, and *** statistical significance at p≤.001

Figure 3: RFLC Change Unit Staff and Consumer RSA Subscales at Time 2
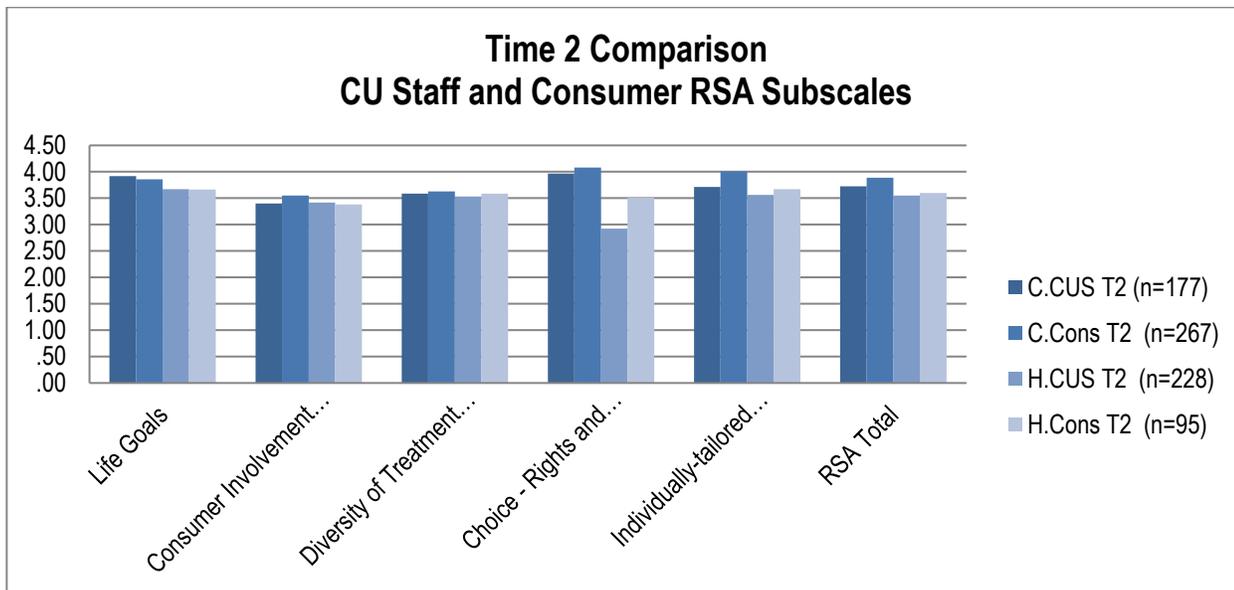
At Time 2, the clients at community center change units rated recovery orientation higher than the change unit staff members, except for the category "Life Goals." Alternatively, clients in the hospital change units rated two subscales lower than staff members: "Life Goals" and "Consumer Involvement and Recovery Education," while staff rated three subscales lower than patients for "Diversity of Treatment Options", "Choice - Rights and Respect" and "Individually-tailored Services." Ultimately, the only statistically significant differences between change unit staff and the change unit clients were for the higher scores given to "Individually-tailored Services" by center clients, and the higher overall RSA summary score for the center clients. The hospital patients scored "Choice – Rights and Respect" at a significantly higher score than the Change Unit staff.

Recovery Knowledge Inventory

The Recovery Knowledge Inventory was originally created for the statewide recovery training campaign in Connecticut as a way to assess training and education needs of practitioners. The instrument covers knowledge and personal attitudes in four domains: Roles and Responsibilities, Nonlinearity of the Recovery Process, The Roles of Self-Definition and Peers in Recovery, and Expectations regarding Recovery (Bedregal, O'Connell, & Davidson, 2006). A description of each of the subscales is provided in Appendix W.

The results of a comparison of Time 1 and Time 2 results for change unit staff members are presented in Table 11 and are shared in graphic format in Figure 4.

Table 11: Change Unit Staff RKI Subscales Time 1 and Time 2 by Organization Type

	C.CUS T1 (n=213)	C.CUS T2 (n= 173)	T Score	H.CUS T1 (n=273)	H.CUS T2 (n = 226)	TScore
Roles and Responsibilities	3.66	3.73	-1.05	3.15	3.07	1.02
Nonlinearity of the Recovery Process	2.37	2.49	-1.90	2.32	2.35	-.56
The Roles of Self-Definition and Peers	3.97	4.11**	-2.87	3.78	3.76	.36
Expectations Regarding Recovery	3.21	3.39*	-1.95	2.76	2.83	-.93
RKI Total	3.30	3.42**	-2.42	3.01	3.00	.25

Note: C=centers, H=hospitals, CUS=Change Unit Staff T1=Time 1 and T2=Time 2
*denotes statistical significance at p≤.05, ** statistical significance at p≤.01, and *** statistical significance at p≤.001

Figure 4: Change Unit Staff RKI Subscales Time 1 and Time 2 by Organization Type
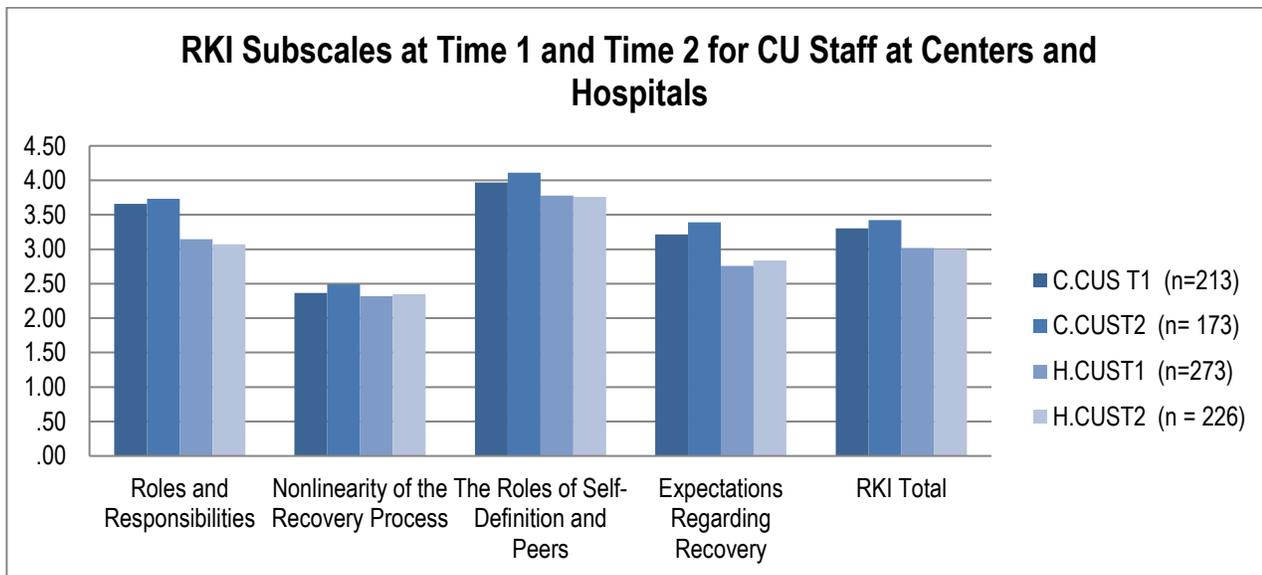
Following the RFLC process, the knowledge and attitudes of center change unit staff members improved. There were statistically significant increases for these staff members in two subscales: "The Roles of Self-Definition and Peers" and "Expectations Regarding Recovery". The RKI Summary Score increase was also statistically significant for the CUS at centers. The other two changes were not statistically significant, although showed an increase in understanding.

The changes over time for hospital change unit staff members had a more mixed pattern. None of the changes were large enough to be statistically significant, although the scores increased for the subscales "Nonlinearity of the Recovery Process" and "Expectations Regarding Recovery." Again, the decreases for the remaining two subscales, "Roles and Responsibilities" and "The Roles of Self Definition and Peers" were not statistically significant.

Conclusions, Recommendations and Future Directions

The Learning Community Process

One of the major premises upon which learning collaboratives are based is the assumption that the change teams are the experts in their own organization's and communities' processes, culture and history. The inputs described previously for the RFLC model were offered as resources, but data collection and analyses were performed on behalf of each team and beyond the commitments made in the application, no tools or processes were required to be used by the RFLC Coordinating Team. Inevitably, teams used tools and resources in different ways, had unique distributions of work within their teams, and approached their goals with distinctive methods. The RFLC Coordinating Team sought feedback consistently and offered relevant resources whenever possible.

Choosing Team Members and Teamwork

Non-traditional Teams

The application was designed to assist each Executive Sponsor in choosing appropriate team members. They were advised to consider both formal and informal leaders, people who were interested in the project, and representation from all stakeholders who would be involved in carrying out any process changes. One executive sponsor reported that s/he did not understand that the change team was going to be 'non-traditional' and so s/he had appointed the clinical supervisor as the change team leader, although that person did not have the experience or desire to serve in that role. This team eventually became quite participative as other members began contributing more to planning and implementation. The RFLC Coordinating Team resolved to be clear that the change teams are expected to be participatory across all levels of the organization and are open to changing membership as the focus of goals (and therefore relevant stakeholders) changes over time.

Hospital Team Members

Direct Care Staff Members

One of the deficiencies of the application process for hospitals was neglecting to include a recommendation to have a direct care staff team member. Psychiatric Nurse Assistants (PNAs) provide daily care to patients, and are therefore considered essential to successful culture change across hospitals. The lack of PNA team members was realized early in the process, but attempts to choose and invite PNA members following the Kick-Off Conference were not generally successful. In a few cases, there was a lack of interest on the part of the PNA, which was understandable considering the late nature of the invitation and the fact that they had not been able to attend the Kick-Off Conference. Probably related to that, several PNAs felt unable to leave the unit to attend change team meetings. Considering the potential for daily recovery coaching which could be provided by PNAs to hospital patients, they should be required change team members for the team's application.

Consumer Members

A requirement for change teams was to have or recruit consumer representation on the change team. This is not difficult for most hospitals as there were peer specialists or proactive patients who were interested in being a part of the change team. However, none of the patient change team members were able to attend the Kick-Off Conference.

The Kick-Off Conference was seen as extremely valuable by most of the participants. The conference provided a shared experience for the team, motivating speakers, visions of success, and hopefully the initiation of the "community" aspect of "learning community".

During the RFLC process, Psychiatric Nurse Assistants and patients did not participate in the Kick-Off Conference and this disparity should be addressed in any future learning collaborative efforts.

Team Change Activities

AIM Statements and Goals

Many teams were not able to complete construction of an AIM statement and set of goals at the Kick-Off Conference. One lesson learned by the RFLC Coordinating Team was that more time should have been set aside for team activities. The first individual site call focused on this essential step. The facilitator reviewed the organization's recovery profile with the change team leader (CTL) and executive sponsor (when relevant), with an exploration of both the 4-6 lowest scoring items and the 4-6 strongest items. A sample AIM and goals, with corresponding change activities, was shared with the CTL. By March, a majority of the teams had AIM statements, goals, and were using a change tool to track, and sometimes to plan, their activities.

Change Tools

The facilitator offered to provide a draft change tool using any sections of the plan which the team had produced. The teams then worked on honing their specific plans with a follow up on the next individual site call. For some teams, two different styles of change tools were provided. Each team then adapted a chosen tool to suit their purposes. Eight CTLs actively used, and valued, their Change Tools, while two CTLs used their Change Tools in response to the facilitator's request, and two CTLs did not use a Change Tool for planning or tracking activities. The UT facilitator found it easier to track activities and progress and discuss progress at for those teams actively using a Change Tool.

Recovery Plans

Each team examined their treatment plans and made changes that ranged from simple language changes to a full scale restructuring. Some of the more ambitious treatment plan re-design attempts became mired in competing or overlapping requirements from relevant agencies. Others sought assistance from the RFLC faculty, and valued the webinars provided by faculty on that subject. In general, the issue of treatment plan re-design was seen as essential and at the end of the RFLC process, many change teams were still making changes to this practice tool. They indicated a need to continue adapting, training for, and refining their recovery plans in order to support the clinical provision, and documentation of, recovery support.

Change Activities

The change activities undertaken by the RFLC teams were creative, varied, and fitting for the local context. However, the majority of the RFLC activities revolved around expanding peer support services, increasing numbers and integration of peer specialists, and supporting clinical staff to provide recovery support services. The change plans (and activities) were influenced by the change model in use by the team. Appendix Q shares the change model of each team, as well as the eventual changes and significant increases or decreases in scores on the Recovery Self Assessment at Time 2.

> [We need to have] other consumers involved and infused into the system as advocates, ambassadors, and consultants to help [the agency] in providing the best services possible (boards, action committees, staffing, etc.) [peer specialist]

On reflection, many Change Team Leaders shared that they still had opportunities to increase the influence of consumers in the day-to-day life of their organizations. The significant increase in the number of peer specialists serving at the RFLC organizations undoubtedly contributed to an increase in recovery orientation locally. However, the voices of clients and family members who are not volunteers or employees are essential to achieve the vision of recovery-oriented services. This remains an area for learning with these teams and for the State as it moves forward to achieve the vision of recovery and resilience for all.

Use and Value of Resources

It is understood that each team is participating in the learning community from within their own unique culture, history, and leadership styles. The RFLC model emphasizes the local expertise of the team, and this is also assumed to be true of each person in the organization. However, in some organizations this was a new way of 'making change' or of thinking about staff members.

Many of the participating change team members expressed appreciation for the amount and quality of support provided by Via Hope through the Recovery Focused Learning Community. Some teams requested and received special consultation and additional or specific on-site trainings. All teams requesting additional resources received good faith consideration and consultation from Via Hope about the relevant issue(s). The only change teams that, on reflection, wished they'd received additional help or changes in processes were those that did not make the relevant request. As many change team leaders expressed surprise at the amount of support provided through the RFLC process, it appears that extra emphasis may need to be used with new participants in this type of project on the responsiveness that is built in, and the responsibility for learning that is expected from each member.

The most valued resources provided through the RFLC, as reported by the Change Team Leaders, were the Kick-Off Conference, followed by on-site technical assistance, and the individual site calls.

Unique Organizational Contexts

It is understood that each team is participating in the learning community from within their own unique culture, history, and leadership styles. The RFLC model emphasizes the local expertise of the team, and this is also assumed to be true of each person in the organization. However, in some organizations this is a new way of 'making change' or of thinking about staff members. At least one change team leader did not feel prepared to lead that type of team. More than one CTL had to be reminded to check back in with his/her Executive Sponsor (ES) when s/he had a difficult time getting change team members to meetings. They acted as if that they didn't have sufficient authority to pull people together. Once they checked with the ES, they understood how 'supported' they actually were by the leadership. In addition, one Executive Sponsor critiqued the participative All Teams Calls as being 'too quiet'. However, she did not see it as her responsibility as a RFLC participant to take action to improve participation, while in contrast, other members exhibited the ownership needed to ask questions and share experiences.

Data Collection

Time 1

Notwithstanding a compressed timeline, the RFLC teams were able to participate in the UT-CSWR team data collection. Initial staff surveys were distributed with the sponsorship of the Executive Sponsors prior to the Kick-Off Conference. Response rates were based on the number of staff expected to complete the survey as provided by the Change Team Leader (CTL). Response rates for hospitals varied from 52% to 141%. As most of the hospitals distributed the staff surveys to the entire organization and included Psychiatric Nurse Assistants, the total number of respondents was 1,596. Apparently, in many cases surveys were forwarded or photocopied to result in a response rate of more than 100% for three hospitals. The community mental health centers' initial response rates ranged from 44% to 93%, with a total survey sample of 839.

The RFLC Coordinating Team wanted to be guided in the process by consumers. Therefore it was felt to be essential to collect parallel Recovery Self Assessment data from change unit clients. Following various discussions with the Institutional Review Boards of the Department of State Health Services and the University of Texas, it was determined that all data collection relating

to the RFLC process was for purposes of quality improvement. This enabled data collection from relevant consumers, including hospital patients, without the requirement of IRB review.

Collection of these data also required the assistance of the change teams, so the first data collection from clients was later in the timeline following the initial staff collection. The change teams made data collection plans that focused on comfort, privacy, and choice. The ideal was to have peer specialists assist clients in completing the surveys, but plans were adjusted to resources, physical layout, schedule, clients' needs, and availability of peers. A total of 559 consumer surveys were collected at Time 1.

Time 2

The second round of data collection for staff members and clients was as late as possible in the RFLC process, with collection of staff data just prior to the Wrap Up Conference, and collection of client data immediately following the staff. There were reported staff shortages in the late summer and with preparation for the Wrap Up Conference, both staff and client data collection did not reach the number accomplished during the initial data collections. Time 2 center staff survey respondents numbered 608 while the hospital staff surveys numbered 1,065. Together, peer specialists or other members of the change teams collected 362 client surveys at Time 2.

Methods

The online staff surveys were user friendly, and facilitated data analyses by producing spreadsheets with collected data. The paper surveys were photocopied and mailed from Austin, distributed and collected by the change team, with data entered later by a research assistant. The initial paper surveys were printed on both sides to save paper. However, when staff members made photocopies, they did not always ensure both sides were copied. This resulted in a few surveys with large sections of missing data.

Online surveys should be used whenever possible to save resources and work for both change teams and researchers. In rural areas, and especially in large hospitals, many staff members do not have adequate access to computers. In addition, clients did not have access to the online surveys at any of the sites. A delay in collecting initial client surveys was helpful as the UT-CSWR team was able to consult the change teams and have them plan the most appropriate methods for each site. The distribution of paper surveys and collection of data would not have been possible without the assistance of the change team, and in particular, peers and peer specialists.

RFLC Timeline

The RFLC change teams each made progress towards improving recovery orientation and increasing peer support services within the scheduled period. Almost every change team leader commented on the amount of progress that they had made in a very short period. They also commented on the intensity of the work required and a feeling of 'overload' at times. A review of learning collaborative experience supports 2-3 face-to-face meetings and the intentional support of social exchange at these meetings to promote trust and learning within the community. Most of the high quality, data-driven learning collaboratives covered several years (Ayers et al., 2005) and had a focus on sustainability in the final years. The funding timelines and a desire to be successful within the funding cycle drove the RFLC schedule, and also supported the decision to provide extensive support for the RFLC members. A long term plan to support mental health providers in transforming the system to one that is recovery oriented would be preferable. Certainly any future learning collaboratives in Texas should build on lessons learned in the RFLC. The natural pace of building trust and learning as a community that is required to create deep and sustainable change should not be rushed.

Outcomes

The AIM identified by the RFLC Coordinating Group was: to build a recovery orientation that fosters, and is supported by, the use of peer support services in the Texas public mental health system. The goals chosen to indicate progress towards this AIM were:

1. organizations that participate in the Recovery-Focused Learning Community increase the number of peer specialist positions;
2. there is an increase in the recovery orientation of the change units of participating organizations, as measured by the Recovery Self Assessment data provided by staff and consumers; and
3. there is an increase in the knowledge of recovery principles of the staff in participating organizations, as demonstrated by a change in each organization's RKI scores.

Peer Specialist Positions

The RFLC change teams were successful in increasing the number of peer specialist employees from 22 to 45. Many peer specialists from the sites received certification training, obtained certification, and accessed additional trainings such as WRAP and Focus for Life. Additionally, most sites sent one representative to peer supervisor training through Via Hope. They often felt that the agency was better able to utilize peer specialists following the acquisition of this knowledge. Many returned from the training and prepared short trainings for other staff on the role of peer support. All participating sites expanded peer support services in one or more ways.

Recovery Orientation

One useful measure of change was considered to be the staff and consumer perspectives of recovery orientation, as shared via the Recovery Self Assessment Survey (RSA) at two different time points. The intermittent results were also shared with the change teams to assist in planning activities.

Staff Measures

Comparing change team staff RSA results (except in cases where there was no significant difference in the number of change team vs. other staff members) between the first and second administration, UT-CSWR looked for statistically significant differences. Over the eight month period, measured recovery orientation of the sites showed statistically significant changes in (one to three) subscales of the Recovery Self Assessment for twelve of the fifteen participating change units. Two participating sites had no statistically significant changes and one site did not collect sufficient data for analyses. The major area of improvement was recovery education and consumer involvement (for six of the 12 sites with significant changes). In addition, there were also both statistically significant negative and positive changes for "choice, rights and respect".

Consumer Measures

In general, both center and hospital change unit clients rated recovery orientation higher at Time 2 then those consumers completing the survey at Time 1.

Although all center scores were higher at Time 2, analyses revealed statistically significant differences in only two subscales: "Consumer Involvement and Recovery Education" and "Diversity of Treatment Options". Hospital consumers, on the other hand, perceived higher recovery orientation subscale scores at Time 2 related to four of the five subscales, although none of the changes were statistically significant.

With the second data collection for consumers and staff members occurring at almost the same time (August/September), UT-CSWR were able to compare staff and consumer perspectives of the change unit recovery orientation through the Recovery Self Assessment. For centers, consumers scored higher on four of the five subscales, with a significant difference on their perception on individually-tailored services. For hospitals, consumers rated three of the five subscales higher than staff, with a significantly higher score for their perception of choice, rights and respect. Staff members were mostly gratified to find consumers having a positive perception of recovery orientation. Change teams also were able to use specific findings to open a discussion with clients around topics of concern.

Changes in RSA Scores

In general, there were improvements in RSA-measured perceptions of recovery orientation over the RFLC process. All change team leaders felt that more improvements could be made with additional time investment, or a longer timeline.

Attitudes Towards, and Knowledge of, Recovery Principles

Any statistically significant change in either the hospital staff or the center staff Recovery Knowledge Inventory (RKI) scores over the nine month period of the RFLC would be indicative of results possibly related to the activities of the local change teams (including on-site trainings).

> 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.

Centers

Many centers showed significant increases on different subscales, which may be related to their change models, the existing culture, the use of resources and tools, the effectiveness of individual teamwork, and other complex factors. However, for the nine center sample, there were significant increases in the knowledge of recovery principles of the center change unit staff members for the topics "The Roles of Self-Definition and Peers" and "Expectations Regarding Recovery" in the data collected at Time 1 and Time 2.

Hospitals

When analyzing forensic and non-forensic hospitals separately, there were significant changes in the subscale "Roles and Responsibilities" for both samples. Forensic hospital change unit staff scores for this subscale decreased and non-forensic employees' scores increased significantly between Time 1 and Time 2. However, there were no statistically significant changes over time when measuring the larger general sample of hospital change unit employees' knowledge of, or attitudes towards, recovery principles using the RKI.

Limited Changes in RKI Scores

A consistent finding over time was notwithstanding any increases, the subscale "non-linearity of recovery" remained low among all organizations. There is a need for further recovery education for staff members, and possibly consumers regarding the unique and unpredictable nature of each person's recovery journey. Staff members also need to gain new skills in order to support persons in recovery as they plan, and reach, recovery goals. As staff members are able to witness increasing numbers of clients reaching recovery goals and finding their own places in the community, this score will naturally increase.

Change teams were able to initiate process, policy, educational, and sometimes cultural changes in their change units. It is probable that with more time to continue their work, or receive consultation, or arrange for further on-site trainings, they would show significant improvement in RKI scores for their staff members.

Conclusions

The members of the RFLC maintained a high level of participation and measurably increased some aspects of their provision of recovery support services within a supportive environment. The number of peer specialists serving at the participating organizations more than doubled (a 104% increase) in a nine month period. Statistically significant improvements in consumer involvement and recovery education subscale of the Recovery Self Assessment were produced at the change units for both centers and hospitals. In addition, other statistically significant changes (increase in diversity of treatment options and "choice – rights and respect" in centers and a significant decrease in "choice – rights and respect" for hospitals) show an impact on the perceptions of change unit staff in the nine month time period. Positive changes are welcome, but it should be considered that a negative change may indicate increased knowledge about recovery in staff who previously did not fully understand the concepts of recovery. With this possibility, any significant change is an indication of impact of the RFLC within a condensed schedule.

The majority of RFLC participants indicated satisfaction with the program and their own investment in the learning community activities. They were proud of the work done and changes accomplished. In addition, the learning community format and philosophy supported the sharing of lessons learned by individuals and organizations across the community. As a result of the increase in the ability of the RFLC community members to 'learn to learn together', recommendations that emerged from their experience were the recommendations of expert learning community members. Their recommendations should be considered in all future efforts at transformation of the public mental health system in Texas.

The learning community model is a resource-rich method for supporting organizational learning in participating agencies and for building the transformational systems change that will be necessary to "promote hope, build resilience, and foster recovery" (Texas Department of State Health Services, n.d.-a) throughout the Texas public behavioral health system.

Recommendations:

Lessons about Learning Communities

Consideration: The Kick-Off Conference was seen as extremely valuable by most of the participants. The conference provided a shared experience for the team, motivating speakers, visions of success, and hopefully the initiation of the "community" aspect of "learning community". During the RFLC, Psychiatric Nurse Assistants and patients did not participate in the Kick-Off Conference. In addition, over the course of the RFLC, at some hospitals, patients indicated an interest in training as peer specialists and providing volunteer peer support services to others.

Recommendation: For hospitals to access the change team contributions which could be made by PNAs and long-stay patients, another model for on-site learning community initiation could be considered. In addition, on-site peer specialist training could be considered for an innovative hospital with motivated staff and patients.

Consideration: Teams (and individuals) had different levels of comfort with experimentation and with asking for help. Some teams requested extra on-site trainings, and received them. In contrast, one Change Team Leader reported at the end of the project "I wish my executive sponsor had been able to sit in on the Individual Site Calls". Other teams heard the message that was allowed, if not encouraged.

Recommendation: In the future send repeated messages about partnership and the necessity of two-way giving of feedback. It is assumed that a longer term learning community would build the level of trust for these messages to be received and acted upon. In any case, ensure this message is sent early and often.

Consideration: One of the deficiencies of the application process for hospitals was neglecting to include a recommendation to have a direct care staff team member. Psychiatric Nurse Assistants (PNAs) provide daily care to patients, and are therefore considered essential to successful culture change across hospitals.

Recommendation: Considering the potential for daily recovery coaching which could be provided by PNAs to hospital patients, they should be included as required change team members for the team's application.

Consideration: As part of the RFLC process, the teams created their own AIM statements, and goals. Upon creation of these organizing devices, the change activities of the team became more focused and easier to track. Eight of the fifteen RFLC change teams found it helpful to plan and track change activities using a form of the Change Tool. The UT facilitator also found it easier to track activities and progress for those teams that were actively using a Change Tool.

Recommendation: Include the intention to create useful tools as an expectation of participation in future learning communities. Obtain assistance from LC members in their creation and use.

Consideration: Change teams across the RFLC indicated that they would benefit from communication and technical assistance from members of change teams from other locations.

Recommendation: Create more user-friendly ways to increase opportunities for communication among learning community members and request assistance of specific members to share their success stories and areas of expertise.

Consideration: Consumers on hospital change teams cannot attend conferences with other team members.

Recommendation: Allow consumers to participate to the greatest extent possible. For hospitals, this may require the use of technology or possibly an on-site visit, or an increase in the number of on-site visits.

Consideration: Organizations have their own unique culture and leadership styles, which at times are not as comfortable with the participatory nature of change team activities as promoted by the learning community model.

Recommendation: Emphasize the non-traditional nature of team learning used with the learning community model and check for understanding with executive sponsors prior to final participant decisions.

Consideration: Change teams across the RFLC indicated that they would like more time to work together in a facilitated fashion at the Kick-Off Conference.

Recommendation 1: Create time, space, and support at the Kick-Off Conference (or other type of Initial Activity) for teams to accomplish work together.
Recommendation 2: Increase interaction/experiential activities at Kick-Off conference.

Consideration: One participant at the Kick-Off Conference noted the lack of activities set aside particularly for the peer specialists attending.

Recommendation: At every meeting opportunity planners should include peer-focused meetings and activities. This would serve to emphasize the importance of the role, as well as provide peer support to those attendees. A statewide network of peer-to-peer connections would also support further system change.

Consideration: The RFLC's 15 teams required a consistently high level of attention and care. Although all teams expressed satisfaction with their participation in the RFLC, the teams were not all able to sustain the same level of change team activity within the planned schedule. The RFLC had 2 full time staff members, a large faculty, and 4-5 part time staff. Although the required work was accomplished, the initiative required workloads that went beyond a reasonable capacity of the individuals directly involved. Five to eight teams might have been more appropriate for the existing staff resources.

Recommendation: For a highly-resourced model of a learning community such as the one used for the RFLC, the number of teams should be kept to a number that corresponds to the staff support coverage. Future decisions on team applications should be made with an understanding that the number of teams accepted can be realistically supported by the capacity of the expected staff team.

Collection of Data Measuring Quality of Recovery Support Services

Consideration: The executive sponsors assisted with planning the staff data collection. Wherever possible, online surveys were used. However, in rural areas, and especially in large hospitals, many staff members do not have adequate access to computers, so paper surveys were used. The process was more onerous and took longer for paper surveys. The change teams assisted in the collection of data from consumers and used peer specialists' assistance wherever possible. The change teams made data collection plans that focused on comfort, privacy, and choice, and plans were adjusted to resources, physical layout, schedule, clients' needs, and availability of peers.

Recommendation: Online surveys should be used whenever possible to save resources and work for both change teams and researchers. In rural areas, and especially in large hospitals, however, many staff members do not have adequate access to computers. The assistance of change teams in planning and implementing site-appropriate data collection was valuable and is recommended for future data collection whenever possible.

Consideration: Use of the Persons in Recovery version of the Recovery Self Assessment was greatly assisted when peer specialists helped with distribution and collection. With an increasing number of peer specialists serving in public mental health service providers, this should improve data collection and increase comfort of clients with this type of data. However, consumers and community members alike are powerfully affected by the sharing of recovery stories.

Recommendation: Future data collection efforts should include interviews or focus groups with clients to allow this type of data to be considered when assessing the quality of recovery support services being provided. Again, these efforts could be supported by local peer specialists.

Consideration: Most of the high quality, data-driven learning collaboratives required that the teams collect data to guide their own change activities and show outcomes (Ayers et al., 2005). However, considering the short timeline and the depth of data collection desired, the RFLC coordinating team had UT-CSWR collect data to assist the teams. Following the provision of mid-point reports to all 15 teams, only one CTL requested a phone call with UT-CSWR to discuss the findings.

Recommendation: Continue to include team needs in planning of data collection. Perhaps include an All Teams Call presentation, or module for change teams presenting examples of teams using data to achieve results. Another possibility is to coach Change Team Leaders and Executive Sponsors on ways to use data in support of change efforts.

Continuing Systems Change in the Texas Public Mental Health System

Learning Communities offer a way for participating organizations to become more nimble

Consideration: The RFLC Executive Sponsors' greatest concerns were listed as: 1) clients/outcomes/quality of services, 2) staff retention and development, 3) availability of peer specialists/recovery orientation of agency, 4) funding cuts/lack of financial support, 5) organizational efficiency and compliance, 6) capacity, and 7) stigma/justice system. The most frequently mentioned challenges related to staff retention and development and this is likely to remain a challenge for the foreseeable future.

Recommendation: Learning communities are an effective way to deal with multiple needs that are affected by or related to inadequate resources. The engagement of a diverse team of employees to solve problems, increase quality, and create recovery outcomes for persons they serve also can be related to the development of locally relevant new knowledge and to improved staff morale. Learning communities should be considered an important element in planning for long term system change, as well as responding to sudden environmental changes.

Consideration: Most of the high quality, data-driven learning collaboratives had timelines covering several years (Ayers et al., 2005) and had a focus on sustainability in the final years. The funding timelines and a desire to be successful within the funding cycle drove the RFLC schedule, and also supported the decision to provide extensive support for the RFLC members. Although proud of their accomplishments, many change team leaders regretted the short timeline.

Recommendation 1: A long term plan is needed to support mental health providers in transforming the system to one that is recovery oriented.

Recommendation 2: The natural pace of building trust and learning in a learning community should not be rushed if the desire is to create deep and sustainable change. Consideration by the State of longer-term learning community projects is encouraged.

Recommendation 3: In addition, to build on the momentum of the participating RFLC agencies, it is recommended to provide the RFLC teams with different avenues (and levels of intensity) for participation in the future system change efforts across Texas. Each team will be able to provide unique leadership in local and statewide efforts. They are likely to consider different levels of commitment as they learn more about the statewide drive to create systems change.

Consideration: The CTLs reported that the most valued RFLC resources were the Kick-Off Conference, followed by on-site technical assistance, the individual site calls, and Via Hope resources. For many teams, the All Teams Calls were not as valued. The literature on collaborative learning supports the importance of cross-team learning and sharing. However, it also acknowledges the need for more face-to-face meetings in the interests of building necessary trust. Considering the resources available for further system work, an increase in face-to-face meetings is not likely. Also, some RFLC members requested the opportunity to communicate with each other following the end of the project.

Recommendation: Create a way to test multiple models of 'learning communities' for Texas. Considering the inability for all of the hospital change team members (patients) to attend out of town meetings, assess the effectiveness of a more local approach: building local learning networks around the topic of recovery. Also consider increasing the use of conference calls and webinars for a widespread learning community. Test models with more or less face-to-face time for the development of trust within the learning community members.

Leadership

Consideration: The most common need or plan identified was training (including CPS, peer supervisor, and recovery skills). The second most requested support was consultation, and, specifically, consultation provided on-site. The respondents then cited: continued communication with other RFLC members, continuation of all or part of the RFLC program, DSHS leadership and policy support, and finally, money. All the teams anticipated continuing the work.

Recommendation: As the State continues its efforts to transform the mental health system, the plans should include continuing development of the current RFLC teams in ways that fit with their needs. The RFLC teams exhibited leadership and continue to learn about recovery services. They comprise a pool of potential leaders for the State of Texas in its recovery diffusion efforts.

Learning Communities provide new ways to train staff across the state as 'participants in change work'

Consideration: Via Hope provided a travel / lodging stipend to offset most of the costs for the teams to attend both the Kick-Off and Wrap-Up conferences in Austin. The most frequently mentioned challenge of the Executive Sponsors of the RFLC teams was "staff retention and development", and there is a question whether any of the teams could have participated without the financial support enabling all RFLC activities, especially the face-to-face meetings.

Recommendation: There will be a need for further financial support to enable the local change teams from LMHAs and hospitals to fully participate in any future learning communities. One possibility is that as DSHS moves further towards its vision of recovery and resiliency for all, they could encourage LMHAs and hospitals to use their training budgets to support participating in these types of initiative as opposed to 'training as usual'. DSHS could also act as a role model in pursuing learning community models to create powerful changes within its own system.

Consideration: DSHS is not always in a position to react quickly to unique issues arising from the field in learning community projects.

Recommendation: Assemble a DSHS work group to do parallel work to the learning communities, and provide responses to requests for advice or support coming from these types of projects within one week.

Need for statewide recovery diffusion efforts (and selected pilot projects)

Consideration: All the RFLC change teams began the process of creating documentation for recovery planning. They see this as an essential tool in the provision and documentation of recovery support services by their clinicians. Many participants requested additional consultation for this work.

Recommendation: Creation of recovery planning processes and documentation for behavioral health providers across the State would add impetus to the system changes necessary to provide recovery support services in a consistent manner. A recommended next step for this system change should include a pilot project through which intensive training and coaching on person-centered recovery planning could be provided to sites in a learning project. Upon completion of this pilot, lessons would be used to create a next cohort of learning organizations.

Consideration: In 2006, the Committee on Crossing the Quality Chasm: Adaptation to Mental Health Addictive Disorders recommended that the Chronic Care Model be used in agencies caring for persons in recovery with mental illness and addiction in order to improve coordination of their care, in addition to other aspects of quality assurance.

Recommendation: A recommended next step for this system change should include a pilot project within an innovative center or a small group of innovative centers to use the Chronic Care Model as an organizing guide for process improvement efforts relating to recovery support services

Consideration: On reflection, many Change Team Leaders shared that they still had opportunities to increase the influence of consumers in the day-to-day life of their organizations. The voices of clients and family members who are not volunteers or employees are essential to achieve the vision of recovery-oriented services.

Recommendation: The RFLC teams and others in the State could learn more about how to increase the voices and influence of clients and family members on all aspects of the care provided by an organization. This remains an area for learning with these teams and for the State as it moves forward to achieve the vision of recovery and resilience for all. One possibility is to create a theme-based short term project, support existing RFLC members in some way so they can continue to work on this aspect of care, or include it as a major focus of a future learning community.

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