

East Texas Coalition for Mental Health Recovery

Program Evaluation Report
(2010-2014)

H. Stephen Cooper, Ph.D., LCSW
Freddie L. Avant, Ph.D., LMSW-AP, ACSW, C-SSWS



ACKNOWLEDGEMENTS

The authors gratefully acknowledge the Hogg Foundation for Mental Health for their financial support of the East Texas Coalition for Mental Health Recovery and the commitment of the East Texas Behavioral Health Network's administration and members. The success of this project is a direct result of assistance from many people, including Dr. Michele Guzmán (Hogg Foundation), Stephany Bryan (Hogg Foundation), Tammy Heinz (Hogg Foundation), Jim Lemon (ETCMHR), Tuesday Marler (ETCMHR), Gary Brameltt (ETBHN), and Terry Reeder (Burke Center). The authors appreciate the assistance provided by the following researchers: Dr. Tiffany Bice-Wigington (interviews and focus groups), Dr. Kim Rich-Rice (interviews and focus groups), Dr. Mark R. Ludorf (TRAG data and consumer outcomes), and Alicia Moss (transcription and data entry). Finally, the authors would like to thank the members of the East Texas Coalition for Mental Health Recovery and East Texas Behavioral Health Network for taking time from their busy schedules to share their valuable opinions.

©2014 by H. Stephen Cooper & East Texas Behavioral Health Network.

All Rights Reserved.

TABLE OF CONTENTS

INTRODUCTION	1
ETCMHR DEVELOPMENT PROCESS	3
Methodology	3
Participants and Sampling	3
Measurement	3
Design and Data Collection	4
Limitations	4
Results	5
Domain and Statement Scores	5
Comparison by Evaluation Year	9
Narrative Questions	10
RECOVERY ORIENTATION OF ETCMHR	13
Methodology	13
Participants and Sampling	13
Measurement	13
Design and Data Collection	15
Limitations	15
Results	15
AACP ROSE	15
RSA-R	17
Narrative Questions	18
A SNAPSHOT OF THE PEER SPECIALISTS (YEAR ONE)	22
Methodology	22
Participants and Sampling	22
Measurement	22
Design and Data Collection	23
Limitations	23
Results	23
Job Description Questionnaire	23
Social Support Scale	24
A SNAPSHOT OF THE PEER SPECIALISTS (YEARS TWO & THREE)	26
Methodology	26
Participants and Sampling	26
Measurement	26
Design and Data Collection	27
Limitations	27
Results	28

Descriptive Analysis.....	28
Group Comparisons.....	29
RECOVERY EXPERIENCES OF THE PEER SPECIALISTS	30
Methodology	30
Participants and Sampling.....	30
Design and Data Collection	30
Results.....	31
Impact of Recovery	31
Looking Forward	42
ETCMHR’s Impact on the Recovery Process	47
RECRUITING PEER SPECIALISTS.....	56
Methodology	56
Participants and Sampling.....	56
Design and Data Collection	56
Results.....	57
Recruiting Peer Specialists.....	57
Transitioning to the Role of Peer Specialist	60
Providing Peer-to-Peer Support Services	62
OUTPUTS AND OUTCOMES FOR CONSUMERS	66
Methodology	66
Participants and Sampling.....	66
Measurement.....	67
Design and Data Collection	67
Limitations	67
Results.....	67
Exploratory Analyses	67
PSRS, BNSA, BDSS and QIDS	68
Peer Interactions and Facility Visits	69
Frequency of Peer Interactions and Facility Visits.....	69
DISCUSSION.....	70
East Texas Coalition for Mental Health Recovery	70
Local Mental Health Authorities	71
Understanding Recovery	72
Recruiting Peer Specialists	73
Outcomes for Peer Specialists	75
Outputs and Outcomes for Consumers	75
Outputs	75
Outcomes.....	76

CONCLUSION.....	78
REFERENCES.....	79
APPENDIX A - ETCMHR DEVELOPMENT PROCESS	81
Demographic Information for Participants	81
Year One	81
Year Two	81
Year Three	81
APPENDIX B - RECOVERY ORIENTATION OF ETCMHR	82
Demographic Information for Participants	82
Results.....	84
AACP ROSE	84
RSA-R.....	86
APPENDIX C - A SNAPSHOT OF THE PEER SPECIALISTS	88
Demographic Information for Participants	88
Year One	88
Years Two and Three	89
Results.....	92
APPENDIX D - RECOVERY EXPERIENCES OF THE PEER SPECIALISTS.....	93
Demographic Information for Participants	93
Group 1.....	93
Group 2.....	93
Interview Questions	95
Year Two - Initial Interview with Group 1 Peers.....	95
Year Three - Initial Interview with Group 2 Peers.....	96
Year Three - Follow-up Interview with Group 1 Peers.....	96
APPENDIX E - RECRUITING PEER SPECIALISTS.....	97
Demographic Information for Participants	97
Individual Characteristics	97
Employment Related Characteristics	97

INTRODUCTION

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

The primary goal of this initiative was to provide peer partners who are skilled, knowledgeable, and trained in recovery, in hopes of assisting the mental health system in East Texas with improving its outcomes and understanding of recovery and wellness. Along these lines, ETCMHR has spent the past four years focusing on the development of a learning community in which consumers and their families can share their experiences, learn from one another, and come together to strengthen recovery and wellness resources in the region. ETCMHR highlights a renewed commitment to consumer led recovery and wellness, provides the structure and accountability mechanisms to measure and assess progress, and provides a means to sustain progress. It also serves as an anchor for each participating entity's commitment to wellness and recovery during a time of significant challenges in the delivery of mental health services. Furthermore, it is a mechanism for collaborative learning where participants can work together and learn from each other as they develop this system. More importantly, ETCMHR has and continues to recruit and train consumers to become advocates and peer specialists¹, thus adding an important component to mental health services in the region.

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

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

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

the same process and could serve as a source of support. The quarterly face-to-face meetings typically included a half-day of WRAP related activities and a day of activities centered on the development of ETCMHR, as well as addressing challenges to providing peer support services within the LMHAs and larger region. Finally, the consumers participated in monthly conference calls and ongoing voluntary activities such as attending conferences and trainings (e.g., WRAP 101 and Respect Institute) and speaking at relevant conferences.

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

In order to assist ETCMHR in evaluating its efforts, the authors worked closely with the Hogg Foundation to design an evaluation plan consisting of six components. The first two components focus on the collaborative process employed in the development of ETCMHR and its orientation to recovery. Specifically, the *Working Together: A Profile of Collaboration* instrument was used to identify members' perceptions about the following aspects of the collaborative process: history, context, structure, membership, process, decision-making and results of collaborative efforts. Organizational orientation to recovery was examined during years two and three with the AACP ROSE and RSA-R, respectively. In the first grant year, the third component examined the job functions and social support provided to peers. The focus changed in years two and three to understanding where the peer specialists were in the recovery process, which employed the MHRM. The fourth component sought to develop an understanding of the recovery experiences of peer specialists through individual interviews. The fifth component employed focus group meetings with peer specialists to explore the development of an identification and recruitment process for peer specialists. The last component of the evaluation involved a preliminary examination of outcomes related to peer support services. The methodology and results for each component are presented in the following report, as well as a discussion of the results and their implications.

ETCMHR DEVELOPMENT PROCESS

One of the primary goals of the Hogg Foundation's initiative was to develop a leadership network that would strengthen recovery and wellness related resources in the East Texas region. The first component of the evaluation focuses on the collaborative process employed in the development of ETCMHR. Specifically, the study sought to answer the following questions:

1. What is the nature of the collaborative efforts of the ETCMHR?
2. What are the members' perceptions of areas for improvement, effectiveness of the collaborative efforts, and incentives for participation?

In addition to the above questions, the researchers also examined changes in perceptions of the coalition's collaborative efforts over the course of the first three years of the grant. The methodology and results of the collaboration profile are presented below. A discussion of the results and their implications is provided later in the report.

Methodology

Participants and Sampling

ETCMHR operates under the auspices of ETBHN, an organization comprised of 11 LMHAs that deliver community-based mental health services to 70 Texas counties. The member LMHAs are ACCESS (Anderson Cherokee Community Enrichment Services), Andrews Center, Bluebonnet Trails MHMR, Burke Center, Community Healthcore, Gulf Bend Center, Gulf Coast Center, Lakes Regional MHMR, Pecan Valley MHMR, Spindletop MHMR, and Tri-County Services. ETBHN is governed by the Regional Oversight Committee (ROC), which consists of the CEOs of member LMHAs and one at large member who represents consumers of mental health services. All of the members of the ROC were asked to participate in the study during years one, two and three. ETCMHR's representative from RSH was asked to participate during year three of the evaluation. Demographic information for the participants is presented in Appendix A - ETCMHR Development Process. The number of participants for evaluation years one, two and three are as follows: 10 of 12 (83.3% response rate), 5 of 12 (41.6% response rate), and 8 of 13 (74%), respectively. It is important to note that ten instruments were returned during the third year, but two were excluded because they were not completed by the organization's representative to the ROC.

Measurement

The study employed *Working Together: A Profile of Collaboration* to gather the data, which was originally developed by the Omni Institute (1992) based on the research presented by Chrislip and Larson (1994). The original instrument consists of 40 questions that are grouped into five domains or subscales based on their conceptual similarity. The five domains are: Context of the Collaboration, Structure of the Collaboration, Collaboration Members, Collaboration Process and Results of the Collaboration. The version utilized in this study was modified by Streeter and Rivaux (2002) for their evaluation of the Georgetown Safe Schools/Health Students Initiative (Georgetown, Texas). Specifically, they added nine questions that are grouped into two domains, The History of Collaboration and Collaboration Decision-Making (Streeter & Rivaux, 2002; Streeter, Rivaux, & Lee, 2002). Each of the aforementioned domains consist of statements that participants respond to using a 1 to 4 Likert scale (1 = False, 2 = More false than true, 3 = More true than false, and 4 = True). The instrument utilized during year one included five open-ended questions that were designed to

collect additional information about the network's activities and impact. These questions were expanded during year two, resulting in twelve open-ended questions.

While the original instrument is said to have face validity (Omni Institute, n.d.) and appears to have content validity, it seems that efforts to establish empirical validity have not been undertaken. However, the Omni Institute (n.d.) has tested the internal consistency reliability of the instrument with Cronbach's Alpha. The Omni Institute's (n.d.) analysis yielded the following scores: Context of the Collaboration ($\alpha = 0.46$), Structure of the Collaboration ($\alpha = 0.77$), Collaboration Members ($\alpha = 0.87$), Collaboration Process ($\alpha = 0.85$), and Results of the Collaboration ($\alpha = 0.80$). Typically, an Alpha coefficient of .70 or higher is considered to be reliable. Based on this criterion, four of the five domains have an acceptable degree of internal consistency. Streeter et al. (2002) also examined the internal consistency reliability of the instrument and found that the History of the Collaboration was not internally consistent ($\alpha = 0.47$). However, they found that Collaboration Decision-Making was internally consistent ($\alpha = 0.89$). Evaluation studies conducted by Cooper & Avant (2007, 2009, 2010, 2011) with the Rural East Texas Health Network (RETHN) yielded similar internal consistency reliability scores. The number of participants in the current study did not allow for the calculation of Alpha coefficients. One should be mindful of this when interpreting the results.

Before discussing design and data collection, it is important to point out the benefits of the *Working Together* instrument for evaluating ETCMHR. Much of its value lies in the ability to examine the extent of the interaction or relationships among the participants in achieving the objectives and goals of ETCMHR. This approach to evaluation is of particular importance to ETCMHR, especially given the group's emphasis on addressing issues in rural areas by building relationships among individuals, agencies and community groups. One of the dominant factors in determining successful outcomes of collaboration in rural areas is the significance of working relationships. Some projects in rural areas have not been successful because they overlooked the interaction between the rural environment and other systems that influence outcomes. Ideally, understanding the extent of the collaboration among participants will translate into a better understanding of the issues and help shape activities to improve service delivery.

Design and Data Collection

The investigators utilized a cross-sectional design to evaluate ETCMHR's collaborative efforts. ETBHN's Executive Director distributed the instrument to the participants via the U.S. Postal Service during the summer of years one, two, and three. Specifically, each potential participant received a packet containing a consent form, instrument, and self-addressed postage paid envelope. The participants were asked to complete the instrument and return it to the investigators via the postage paid envelope. The data was collected in a manner that allowed respondents to remain anonymous. All respondents were contacted on at least one occasion by ETBHN's Executive Director as a reminder to complete and return the instrument.

Limitations

When reviewing the results, it is important to be mindful of the limitations. The small sample size in all three years and low response rate in year two limited the examination of instrument reliability. The low response rate also raises questions about the representativeness of the sample and limits generalization of the year two results. Furthermore, questions regarding the reliability of the subscales for History of the Collaboration and Context of the Collaboration have been raised by previous studies. Whereas the instruments were to be completed by members of the

ROC, there were at least two instances of the responsibility being assigned to another individual during year three. Doing so could contribute to inaccuracies in the information provided. Finally, assumptions were violated for some of the statistical tests, requiring one to be cautious when interpreting the results (specific instances of violations are noted in the results section).

Results

As previously discussed, the *Working Together* instrument consists of 49 statements that are grouped into 7 subsets or domains. Subjects were asked to respond to each statement using the following Likert scale: 1 = False, 2 = More false than true, 3 = More true than false, and 4 = True. Once the instruments were received and the data was entered into SPSS, the mean scores and standard deviations for all participants were calculated for each statement, as well as the seven domains. The responses to the narrative items were examined via thematic analysis. The results are presented in the following sections. The implications of the results are discussed later in the report.

Domain and Statement Scores

Each domain score represents the arithmetic mean or average of all the valid responses for the statements that constitute the domain. Specifically, the scores are summed and then divided by the number of valid responses. The scores/means range from 1 to 4 and are based on the Likert scale mentioned earlier. A smaller score indicates that respondents tended to perceive the statement as false and a larger score indicates that respondents tended to perceive the statement as true.

The standard deviation was also calculated for each domain and statement. The standard deviation is a measure of variability or dispersion that indicates the amount of variation among the scores. Another way of thinking about variation is as an indicator of how closely scores are grouped together (similar) or spread apart (dissimilar). The benefit of examining the standard deviation is that it allows us to consider the degree of difference among responses and how those differences may impact the mean. In terms of interpreting the standard deviation, a lower score indicates a greater degree of agreement or similarity among responses. On the other hand, a higher score indicates a lesser degree of agreement or similarity among responses.

The History of the Collaboration. The domain score for each of the evaluation years indicates that in general the respondents had a positive perception of the domain (see Table 1). Furthermore, the standard deviation score, which is less than 1 in each year, indicates a considerable amount of agreement among the respondents. In terms of the individual statements, the mean scores indicate that in general the respondents perceived statements 1, 2, 3, and 6 to be true (the mean is 3 or greater). As for statement 5, this was the case in year one and two, but not year three. More than likely, this is the result of the addition of new members to ETCMHR during the third funding year. While statement 4 tended to be perceived as more false than true, these responses make sense given the context of the project. For example, given the size of ETCMHR's region, it is difficult to know everyone professionally, much less personally (statement 4). Overall the standard deviation scores suggest agreement among the participants, with the exception of statement 5 (year two).

Table 1- The History of the Collaboration (Mean Scores)

Statement	Year One		Year Two		Year Three	
	\bar{X}^2	SD^3	\bar{X}	SD	\bar{X}	SD
1 Members have worked together in the past on joint projects	3.89	.333	4.00	.000	3.75	.463
2 Members have a history of valuing collaborative efforts	3.89	.333	4.00	.000	3.88	.354
3 Members knew one another professionally before becoming involved in this collaboration	3.44	1.01	3.40	.894	3.38	.916
4 Members knew one another personally before becoming involved in this collaboration	2.88	1.13	2.60	.548	2.75	.707
5 Organizations represented in the collaboration have a history of working with the same clients	3.00	1.01	3.52	1.50	2.63	1.19
6 In the past, organizations represented in the collaboration have shared funding and other resources	3.89	.333	4.00	.000	3.50	.535
<i>Domain Score</i>	<i>3.44</i>	<i>.621</i>	<i>3.55</i>	<i>.218</i>	<i>3.13</i>	<i>.449</i>

The Context of the Collaboration. The domain score for each of the evaluation years indicates that respondents perceived the domain as being true (see Table 2). Furthermore, the standard deviation score indicates a considerable amount of agreement among the respondents. In terms of the individual statements, the mean scores indicate that respondents perceived statements 7, 8 and 9 to be true. The standard deviation scores suggest a high degree of agreement among respondents. An exception to this occurs with statement 9 in year three, where the mean suggests that the issues are not as critical as in previous years. Whereas it is possible that the change in opinion is due to the addition of new members, the standard deviation suggests that respondents were in agreement. There also appears to be a decline in the perception that ETCMHR’s efforts are timely (statement 7).

Table 2- The Context of the Collaboration (Mean Scores)

Statement	Year One		Year Two		Year Three	
	\bar{X}	SD	\bar{X}	SD	\bar{X}	SD
7 Now is a good time to address the issue about which we are collaborating	3.89	.333	4.00	.000	3.50	.535
8 Our collaborative effort was started because certain individuals wanted to do something about this issue	3.44	.726	3.60	.548	3.63	.518
9 The situation is so critical, we must act now	3.00	.866	3.20	.447	2.88	.835
<i>Domain Score</i>	<i>3.44</i>	<i>.527</i>	<i>3.60</i>	<i>.279</i>	<i>3.33</i>	<i>.535</i>

The Structure of the Collaboration. The domain scores indicate that respondents perceived the domain as being true and the standard deviation scores suggest a considerable amount of agreement among the respondents (see Table 3). In terms of the individual statements, the mean scores indicate that respondents perceived statements 10 through 21 to be true.

Table 3- The Structure of the Collaboration (Mean Scores)

Statement	Year One		Year Two		Year Three	
	\bar{X}	SD	\bar{X}	SD	\bar{X}	SD
10 Our collaboration has access to credible information that supports problem solving and decision making	3.56	.527	3.80	.447	3.50	.535
11 Our group has access to the expertise necessary for effective meetings	3.67	.500	3.80	.447	3.63	.518

² \bar{X} = Mean

³ SD = Standard Deviation

Statement	Year One		Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
12 We have adequate physical facilities to support the collaborative efforts of the group and its sub-committees	4.00	.000	4.00	.000	3.75	.463
13 We have adequate staff assistance to plan and administer the collaborative effort	3.56	.726	3.60	.548	3.62	.518
14 The membership of our group includes those stakeholders affected by the issue	3.56	.527	3.80	.447	3.50	.926
15 Our membership is not dominated by any one group or sector	3.56	.527	3.80	.447	3.25	.707
16 Stakeholders have agreed to work together on this issue	3.56	.527	3.80	.447	3.75	.463
17 Stakeholders have agreed on what decisions will be made by the group	3.38	.518	3.80	.447	3.13	.991
18 Our group has set ground rules and norms about how we will work together	3.50	.535	3.20	.447	3.50	.535
19 We have a method for communicating the activities and decisions of the group to all members	3.78	.441	3.60	.548	3.50	.535
20 Our collaboration is organized in working sub-groups when necessary to attend to key performance areas	3.56	.527	3.40	.548	3.38	.744
21 There are clearly defined roles for group members	3.44	.527	3.20	.447	3.13	.354
<i>Domain Score</i>	<i>3.59</i>	<i>.245</i>	<i>3.65</i>	<i>.273</i>	<i>3.47</i>	<i>.321</i>

Collaboration Members. The domain scores indicate that respondents perceived the domain as being true and the standard deviation scores indicate a considerable amount of agreement among the respondents (see Table 4). The mean score for statement 22 in year two suggests that some members may have been perceived as oriented towards their own interests rather than those of the overall group. However, this could have been due to the low the response rate and appears to have improved during year three. The mean scores for statements 23 through 29 indicate that respondents perceived the statements to be true, which is especially encouraging given the large size of the geographic region served by ETCMHR. Overall, the results suggest that members are able to work together in the best interest of the network, as well as trust one another to do so. In terms of the standard deviation scores, respondents appear to agree on statements 22-29.

Table 4- Collaboration Members (Mean Scores)

Statement	Year One		Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
22 Members are more interested in getting a good group decision than improving the position of their home organization.	3.13	.354	2.80	.837	3.50	.535
23 Members are willing to let go of an idea for one that appears to have more merit	3.38	.518	3.40	.548	3.25	.463
24 Members have the communication skills necessary to help the group progress	3.63	.518	3.40	.548	3.38	.518
25 Members of the collaboration balance task and social needs so that the group can work comfortably and productively	3.38	.518	3.60	.548	3.38	.518
26 Members are effective liaisons between their home organizations and the group	3.50	.535	3.60	.548	3.63	.518
27 Members are willing to devote whatever effort is necessary to achieve the goals	3.00	.535	3.40	.548	3.38	.518
28 Members monitor the effectiveness of the process	3.13	.354	3.00	.707	3.13	.641
29 Members trust each other sufficiently to honestly and accurately share information, perceptions and feedback	3.38	.518	3.60	.548	3.88	.354
<i>Domain Score</i>	<i>3.31</i>	<i>.334</i>	<i>3.35</i>	<i>.324</i>	<i>3.44</i>	<i>.291</i>

The Collaboration Process. As with the previous domains, the domain scores indicate that respondents perceived the domain as being true and the standard deviation scores indicate a considerable amount of agreement among the respondents (see Table 5). In terms of the individual

statements, the mean scores indicate that respondents perceived statements 30 through 40 to be true and the standard deviation scores suggest that respondents tend to agree on the statements. The responses to these statements suggest that members are able to place the group's best interest before self-interest and that they share a common belief in the group's ability to bring about change. Finally, the responses to statements 37, 38 and 39 are also encouraging in that they indicate the presence of elements necessary for fostering trust, ownership and commitment.

Table 5- The Collaboration Process (Mean Scores)

Statement	Year One		Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
30 We frequently discuss how we are working together	3.50	.535	3.25	.500	3.38	.518
31 Divergent opinions are expressed and listened to	3.75	.463	3.75	.500	3.50	.535
32 The process we are engaged in is likely to have a real impact on the problem	3.38	.518	3.75	.500	3.38	.518
33 We have an effective decision making process	3.25	.463	3.50	.577	3.38	.518
34 The openness and credibility of the process help members set aside doubts or skepticism	3.38	.518	3.50	.577	3.50	.535
35 There are strong, recognized leaders who support this collaborative effort	3.75	.463	4.00	.000	3.75	.463
36 Those who are in positions of power or authority are willing to go along with our decisions or recommendations	3.29	.488	3.50	.577	3.50	.535
37 We set aside vested interests to achieve our common goal	3.14	.378	3.25	.500	3.25	.463
38 We have a strong concern for preserving a credible, open process	3.57	.535	3.50	.577	3.75	.463
39 We are inspired to be action-oriented	3.25	.463	3.75	.500	3.75	.463
40 We celebrate our group's successes as we move toward achieving the final goal	3.14	.690	3.25	.500	3.50	.535
<i>Domain Score</i>	<i>3.39</i>	<i>.319</i>	<i>3.55</i>	<i>.3397</i>	<i>3.51</i>	<i>.295</i>

Collaboration Decision-Making. The domain scores suggest that respondents perceived the domain as being true and the standard deviation scores indicate a considerable amount of agreement among the respondents (see Table 6). In terms of the individual statements, the mean scores indicate the respondents perceived statements 41, 42 and 43 to be true and the standard deviation scores suggest agreement among the respondents. The responses indicate that overall respondents are satisfied with the decision-making process. However, when examining statement 42, the mean for year two is higher than the mean for years one and three. Again, this could be due, at least in part, to the low response rate for year two.

Table 6- Collaboration Decision-Making (Mean Scores)

Statement	Year One		Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
41 Decisions are made by the group as a whole after all members have had an opportunity to present their views	3.44	.527	3.60	.548	3.50	.535
42 When important decisions require that members commit resources, representatives of the member organizations have the authority to make those commitments	3.44	.527	4.00	.000	3.38	.744
43 Decision-making for the collaboration includes input from staff at all levels of the member organizations (i.e., upper management, middle management, front-line staff)	3.11	.601	3.20	.837	3.38	.744
<i>Domain Score</i>	<i>3.33</i>	<i>.373</i>	<i>3.60</i>	<i>.365</i>	<i>3.42</i>	<i>.527</i>

The Results of the Collaboration. The domain scores indicate that respondents perceived the domain as being true and the standard deviation scores indicate agreement among the

respondents (see Table 7). The same held true for the individual statements, with the exception of statement 44. Specifically, the mean score for year three suggests the lack of measurable goals. Overall, the responses to these statements are especially encouraging given their importance to fostering trust, ownership, commitment and accountability.

Table 7- The Results of the Collaboration (Mean Scores)

Statement	Year One		Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
44 We have concrete measurable goals to judge the success of our collaboration	3.13	.354	3.40	.548	2.87	.641
45 We have identified interim goals to maintain the group's momentum	3.38	.518	3.20	.447	3.00	.756
46 There is an established method for monitoring performance and providing feedback on goal attainment	3.25	.707	3.20	.837	3.00	.535
47 Our group is effective in obtaining the resources it needs to accomplish its objectives	3.38	.518	3.20	.447	3.13	.354
48 Our group is willing to confront and resolve performance issues	3.50	.756	3.40	.548	3.13	.354
49 The time and effort of the collaboration is directed at obtaining the goals rather than keeping itself in business	3.38	.744	3.40	.548	3.25	.463
<i>Domain Score</i>	<i>3.33</i>	<i>.488</i>	<i>3.30</i>	<i>.447</i>	<i>3.06</i>	<i>.344</i>

Comparison by Evaluation Year

One-way ANOVAs were utilized to compare the mean domain scores for the data collected during years one, two and three. The main effects indicated the absence of a statistically significant difference among the evaluation years for each of the seven domains ($\alpha = .05$). The specific results for each domain are as follows:

- The History of Collaboration - $F(2,21) = .375$, $MSE = .093$, $p = .692$
- The Context of Collaboration - $F(2,21) = .459$, $MSE = .110$, $p = .639$
- The Structure of Collaboration - $F(2,21) = .747$, $MSE = .059$, $p = .487$
- Collaboration Members - $F(2,20) = .326$, $MSE = .032$, $p = .726$
- The Collaboration Process - $F(2,19) = .397$, $MSE = .042$, $p = .679$
- Collaboration Decision-Making - $F(2,21) = .607$, $MSE = .115$, $p = .555$
- The Results of the Collaboration - $F(2,20) = .909$, $MSE = .167$, $p = .420$

Whereas the assumption of homogeneity of variance was satisfied for each of the seven domains, the assumption of a normal distribution was violated for The History of the Collaboration and Collaboration Members. Given that these violations raise the possibility that the results could be due to the distribution of scores rather than differences in the means, the results for the identified domains should be interpreted with caution. The domain means for each of the three evaluation years are presented in Table 8.

Table 8- Comparison of the Domains by Evaluation Year (Mean Scores)

Domain	Year One		Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
The History of the Collaboration	3.44	.621	3.55	.218	3.13	.449
The Context of the Collaboration	3.44	.527	3.60	.279	3.33	.535
The Structure of the Collaboration	3.59	.245	3.65	.273	3.47	.321
Collaboration Members	3.31	.334	3.35	.324	3.44	.291
The Collaboration Process	3.39	.319	3.55	.3997	3.51	.295
Collaboration Decision-Making	3.33	.373	3.60	.365	3.42	.527
The Results of the Collaboration	3.33	.488	3.30	.447	3.06	.344

Narrative Questions

Participants were asked to respond to open-ended questions that provided them an opportunity to offer specific suggestions and ideas that could be used to evaluate the collaborative process and assist with achieving the desired outcomes of ETCMHR. The instrument for year one included five questions that solicited input regarding ETCMHR's strengths, areas for improvement, and participation. The instrument for years two and three addressed these areas, as well as the role of the Hogg Foundation in ETCMHR, replication of ETCMHR, the impact of the Hogg Foundation's efforts, and peer specialists' involvement with treatment teams. Once the instruments were completed, the responses for each question were aggregated and reviewed in order to identify the most frequent ideas and suggestions. Responses were then grouped by common theme and reviewed again for consistency with the related theme. A summary of the common themes, as well as unique ones, is provided below.

Strengths and areas of improvement. The key strength identified during years one and three was the **presence of relationships and trust among the coalition members** prior to embarking on the development of ETCMHR. Several participants noted that their relationships had been strengthened through positive group experiences. Other strengths included: open and honest communication among members, the relationships among peer specialists within the region, opportunities for training, and ETCMHR's commitment to keeping its focus on peer support and mental health recovery.

“The focus on recovery through strong peer support and peer involvement enables ETCMHR to stay focused on appropriate and viable recovery needs and issues.”

Finally, it is important to note that Jim Lemon, ETCMHR's first Peer Coordinator, was commended for his efforts in each of the three evaluation years, by both administrators and peer specialists.

The most common area for improvement identified during year one was **decision-making**. Specifically, suggestions focused on expediting the decision-making process and involving center staff in the process. Other suggestions included expanding collaborative efforts and providing additional funding and resources to support project planning and implementation. One participant mentioned the geographical distance among centers presented some challenges to interaction.

The suggested areas for improvement in year two shifted to focus primarily on the need for **additional resources and training**. In terms of resources, the primary concern centered on support for the provision of peer support services. For example, several comments noted the lack of funding sources for peer support services and the transition to a recovery model. Along these lines, several participants spoke to the importance of staff training related to peer support services and mental health recovery.

As for year three, responses tended to focus on two specific areas: the need to **involve the treatment team staff** (professional staff) in the process of transitioning to a recovery model and to **create opportunities for professional staff**

Areas for Improvement

“Additional funding, resources or more local trainers are needed to train a large population of persons with mental health issues to support the transition from the clinical model to the recovery model.”

and peer specialists to work together.

The next step is to help these people [treatment team staff] along and reinforce stronger networking and partnership between treatment teams and peers.

Other suggestions included developing a strategic plan to guide future efforts and the use of technology to allow consumers and peer specialists to participate in meetings.

Incentives for Participation

“Promoting wellness and recovery within our Local Mental Health Authority where the individuals can grow and become productive citizen with value in their lives.”

“ETCMHR offers expertise, resources, and networking that helps our organization move forward much quicker and effectively.”

“Our agency has established a goal to create and support service platforms that promote recovery and resiliency.... ETCMHR communication networks and training opportunities have been invaluable in moving this initiative forward.”

Participation. The majority of the comments from years one, two and three identified one or more of the following incentives for participation: **training opportunities, knowledge and resources.** All of these incentives were perceived as important to ETCMHR’s efforts to transition services to a recovery oriented model. Participants during year one also mentioned improvements in service delivery, cost savings, and information sharing, which participants felt were best achieved via collaboration.

As for increasing participation, questions were raised as to whether or not ETCMHR’s structure could support expansion. Several participants indicated that there were not enough resources to meet the demand for training. Others noted the substantial cost of travel for meetings. Suggestions for addressing these concerns included: strengthening efforts to educate members about the network and its purpose, utilizing teleconferencing to offset travel costs, and implementing a sustainability plan. It is not surprising that the concern about sustainability was not expressed until year three.

Role of the Hogg Foundation. The instrument employed in years two and three asked respondents to share their perceptions of the Hogg Foundation’s role in the development of ETCMHR. When examining responses from both years, the following roles were common: **financial, vision** (guidance), **technical assistance**, and **training**. One participant noted that as a result of the training made possible by the Hogg Foundation, “*many individuals with mental health issues have been able to take control over their illnesses and achieve their dreams of a productive lifestyle.*” Whereas most felt that the network would have eventually formed without assistance from the Hogg Foundation, there is an overwhelming consensus that their assistance expedited the process and has contributed greatly to ETCMHR’s success. For example,

Role of Hogg Foundation

“Because of ETCMHR... we have been able to achieve one of our long-range recovery goals, to develop and create certified peer specialists at our agency.”

“The recovery movement has been building steam for years. Some sort of coalition would have formulated, but not as geographically diverse as the Hogg Foundation has allowed. Hogg Foundation’s assistance has accelerated the movement’s growth. It would have been years down the road before ETCMHR could get to where it is now.”

It is important to note that a substantial number of the responses suggested a limited understanding of the Hogg Foundation’s role in and support of ETCMHR, especially at the grassroots level.

Replication. Respondents for years two and three were asked their opinions about what elements of the development process should be kept and discarded if the coalition were to be replicated in other areas of Texas. Overwhelmingly, respondents noted that the majority of the elements should not be changed. The **importance of existing relationships** and **consumer involvement** were mentioned specifically as elements to remain.

“The heavy focus on developing a grassroots network that was anchored in strengths based model was very powerful. Often the focus is on engagement of executive and senior staff that generates “white papers” and best practice models, but fails to engage peers and family in a meaningful way, so there is not system change. By utilizing empowerment strategies, ETCMHR has established a real peer system that can be expanded and enhanced over time that can lead to a significant system change.”

However, they did suggest the addition of efforts to involve staff in the process, such as training related to mental health recovery and peer specialists’ involvement in service delivery.

Impact. Respondents for years two and three were asked about the impact of ETCMHR on the delivery of peer support services and related policies. The year two respondents appeared to have a limited understanding of ETCMHR’s impact on either of these aspects. However, year three respondents were unanimous in their responses. They attributed ETCMHR with impacting service delivery by increasing the number of peer specialists in the region. In terms of policies, responses focused on changes in agency policy without mention of state level mental health policies. The changes in agency policy were most commonly related to the employment of peer specialists.

Treatment team. Ten of the eleven participants who responded to this item reported that peer specialists are treated as valued members of the treatment team. The following quotes exemplify their responses:

“All peer specialists are treated with dignity and respect, input is valued by peers, qualified mental health professionals, treating doctors, directors and Chief Officers.”

“Yes, absolutely integral member of team. Provide insight into recovery and ‘walked in their shoes.’ Gives hope and encouragement.”

“Peers are highly valued for their ability to help clients begin to understand that the locus of power change and recovery is them. Therapists and doctors assist but it is the clients themselves that are the only ones that actually make this shift occur.”

The one “no” included a comment that progress was being made toward integration. It should be noted that the participants’ perceptions regarding peer specialists’ integration with the treatment team are different from those of the peer specialists. These differences will be discussed later in the report.

RECOVERY ORIENTATION OF ETCMHR

During the course of planning the evaluation activities for the second funding year, the Hogg Foundation decided that it was interested in a preliminary examination of the recovery orientation of ETCMHR. The Hogg Foundation also wanted feedback from the peer specialists about their perceptions of the foundation's role in delivering peer support services in the East Texas region. The specific research questions are:

1. How do the peer specialists view the overall orientation of the LMHAs to recovery?
2. How do the peer specialists view the Hogg Foundation's role in the delivery of peer support services in the region?

During the second year, the first research question was investigated with the American Association of Community Psychiatrists Recovery Oriented Services Evaluation (AAP ROSE). The AAP ROSE was replaced by the Recovery Self-Assessment - Revised (RSA-R) for the year three evaluation. Both years employed the same set of open-ended questions to investigate the second research question. The methodology and results are detailed below. A discussion of the results and their implications is provided later in the report.

Methodology

Participants and Sampling

Year two. The year two participants consisted of peer specialists who were recruited during the first grant year. They are referred to as the Group 1 Peers. The study was conducted in conjunction with an ETCMHR training event that was open to all of the peer specialists who were involved with the coalition. The event was attended by 16 of the 22 peer specialists, all of who chose to participate in the study. Demographic information for the participants is presented in Appendix B - Recovery Orientation of ETCMHR.

Year three. The year three participants consisted of Group 1 Peers and peer specialists who were recruited during the second grant year (Group 2 Peers). The study was conducted in conjunction with two separate training events, one for each group. The first event was attended by Group 2 Peers, 15 of who chose to participate. The second event was attended by Group 1 Peers, 16 of who chose to participate. Unfortunately, peer specialists from RSH were unable to participate due to delays in the Texas Department of State Health Services' (TDSHS) IRB approval process. Demographic information for the participants is presented in Appendix B - Recovery Orientation of ETCMHR.

Measurement

The AAP ROSE was used during year two and the RSA-R during year three. Participants also responded to four narrative questions that were developed for this study.

AAP ROSE. The AAP ROSE is a self-report measure designed to measure an organization's orientation to mental health recovery and can be used to monitor progress toward developing a recovery oriented environment (Campbell-Orde, Chamberlin, Carpenter & Leff, 2005). The instrument is based on the AAP's (American Association of Community Psychiatrists) Guidelines for Recovery Oriented Services, which includes specific indicators for progress toward recovery orientation in the following three domains: administration, treatment and supports (AAP,

2011). The three domains and one additional domain, organizational culture, are measured by 46 items that are rated using the following 5 point Likert scale: strongly disagree (0), disagree (1), not sure (2), agree (3) and strongly agree (4). Each of the four domains can be treated as subscales (Campbell-Orde et al., 2005). There are no specific guidelines for scoring the instrument and interpreting the scores. In general, organizations that score higher are more likely to have positive recovery related outcomes (Campbell-Orde et al., 2005). It is important to note that the reliability and empirical validity of the AACP ROSE have yet to be studied. However, the measure does appear to have content validity. In terms of the current study, the internal consistency reliability of the overall instrument was determined using Cronbach's Alpha, which yielded an alpha coefficient of .98 ($n = 14$). The results for the subscales are as follows ($n = 16$): administration ($\alpha = .94$), treatment ($\alpha = .97$), supports ($\alpha = .92$), and organizational culture ($\alpha = .85$).

RSA-R. The RSA-R is another self-report instrument designed to measure an organization's orientation to mental health recovery. The original version (RSA) consists of 36 items that measure the following domains: life goals, involvement, diversity of treatment options, choice, and individually tailored services. The items are based on a five point Likert scale (1 = strongly disagree to 5 = strongly agree). In terms of psychometrics, the RSA is said to have face validity and internal consistency reliability based on Cronbach's alpha (life scales = .90, involvement = .87, diversity of treatment options = .83, choice = .76, and individually-tailored services = .76) (O'Connell, Tondora, Croog, Evans, & Davidson, 2005).

The current study employed a revised version of the original instrument (RSA-R) that measures the same domains, but has four less items. The RSA-R was chosen to replace the AACP ROSE because it is available in four versions, each of which is specific to a different stakeholder group (person in recovery, family member/significant other, provider, and administrator/manager). The advantage is that the items are worded in a manner that is relevant to the target audience rather than general terms, which may yield an item(s) irrelevant to a stakeholder group(s). At this point, the drawback to the RSA-R is the lack of information about its psychometric properties. Instrument reliability for the current study was determined using Cronbach's Alpha, which yielded an alpha coefficient of .95 ($n = 10$). The results for the subscales are as follows: life goals ($\alpha = .88$, $n = 16$), involvement ($\alpha = .70$, $n = 20$), diversity of treatment options ($\alpha = .39$, $n = 14$), choice ($\alpha = .56$, $n = 18$), individually tailored services ($\alpha = .76$, $n = 14$) and invite ($\alpha = .67$, $n = 26$).

Narrative questions. The AACP ROSE and RSA-R were accompanied by four narrative questions that were developed by the evaluators to gather information about the peer specialists' perceptions of ETCMHR's activities. Specifically, they were asked to respond to the following questions:

- In your opinion, has the coalition (ETCMHR) had a positive impact upon the delivery of peer support services? Why or why not?
- In your opinion, are peer support providers⁴ treated as valued members of the treatment team? Why or why not?
- If the Hogg Foundation were to replicate this coalition in other areas of Texas, what elements should remain the same? Why?

⁴ The decision to use "peer specialist" in place of "peer support provider" was made after the third year evaluation efforts were underway. The change was made based on Texas' use of it to represent consumers who provide formal support services to other consumers.

- If the Hogg Foundation were to replicate this coalition in other areas of Texas, what elements should be changed? Why?

The analysis of the responses to these questions is discussed later in the results section.

Design and Data Collection

As previously noted, this component of the evaluation sought to develop an understanding of the peer specialists' perceptions of: 1) the LMHA's orientation to recovery and 2) the Hogg Foundation's role in the delivery of peer support services in the region. A cross-sectional design was employed to collect this information. The instruments were administered during ETCMHR training events. The researcher met with the participants, at which time he provided each participant with an informed consent form, reviewed the form, and answered related questions. The participants were then provided a copy of the demographic information form, AACP ROSE (year two) or RSA-R (year three), and narrative questions. Participants worked independently to complete the instruments and, upon completion, placed them in a folder at the front of the room. The researcher was present for the entire time, but was seated at the back of the room and did not collect the completed instruments until all of the participants had finished. Once the completed instruments were received, the data was entered into SPSS and analyzed. The narrative responses were aggregated by item and analyzed for common themes.

Limitations

When reviewing the results, it is important to be mindful of the study's limitations. The AACP ROSE does not have specific scoring and interpretation guidelines and the psychometrics have not been established. There is one version for use with all of the constituent groups, which may contribute to measurement error. As for the RSA-R, empirical validity has not been established. Both instruments were designed to examine a single organization rather than an aggregate of organizations, such as a network. However, the small n for LMHA subgroups prevented individual analyses and comparisons among the LMHAs. When generalizing the results, it is important to consider the absence of RSH from the sample. Furthermore, the change in instruments from year two to year three prevented comparison between groups. Finally, assumptions were violated for some of the statistical tests, requiring one to be cautious when interpreting the results (specific instances of violations are noted in the results section).

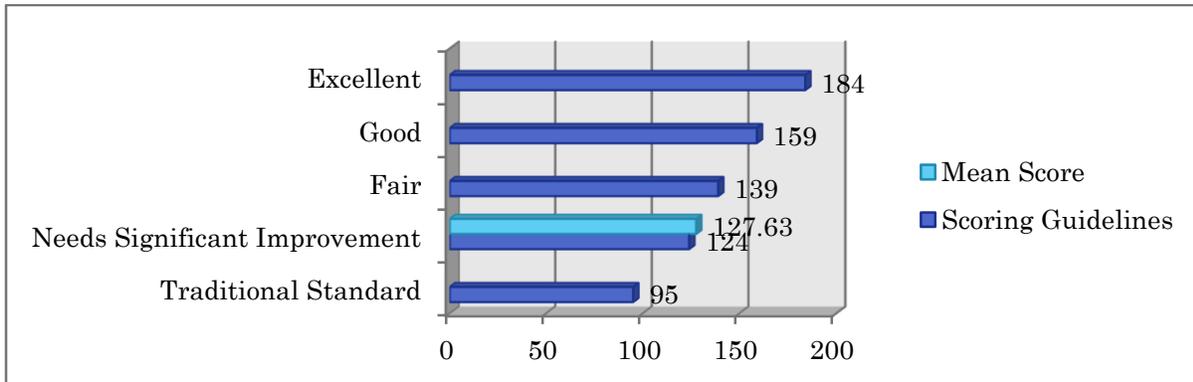
Results

AACP ROSE

Once the information from the AACP ROSE was entered into SPSS, descriptive analyses were conducted for the four domains and individual items. Missing scores for items were coded as missing and not included in the analyses. However, this was not a common issue. When interpreting the results, it is important to keep in mind that the AACP ROSE is designed to assess the recovery orientation of an organization from multiple perspectives (consumers, family members of consumers, peers, clinicians, administrators and staff). The current study did not include clinicians, administrators and staff. Furthermore, participants were responding to the items in reference to the LMHA they were associated with rather than ETCMHR. Therefore, four of the participants rated the overall orientation of ACCESS, three rated Andrews Center, three rated Burke Center, one rated Community Healthcore, and three rated Spindletop MHMR (two did not

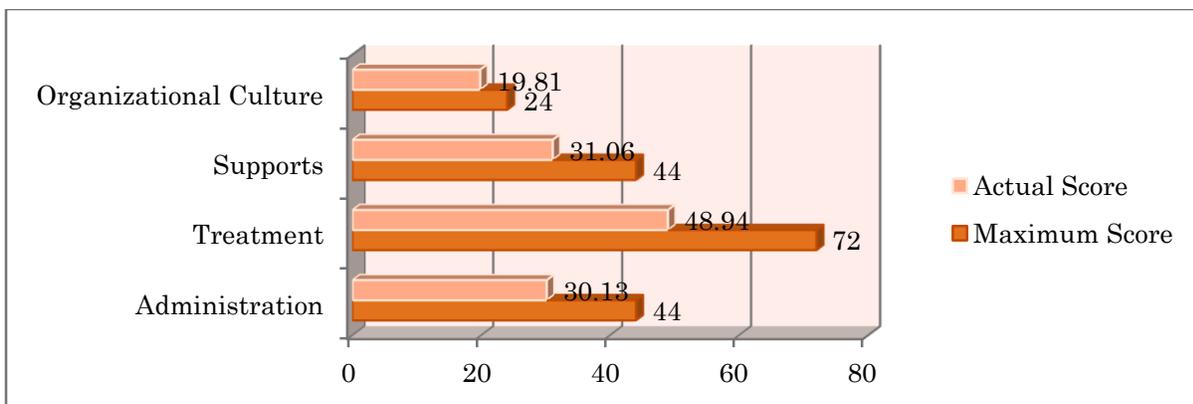
identify a LMHA). Given the implications of the small sample size for statistical comparisons and maintaining participants' confidentiality, the results are reported as an aggregate.

Figure 1- AACP ROSE- General Scoring Guidelines



Although the four domains are intended to function as subscales, there are no specific guidelines for scoring the instrument and interpreting the responses (Campbell et al., 2005). The general scoring guidelines and the mean overall score are presented above in Figure 1. The mean overall score for participants was 127.63 ($n = 16$, $SD = 33.01$, $\min^5 = 72$, $\max^6 = 184$). However, one of the participants answered 4 (the highest rating) for all of the items, which suggests an acquiescent response set. When this case was removed, the overall mean score was: 123.87 ($n = 15$, $SD = 30.41$, $\min = 72$, $\max = 161$). Although the distributions for both means were normal, the medians were calculated as a precaution. The medians were consistent with the means (128 and 124, respectively). It is important to note that in both cases, the mean and median fall on the border of “needs significant improvement” and “fair.” Given the limited impact on the overall scores, the case suspected of an acquiescent response set was included in the subsequent analyses. The mean sums for the domains are presented in Figure 2. The mean sums and scores for the four domains and the individual items are reported in Appendix B - Recovery Orientation of ETCMHR (Table 16 and Table 17, respectively). When interpreting the domain scores, the following maximum sums should be kept in mind: administration (max = 44), treatment (max = 72), supports (max = 44) and organizational culture (max = 24).

Figure 2- AACP ROSE- Mean Sums for Domains



⁵ min = minimum value

⁶ max = maximum value

RSA-R

Once the information from the RSA-R was entered into SPSS, descriptive analyses were conducted for the overall instrument, six domains, and individual items. Missing scores for items were coded as missing and not included in the analyses. Whereas the six domains can be treated as subscales, there are no specific guidelines for interpreting the responses. As with the AACP ROSE, the RSA-R is designed to assess the recovery orientation of an organization from multiple perspectives (consumers, family members of consumers, peers, clinicians, administrators and staff). In terms of interpreting the overall score and domain scores reported below, it is important to keep in mind that the current study did not include clinicians, administrators and staff. Furthermore, participants were responding to the items in reference to the LMHA they were associated with rather than ETCMHR (see Figure 3). Given the implications of the small sample size for statistical comparisons and maintaining participants' confidentiality, the results are reported as an aggregate rather than by LMHA. A comparison of the mean scores for the six domains is presented in Figure 4. The mean scores and standard deviations for the domains and individual items are reported in Table 18 and Table 19, respectively (see Appendix B - Recovery Orientation of ETCMHR).

Figure 3- Participants' Center of Employment

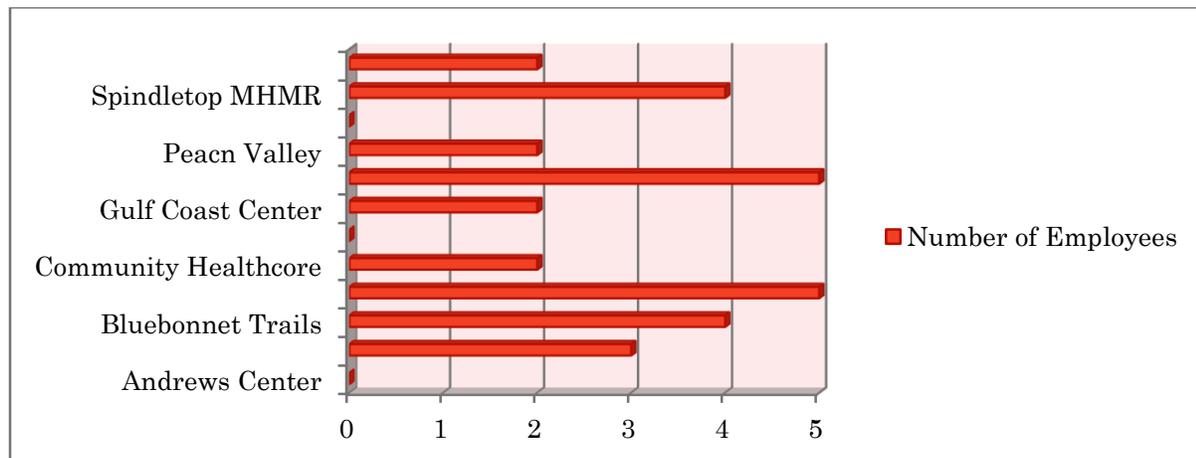
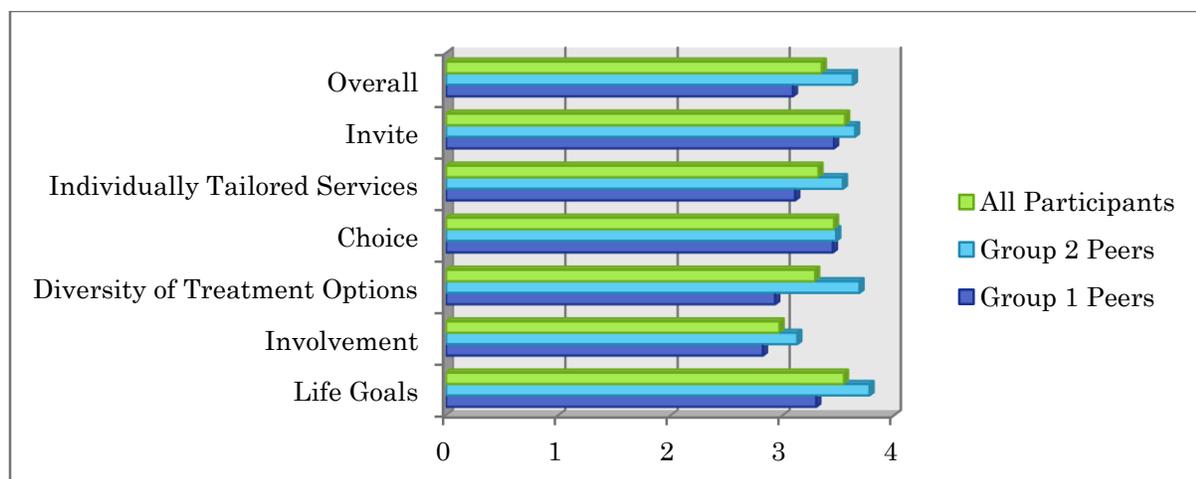


Figure 4 - Mean Scores for RSA-R (Overall and Domains)



The responses point to concerns about the involvement of consumers and peers in service delivery, decision-making, and evaluation. For example, the domain and items scores for Involvement suggest the need for improvement in efforts to involve consumers in civic activities, as well as program development, evaluation and decision-making. Item 20 speaks specifically to a lack of consumer involvement in mentoring. The scores for items 13, 14, 15, 17, and 18 indicate the need for improving the holistic nature of treatment. It is important to note Group 1 Peers tended to rate these items lower than the Group 2 Peers. Given this, independent groups t-tests were employed to compare the overall and domains scores for the two groups, which indicated a difference in the scores for diversity and the overall scores. Specifically, the Group 1 Peers scored lower on the Diversity of Treatment Options domain than the Group 2 Peers ($t = -2.335$, $df = 21$, $p = .030$, $\alpha = 0.05$). Also, they had a lower overall score than the Group 2 Peers ($t = -2.100$, $df = 23$, $p = .047$, $\alpha = 0.05$). In considering these results, it is important to note that the assumption of a normal distribution was violated for Diversity of Treatment Options and Choice. These results are consistent with the individual scores for each of the items in the domains, as well as the narrative responses from this and previous years.

Narrative Questions

Four narrative questions provided participants an opportunity to offer specific suggestions and ideas that could be used to evaluate the collaborative process and assist with achieving the desired outcomes of ETCMHR. The responses for each question were aggregated and reviewed in order to identify the most frequent ideas and suggestions. Responses were then grouped by common theme and reviewed again for consistency with the related theme. A summary of the common themes, as well as unique ones, for each of the questions are presented below.

Positive impact on peer support services. The first question sought opinions about whether or not ETCMHR had positively impacted the delivery of peer support services. Fifteen of the 16 year two participants responded to this question, all of who felt that ETCMHR had positively impacted peer support services. Specific examples of positive change include an increase in **education and training** related to mental health recovery, the opportunity to **develop relationships** with other peer specialists, and the sense of **empowerment** resulting from participation in the network. For example, a participant stated that ETCMHR created opportunities for *“forming invaluable friendships and sharing knowledge.”* In terms of empowerment, a participant noted that *“ETCMHR has given us a voice.”* Several participants attributed their understanding of recovery and the development of related skills to participation in the network. The following quote captures the essence of the responses to this item:

“... I was just a consumer when the coalition brought me in as a founder, and now I am WRAP facilitator certified, respect institute certified, [identifying information removed], am employed as a peer provider and working toward CPS certification. If that’s not a positive impact, then you might be looking for miracles. I am thankful for what they have done for me and I am paying it forward.”

Another common theme, which was present in the previous quote and other responses, was that ETCMHR provided participants with an opportunity to use their knowledge and skills to assist others or to **pay it forward**.

“This GRANT has afforded us the ability to have FUN - which a lot of peers don’t ever get to do.

Twenty-six of the year three participants responded to this item and, for the most part, their responses were consistent with the responses from the previous year. Their responses focused on the importance of **support for training**, the **opportunities for interaction** with their fellow peer specialists, and **changes in the system**. One of the participants noted that trainings and other opportunities provided an opportunity for the peers to “*have fun*,” which is an important aspect of recovery (enjoyment in life). In terms of comparing the two groups, their topics were either the same or very similar. However, the focus of Group 1 Peers tended to be on the larger system and Group 2 Peers tended to focus on ETCMHR’s impact on themselves and their fellow peers. For example, a Group 2 Peer offered the following comment:

“...I am not a lost cause anymore, I can regain my dignity and again be counted for. I feel safe and secure know [sic] in life.”

It is important to note that Jim Lemon’s efforts were mentioned in multiple responses.

Treatment team membership. The purpose of this question was to ascertain whether or not peer specialists were treated as valued members of the treatment team. Of the responses from year two, eight indicated that they were included as a member of the treatment team, five indicated they were not included, two did not directly respond to the question and one left the item blank. Whereas most of the “yeses” suggest they have input, the degree of their involvement is unclear. One of the common themes across the “yes” responses was that they **felt valued** because of their experiences as a consumer. For example,

“I think we are treated as a valuable member because we have experience as a consumer and other consumers feel more comfortable talking and listening to someone who have [sic] been there. They learn from our experiences that worked for us and want to see if it will work for them, too. The clinicians don’t have this kind of relationship with the consumers ‘cause they just have theories of what it might be like and I think that they respect the way we can approach consumers.”

Of those who reported not feeling valued by the treatment team, most cited **resistance to their involvement**. For instance,

“old school’ psychiatrists don’t treat them with respect”

“I haven’t heard much from peers that their input is being sought out for recovery plan development. I am skeptical that peers are seen as ‘equal’ contributors in fostering recovery...”

One participant noted that he/she did not feel valued by his/her LMHA, but that he/she did feel valued by the Hogg Foundation.

The responses from year three are fairly consistent with those of year two. Of the 31 participants, 26 responded to this question and 19 of them provided a clear yes/no answer. Specifically, eight participants stated that they were either actively involved with the treatment team or had experienced significant progress toward such. However, the other 11 stated that they were not involved in the treatment team. As with the previous evaluation year, the issue appears to be whether or not the individual LMHAs and/or their administration and staff have “turned the

corner” and embraced the idea of mental health recovery. As demonstrated by other aspects of the evaluation, the LMHAs are at different points in the transition process. The following comment exemplifies LMHAs that have made the transition, “...they go the extra mile to make us feel valued. They constantly ask for our feedback and really listen to what we say.” On the other end of the continuum, peer specialists do not feel respected or valued by their LMHA offered the following comments,

“No - they are treated as outsiders & treated like they shouldn’t be there”

“No- peer providers are not respected for their knowledge and training through the coalition”

“No. They don’t ask for our input nor do they encourage it”

“And why is it not called a recovery team? That fact alone speaks volumes. We get ‘throne a bone’ every once and a while.”

When comparing the responses from Group 1 and Group 2, more of the Group 2 peers responded in a positive manner. In other words, it appears that a greater number of the respondents from Group 2 are associated with an LMHA that values peer specialists and/or is actively working to create such an environment.

“And why is it not called a recovery team? That fact alone speaks volumes.”

Elements that should remain unchanged.

This item asked respondents what aspects of the coalition should remain the same if it were to be replicated in other areas of Texas. Twelve of the participants from year two offered suggestions, one wasn’t sure and three did not respond. Of those who responded, the most frequently identified elements were: **training** (WRAP and Respect Institute), **involving peers** in meetings and conference presentations, and the **emphasis on recovery**. The following statement exemplifies the positive nature of the responses: *“That recovery is the main focus, because recovery creates wellness and the opportunity for a better life.”*

Twenty-three of the year three participants responded to this question, most of them citing either the various **trainings** and/or the **opportunities to network** with other peer specialists. One participant suggested that the model was fine, but it would help for Hogg Foundation to have a greater involvement with the LMHAs. Specifically,

“...maybe their influence a little stronger felt in the centers. Hogg has a solid idea about recovery but my center is so reluctant to jump on board and they are dinosaurs in the recovery movement.”

There were no noticeable differences between the responses of the Group 1 and Group 2 members.

Elements that should be changed. The purpose of this question was to identify elements of the coalition that should be changed if it were to be replicated in other areas of Texas. During the year two evaluation, two of the respondents stated that the coalition should not be changed, noting that it is functioning as expected. For example, one participant offered the following comment: *“None, the coalition is solid and can make recovery possible for all that come in contact with it.”* Eight of the respondents offered suggestions for change, which did not have a common theme. The suggestions included the following: hiring a pair of peer support coordinators for each center (one peer provider and one clinician), placing more emphasis on job training, additional funding for training and related activities, and slowing down the training process. Finally, a participant offered

“I think Hogg [Foundation] is the heart and soul of this coalition and [it] would die on the vine without them.”

the following comment, *“I think Hogg [Foundation] is the heart and soul of this coalition and [it] would die on the vine without them.”*

The majority of the year three participants who responded to this question noted that they would not recommend major changes. Of the changes that were suggested, the common theme centered around **marketing**. Specifically, making people aware of ETCMHR, mental health recovery, and the role of peer specialists. Other suggestions included encouraging a greater degree of buy-in from the LMHAs and conducting background checks at the beginning of the recruitment process.

A SNAPSHOT OF THE PEER SPECIALISTS (YEAR ONE)

The purpose of this component of the evaluation was to examine ETCMHR's use of peer specialists to increase the quality of mental health services provided to consumers in the East Texas region. Specifically, ETCMHR was interested in the job functions and responsibilities assigned to peer specialists, as well as the amount of social support available to peer specialists. The coalition was hopeful that this information would inform efforts to create consistency in peer specialists' functions and responsibilities across LMHAs, as well as ensure that peer specialists had adequate support in fulfilling such responsibilities. The methodology and results are detailed in the following sections. A discussion of the results and their implications is provided later in the report.

Methodology

Participants and Sampling

All of the Group 1 Peers were asked to participate in this study during year one of the grant. Of the 20 Group 1 Peers, 16 of them chose to participate (80% return rate). It is important to note that six of the respondents chose not to complete the demographic information sheet. Respondents reported providing services to the following populations: consumers of mental health services ($n = 9$), families of consumers of mental health services ($n = 2$), veterans ($n = 1$), and families of veterans ($n = 1$). In terms of the primary service population, 9 respondents reported that they primarily served consumers of mental health services and one reported primarily serving families of veterans. Six respondents were Certified Peer Specialists (CPS), four had completed WRAP training and two reported having another related certification. None of the respondents were certified as a peer volunteer or certified by the Respect Institute. Only one of the respondents reported possessing a professional license or certification (teacher). Additional information is presented in Appendix C - A Snapshot of the Peer Specialists.

Measurement

The study utilized the following instruments to collect the data: demographic information sheet, job description questionnaire, and social support scale. The job description questionnaire was designed to identify the primary functions, duties, and responsibilities attached to the position of peer specialist. The items included job title, essential functions, regular duties, responsibilities, and education/skills. The social support scale is based on Cohen & Hoberman's (1983) Interpersonal Support Evaluation List (ISEL). Additional information about the ISEL can be found in Cohen, Memelstein, Kammarck, & Hoberman (1985). The ISEL consists of 40 items that measure the following four dimensions of social support: appraisal, belonging, tangible, and self-esteem. The modified version employed for this project consisted of 30 items that measure appraisal, belonging, and tangible (ETCMHR chose to exclude the self-esteem subscale). Each item is rated as true or false and the responses for each subscale are summed. A higher score indicates a greater presence of the domain being measured and a lower score indicates a lesser presence. The instrument has been shown to be both reliable and valid (Cohen et al., 1985). It is important to note that subsequent studies have led to an abbreviated scale with improved psychometric properties, which was discovered after the data had been collected for this study.

Design and Data Collection

A cross sectional design was employed and the data collection process was anonymous. A packet containing a consent form and the aforementioned instruments was distributed to the peer specialists during the summer of the first grant year by ETCMHR's Peer Support Coordinator. The peer specialists were provided time to complete the instruments during a peer specialist meeting and either chose to return them in a sealed envelope at the end of the meeting or mail them to the investigator. Once the instruments were returned, the data was entered and analyzed. The quantitative data was analyzed using SPSS and the qualitative data was analyzed for common themes. Specifically, the responses for each question were aggregated and reviewed in order to identify the most frequent ideas and suggestions. Responses were then grouped by common theme and reviewed again for consistency with the related theme.

Limitations

When reviewing the results, it is important to be mindful of the study's limitations. Whereas 16 of the 20 peer specialists responded to the study, only 10 of them completed all three instruments. This limited the statistical analysis of the data and prevented comparisons of subgroups within the sample. It also limits the generalizability of the results to the larger group of peer specialists within the region.

Results

Job Description Questionnaire

As previously noted, the job description questionnaire was designed to identify the primary functions, duties and responsibilities assigned to the position of peer specialist. The items included job title, essential functions, regular duties, responsibilities and education/skills. Only 10 of the 16 respondents chose to complete and return the job description questionnaire. The results for each of the items on the questionnaire are reported in the following subsections.

Job titles. Six respondents completed this item. Four of the six responses contained a combination of “peer” and “specialist” (e.g., peer specialist, certified peer specialist, and peer recovery specialist). The other responses included MH case manager and military services family partner.

Essential functions and regular duties. Participants were asked to identify the essential functions and regular duties associated with their positions. Although these were two separate items, most of the participants responded to the items in the same manner. Given this, the results for the two items are reported together. The most commonly reported job function was the provision of individual services (counseling, rehabilitation, skills, etc.), which was closely followed by group services, peer support and recovery related activities. Other activities and the frequency of reporting are as follows: family services (2), staff training (1), client transportation (2), assessment and treatment planning (2), documentation of services provided (3), administrative planning (1), and involvement with community groups such as CRCG (Community Resource Coordination Group) (1).

Responsibilities. Participants were asked about their sole responsibilities, financial responsibilities, and independent decision-making. There were a variety of responses to the sole responsibility item with the most common being the documentation of services provided by the participant. Other responses to this item centered on the provision of services to clients assigned to the participant's caseload. Only one respondent reported responsibility for finances, which was

limited to managing a petty cash account. Seven participants reported that they engaged in independent decision-making. All of such decisions were related to their direct practice with consumers. Several of them specifically stated that all other decisions had to be approved by a supervisor.

Required equipment, computers, and software. Six of the participants responded to this item and all of them noted the importance of computers. Most of them mentioned one or more of the following: internet, email, and productivity software such as Word and Excel.

Frequency of job functions. Participants were asked to report the frequency of each of the following functions: supervision, delivery of instruction/training, decision-making, and delegation. The items were rated on the following Likert Scale: constantly (1), frequently (2), sometimes (3), seldom (4), and never (5). Therefore, the lower the score, the more frequently the function was performed. The results suggest that respondents tend to not engage in supervision and delegation of responsibilities. Their involvement in training is more frequent, with the most frequent activity being decision-making. The results are presented below in Table 9.

Table 9- Frequency of Job Functions

How often do you do the following?	<i>n</i>	\bar{X}	<i>SD</i>
Supervision	7	3.29	1.496
Instruction (Training)	8	2.50	.926
Decision-Making	9	1.78	1.320
Delegation	9	3.56	1.014

Required education, skills, qualifications, and experience. Seven of the participants responded to this item. The most common responses mentioned experience as a consumer of mental health services and empathy. Several of the responses also noted the importance of training as a peer specialist.

Comments. Only two participants chose to provide additional comments. One participant offered the following statement *“I love my job and helping others.”* Another participant offered praise for the network’s efforts,

“Being able to connect with others in the ETMHLN⁷ has given me a support system that has helped me tremendously. The wonderful folks in our network have showed me such remarkable courage and have been such an inspiration!”

Social Support Scale

A modified version of the ISEL was employed to measure the following aspects of social support: appraisal, belonging, and tangible. The respondents rated each of the 30 items as true or false and the scores were summed for each of the three subscales. A higher score indicates a greater presence of the domain being measured and a lower score indicates a lesser presence. The results for each subscale are presented in Table 10.

Respondents who did not complete all of the items on a subscale were excluded from the analysis of that particular subscale (see the *n* column in Table 10 for details). Specific information about interpreting the scores for the original version of the ISEL was not readily available. Therefore, interpretation of the scores is based on an assumption that a score of 5 on the 10 point

⁷ The coalition was originally named the East Texas Mental Health Leadership Network (ETMHLN). The name was changed to the East Texas Coalition for Mental Health Recovery (ETCMHR) late in the first year of the grant.

scale is average. Given this, overall the respondents tend to fall around the average. The standard deviation scores suggest a fair amount of consistency among respondents.

Table 10- Social Support Scale

Subscale	<i>n</i>	\bar{X}	<i>SD</i>	min	max
Appraisal	13	5.38	.650	4	6
Belonging	12	6.08	.669	5	7
Tangible	15	5.40	.737	4	7

A SNAPSHOT OF THE PEER SPECIALISTS (YEARS TWO & THREE)

During the course of planning the evaluation activities for the second funding year, the Hogg Foundation decided to shift the focus on peer specialists from job functions and social support to developing an understanding of their recovery process. The related research question is: How do the peer specialists view their own recovery process? The research question was investigated during years two and three using the Mental Health Recovery Measure (MHRM), which focuses on the individual participant's perceptions of his/her mental health recovery process. The methodology and results are detailed in the following sections. A discussion of the results and their implications is provided later in the report.

Methodology

Participants and Sampling

Year two. The year two participants were Group 1 Peers. The study was conducted in conjunction with an ETCHMR training event that was open to all of the peer specialists who were involved with the coalition. The event was attended by 16 of the 22 peer specialists, all of who chose to participate in the study. Demographic information for the participants is presented in Appendix C - A Snapshot of the Peer Specialists.

Year three. The year three participants consisted of Group 1 Peers and Group 2 Peers. The study was conducted in conjunction with two separate training events, one for each group. The first event was attended by Group 2 Peers, 15 of who chose to participate. The second event was attended by Group 1 Peers, 16 of who chose to participate. Unfortunately, peer specialists from RSH were unable to participate due to delays in the Texas Department of State Health Services' (TDSHS) IRB (Institutional Review Board) approval process. Demographic information for the participants is presented in Appendix C - A Snapshot of the Peer Specialists.

Measurement

The MHRM is a self-report measure that assesses the recovery process in adults who have serious chronic mental health issues (Bullock, 2009). The measure consists of 30 items that are grouped into seven conceptual subscales: overcoming stuckness, self-empowerment, learning and self-redefinition, basic functioning, overall well-being, new potentials, spirituality and advocacy/enrichment. It is important to note that the development of the MHRM and its subscales was informed by grounded theory analysis of the recovery experiences of individuals with mental illness (Bullock, 2005). Each item is rated using the following 5 point Likert scale: strongly disagree (0), disagree (1), not sure (2), agree (3) and strongly agree (4). Since the MHRM is intended to be used as an overall measure of recovery, it is scored by summing the responses for each item (Bullock, 2009). However, the subscales can be examined individually and are scored by summing the responses for items related to the subscale. The range for the total score is 0 to 120, in which a higher score represents a greater degree of progress toward recovery. The MHRM may also be used to monitor change over the course of treatment. Specifically, a change in score equal to or greater than ± 10 points is interpreted as clinically significant (Bullock, 2009).

It is important to note that internal reliability, test-retest reliability and convergent validity have been established for the instrument (Bullock, 2005, 2009). The original normative sample ($n = 279$) for the MHRM yielded an average total score of 80 ($SD = 20$) and an alpha coefficient of .93 for

the internal reliability of the overall instrument (Bullock, 2009). Furthermore, the test-retest reliability after one week was .92 (Bullock, 2009). The alpha coefficient ranges between 0.0 and 1.0. The lower the coefficient, the less consistency there is among the responses for the scale or subscale being evaluated. On the other hand, a higher coefficient indicates a greater degree of consistency.

A more recent normative sample ($n = 671$) yielded an average total score of 78 ($SD = 11.1$) and an alpha coefficient of .95 for the internal reliability of the overall instrument (Bullock, 2009). As for the current study, the internal consistency reliability of the overall instrument was determined for year two using Cronbach's Alpha, which resulted in an alpha coefficient of .94 ($n = 16$). Cronbach's Alpha was also employed to analyze the internal consistency reliability of each subscale, which yielded the following results for year two ($n = 16$): overcoming stuckness ($\alpha = .67$), self-empowerment ($\alpha = .74$), learning and self-redefinition ($\alpha = .63$), basic functioning ($\alpha = .48$), overall well-being ($\alpha = .95$), new potentials ($\alpha = .89$), spirituality ($\alpha = .66$), and advocacy/enrichment ($\alpha = .72$). Cronbach's Alpha was used again in year three, which yielded the following results ($n = 31$): overall instrument ($\alpha = .95$), overcoming stuckness ($\alpha = .77$), self-empowerment ($\alpha = .83$), learning and self-redefinition ($\alpha = .92$), basic functioning ($\alpha = .68$), overall well-being ($\alpha = .81$), new potentials ($\alpha = .71$), spirituality ($\alpha = .99$), and advocacy/enrichment ($\alpha = .49$). The alpha coefficients for the overall instrument are consistent with the results from the normative samples. However, in the context of the current study, the internal consistency reliability of the following subscales is questionable: overcoming stuckness (year two), learning and self-redefinition (year two), basic functioning (years two and three), spirituality (year two), and advocacy/enrichment (year three). The concern is based on the common practice of treating an alpha coefficient of .70 or higher as an indicator of reliability.

Design and Data Collection

As mentioned earlier, this component of the evaluation sought to develop an understanding of the peer specialists' perceptions of their own recovery process. A cross-sectional design was employed to collect this information via the MHRM, which was administered during ETCMHR training events. The researcher met with the participants, at which time he provided each participant with an informed consent form, reviewed the form, and answered related questions. The participants were then provided a copy of the demographic information form and MHRM. Participants worked independently to complete the instruments and, upon completion, placed them in a folder at the front of the room. The researcher was present for the entire time, but was seated at the back of the room and did not collect the completed instruments until all of the participants had finished. Once the completed instruments were received, the data was entered into SPSS and analyzed.

Limitations

When reviewing the results, it is important to be mindful of the study's limitations. Whereas the overall reliability of the MHRM for this study was fairly high, the reliability of five of the subscales was questionable. Therefore, one should be cautious when interpreting results of the following subscales: overcoming stuckness, learning and self-redefinition, basic functioning, spirituality, and advocacy/enrichment. When generalizing the results, it is important to consider the absence of RSH from the sample. Finally, assumptions were violated for some of the statistical tests, requiring one to be cautious when interpreting the results (specific instances of violations are noted in the results section).

Results

Once the information from the MHRM was entered into SPSS, descriptive analyses were conducted for the four domains and individual items. Independent groups t-tests were utilized to compare the overall mean scores for Groups 1 and 2, as well as the various peer support credentials. The methodology and results are detailed in the following sections. A discussion of the results and their implications is provided later in the report.

Descriptive Analysis

Once the information from the MHRMs was entered into SPSS, the individual items for each participant were summed in order to obtain the overall score. For the year two data, two items were missing in two cases and one item was missing in one case. These cases were addressed by replacing the missing responses with “not sure” (2), which is consistent with the recommendations of the measure’s author (Bullock, 2009). In order to place the following scores in perspective, one must keep in mind that the possible scores range from 0 to 120 and individuals who score less than 60 are considered to fall significantly below the average set by their peers (Bullock, 2009). The overall mean score for year two participants (Group 1 Peers) was 95.25 ($n = 16$, $SD = 17.31$, $\min = 56$, $\max = 120$), which suggests that the participants are at a fairly high level of self-reported recovery. For years two and three, only one participant scored below a 60. The mean scores reported in Table 11 are higher than the normative scores discussed earlier in this report, which is most likely due to the fact that the majority of the participants have been in active mental health recovery for at least a year and, in many cases, two or more years. Specifically, individuals who are “recovery sophisticated” are likely to score higher than the normative groups (Bullock, 2009, p. 4).

Table 11 - MHRM- Means Scores for Year Three

Group	<i>n</i>	\bar{X}	<i>SD</i>	min	max
Group 1	16	99.56	14.70	64	120
Group 2	15	92.60	20.04	30	113
All Participants	31	96.19	17.55	30	120

Whereas the MHRM is intended to be used as an overall measure of recovery, the seven subscales may also be examined individually. Each domain score represents the sum of the responses for the statements that constitute the domain. All of the domain scores have a range of 0 to 16, with the exception of spirituality, which has a range of 0 to 8 (it consists of two items rather than four). The domain scores are interpreted in the same manner as the overall score. A higher domain score indicates a higher level of mental health recovery in the context of that specific domain. The mean scores and standard deviations were calculated for each domain and are reported in Table 12.

The mean domain scores and standard deviations for year two are fairly consistent across the first three domains (overcoming stuckness, self-empowerment, and learning and self-redefinition). However, the mean scores for the remaining domains are noticeably lower, with the exceptions of new potentials and spirituality. Although the individual items are not intended to be examined independently, doing so can provide insight into the domain and overall scores (see Table 20 in Appendix C - A Snapshot of the Peer Specialists). For example, in looking at the individual items for basic functioning, one can see that item 13 (I eat nutritious meals everyday) is at least partially responsible for the lower mean score. In terms of overall well-being, the higher standard deviation suggests a greater degree of variance for this domain compared to the other domains. The sources of

the variance appear to be items 17, 19 and 20. Finally, an examination of the individual items for advocacy/enrichment suggests that having enough money to spend on extra things or activities (item 30) may be of concern. All of the mean domain scores and standard deviations for year three are fairly consistent.

Table 12- MHRM- Mean Scores for Domains

Domain	Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
Overcoming Stuckness (Items 1, 2, 3, 4)	13.06	2.54	13.32	2.93
Self-empowerment (Items 5, 6, 7, 8)	13.25	2.49	12.94	2.87
Learning and Self-Redefinition (Items 9, 10, 11, 12)	13.56	2.58	13.71	3.38
Basic Functioning (Items 13, 14, 15, 16)	11.75	2.35	12.42	2.34
Overall Well-being (Items 17, 18, 19, 20)	12.25	4.22	12.10	2.96
New Potentials (Items 21, 22, 23, 24)	12.81	3.41	13.13	2.53
Spirituality (Items 25, 26)	6.87	1.09	6.39	2.01
Advocacy/Enrichment (Items 27, 28, 29, 30)	11.69	3.30	12.19	2.41

Group Comparisons

Year two. Independent groups t-tests were utilized to compare the overall mean scores for the various peer support credentials. The first such comparison was made between those who were a certified peer specialist ($\bar{x} = 96.25$, $SD = 13.07$, $n = 4$) and those who were not ($\bar{x} = 94.92$, $SD = 19.01$, $n = 12$). The difference between the means was not statistically significant ($t = .129$, $df = 14$, $p = .899$, $\alpha = 0.05$). The difference between the mean scores for those who had completed WRAP training ($\bar{x} = 99.91$, $SD = 14.33$, $n = 11$) and those who had not ($\bar{x} = 85$, $SD = 20.47$, $n = 5$), was not statistically significant ($t = 1.694$, $df = 14$, $p = .112$, $\alpha = 0.05$). The difference between the mean scores for those who held a Respect Institute Certification ($\bar{x} = 100.86$, $SD = 12.88$, $n = 7$) and those who did not ($\bar{x} = 90.89$, $SD = 19.71$, $n = 9$), was not statistically significant ($t = 1.156$, $df = 14$, $p = .267$, $\alpha = 0.05$). It is important to note that the independent groups t-test is based on an assumption of a normal distribution for the dependent variable, which was met for each of the comparisons.

Year three. Independent groups t-tests were utilized to compare the overall mean scores for Groups 1 and 2, as well as the various peer support credentials. The first such comparison was made between Group 1 responses for years two ($\bar{x} = 95.25$, $SD = 17.31$, $n = 16$) and three ($\bar{x} = 99.56$, $SD = 14.70$, $n = 16$). The difference between the means was not statistically significant ($t = -.760$, $df = 30$, $p = .453$, $\alpha = 0.05$), which suggests stability in their recovery. A comparison between the year three responses for Group 1 ($\bar{x} = 99.56$, $SD = 14.70$, $n = 16$) and Group 2 ($\bar{x} = 92.60$, $SD = 20.04$, $n = 15$), indicated that the difference between the means was not statistically significant ($t = 1.108$, $df = 29$, $p = .277$, $\alpha = 0.05$). The first comparison based on credentials was made between those who were a certified peer specialist ($\bar{x} = 98.00$, $SD = 17.95$, $n = 24$) and those who were not ($\bar{x} = 90.00$, $SD = 15.68$, $n = 7$). The difference between the means was not statistically significant ($t = 1.064$, $df = 29$, $p = .296$, $\alpha = 0.05$). The difference between the mean scores for those who had completed WRAP training ($\bar{x} = 98.38$, $SD = 21.06$, $n = 16$) and those who had not ($\bar{x} = 93.87$, $SD = 13.16$, $n = 15$), was not statistically significant ($t = .709$, $df = 29$, $p = .484$, $\alpha = 0.05$). The difference between the mean scores for those who held a Respect Institute Certification ($\bar{x} = 100.11$, $SD = 13.64$, $n = 19$) and those who did not ($\bar{x} = 90.00$, $SD = 21.608$, $n = 12$), was not statistically significant ($t = 1.602$, $df = 29$, $p = .120$, $\alpha = 0.05$). It is important to note that the independent groups t-test is based on an assumption of a normal distribution for the dependent variable, which was only met for the comparison of Group 1 Peers' scores for years two and three. Given that these violations raise the possibility that the results could be due to the distribution of scores rather than differences in the means, the results of the other comparisons should be interpreted with caution.

RECOVERY EXPERIENCES OF THE PEER SPECIALISTS

The focus of this evaluation component was on developing an understanding of the recovery experiences of the Group 1 and Group 2 Peers. The related research questions for year two are:

1. How have the Group 1 Peers been impacted by the process of recovery?
2. How has ETCMHR impacted the recovery process for this group?

The research questions were modified for year three to accommodate the addition of the Group 2 Peers and a follow-up interview for the Group 1 Peers. Specifically:

1. How have the Group 1 Peers progressed over the past year?
2. How have the Group 2 Peers been impacted by the process of recovery?
3. How has ETCMHR impacted the recovery process for both groups?

These questions were answered through qualitative data that was collected via individual interviews. The methodology and results are detailed in the following sections. A discussion of the results and their implications is provided later in the report.

Methodology

Participants and Sampling

Year two. The year two participants were peer specialists from Group 1. Of the 22 group members, 13 chose to participate in the individual interviews. Eight of the participants were males and five were females. No other demographic information was collected for this component of the evaluation. However, since these 13 individuals also participated in the focus groups, the demographic characteristics of the focus group participants closely resemble the characteristics of this group (see Appendix E - Recruiting Peer Specialists for details).

Year three. The year three participants were peer specialists from Group 1 and Group 2. Nine of the Group 1 members and five of the Group 2 members chose to participate in the individual interviews. Demographic information for the participants is presented in Appendix D - Recovery Experiences of the Peer Specialists.

Design and Data Collection

Most of the individual interviews were conducted via telephone and the remaining interviews were face-to-face. The interviews were guided by a pre-established protocol and questions (the interview questions are included in Appendix D - Recovery Experiences of the Peer Specialists). The interviews began with a brief introduction, the purpose of the interview, a review of informed consent (participants were provided with a written consent form via email), and an overview of the interview process. Once these elements had been reviewed, the interview was conducted. Digital audio recordings of the interviews were made and used to create a transcript for each interview. Each of the interviewers either transcribed the interviews that she/she facilitated or reviewed the transcripts prior to analysis. Once the transcripts were completed, the responses for each question were aggregated and reviewed in order to identify the most frequent ideas and suggestions. Responses were then grouped by common themes and reviewed again for consistency with the related theme.

Results

The initial individual interviews and follow-up interviews focused on developing an understanding of the peer specialists' experiences with recovery and the role ETCMHR played in their recovery. The narrative questions also provided participants an opportunity to offer specific ideas and suggestions related to improving the recovery process and ETCMHR. A summary of the common themes, as well as unique ones, are presented in this section. Where appropriate, examples are provided using the words of the participants to support the analysis.

Impact of Recovery

Given ETCMHR's emphasis on recovery, there is a particular interest in understanding the recovery process. Specifically, participants were asked to describe their lives before and after recovery, as well as identify the specific changes in their lives that resulted from recovery. They were also asked to identify supports they would employ to maintain their progress toward recovery.

Life before recovery. Participants were asked to describe their lives before they began the mental health recovery process, as well as the challenges to beginning the recovery process.

Group 1 Peers. The primary themes that summarize the lives of the Group 1 Peers before recovery were **recognizing their mental health conditions** and **managing their personal mental health challenges**. In regard to recognizing their mental health conditions, many of the participants commented on being misdiagnosed and their internal struggle with their symptoms. For example, several of the participants talked about experiencing extreme emotional instability, anger, nervousness and limited impulse control. A couple of the participants reported depression and suicidal ideations, as well as wondering what was wrong with them. For example, one of the participants stated *"I didn't see any way out for me to come out of this hole I was in. I had lost all hope in life and just didn't feel like I wanted to live anymore."* Another

participant talked about self-medicating with drugs and alcohol in an attempt to deal with some of the pain. Many participants described a life of isolation and a constant fear of not getting better. As one participant stated, *"I knew I had a problem, but I did not know what it was until I was diagnosed. Then I knew I could do something about it because it had a name."*

The next theme of **managing their personal mental health challenges** conveys the participants' struggles resulting from an understanding that they were dealing with mental health issues, yet not understanding how to address the issues. For example, several participants talked about losing hope and coming to a point at which they no longer wanted to live. Most of the participants talked about struggling with their emotional "ups and downs" and the difficulties of trying to avoid stays at an inpatient psychiatric treatment center. Even though many discussed things they needed to do to manage their mental health conditions, they said they were just unable to do so. For example, several of the participants commented on the need for more structure in their lives and daily activities, such as getting up and spending time outside. Similarly, others talked

Life before Recovery

"I didn't see any way out for me to come out of this hole I was in. I had lost all hope in life and just didn't feel like I wanted to live anymore."

"My life was full of chaos and pain, existing like a zombie."

"My life was very hopeless. I had been diagnosed and I lost all my hopes and dreams..."

about making poor decisions despite a clear understanding that the consequences would not be positive. As one of the participants described, “*my life was full of chaos and pain, existing like a zombie.*” Fortunately, the participants found the recovery process to be helpful in their efforts to address these issues.

Group 2 Peers. The responses of Group 2 Peers were very similar in that they centered around a common theme of **mental health challenges**. Each of the participants talked about dealing with their various mental health diagnoses and the inability to find the appropriate treatment to manage their symptoms. One participant offered the following description:

“It was very chaotic. I had seven children and I had been suffering from symptoms of Bipolar and Depression and I was self-medicating with amphetamines so when I wasn’t high I was asleep. I would sleep fourteen to sixteen hours a day and my children were taken by CPS and that’s when my road to recovery began.”

Other commonalities within the group and between Groups 1 and 2 include misdiagnosis, self-medication, lack of motivation to seek treatment, and hopelessness. For example,

“My life was very hopeless. I had been diagnosed and I lost all my hopes and dreams. My ambition was gone. I slept all day. I didn’t have any initiative and I didn’t have any desire to know how to function, to live, or enjoy life. I didn’t enjoy most things. I didn’t enjoy communicating. I couldn’t handle interactive people. I struggled with agoraphobia. I struggled with a lot of fear, anxiety, major depression issues, and I was in a lot of despair.”

All of the participants indicated a desire to change their lives, but were challenged by a lack of motivation and/or poor choices. Several participants reported that they knowingly made decisions that would have negative consequences.

Life in Recovery

“My passion is knowing I can recover and I can help someone else recover.”

“...I’m very committed to myself to make the changes necessary in my life.”

“I have goals, dreams, and visions of what life can be like for me in the future. I have gumption and life has much more worth for me.”

Life in recovery. Participants were extremely articulate in describing their transition to recovery and how their lives have changed since initiating the recovery process. Their excitement and pride was obvious as they told their stories of triumphs over some of life’s greatest challenges and their transition to recovery.

Group 1 Peers. The analysis of the Group 1 Peers’ responses resulted in the identification of three themes, the first of which relates to **purpose, empowerment and confidence**. Participants talked about a sense of purpose and pride in improving not only their lives, but the lives of others. They also displayed a spirit of confidence and control over their present lives and their future. Many of the participants talked about understanding their situations, as well as their plans to improve them and to sustain such changes. More importantly, they

exhibited a belief that they possessed the ability to control their lives and their illnesses. Similarly, the participants talked about advocating for themselves and others. One participant described her

life as being “*magnificent since I been in recovery.*” Another participant stated “*my passion is knowing I can recover and I can help someone else recover.*”

The second theme related to becoming **more focused, organized and structured**. This theme also represents the participants’ sense of understanding and belief in the recovery process. Many of the participants commented on the importance of structure and organization in helping them achieve their goals. They also felt this was necessary for them to bring about change in their community and others who had not entered the recovery process.

The final theme related to **maintaining their recovery**, as well as the internal and external factors in their lives. Many of the participants commented on the support systems and activities that are very much a part of them. For example, they all commented on peer support through ETCMHR, friends, colleagues at work and family. Some of the participants described their busy schedules and the activities in which they are involved. As a result, many of the participants recognized how easy it is to overextend oneself. Therefore, sustaining their recovery will require them to manage their excitement, empowerment and strong sense of purpose.

Group 2 Peers. The experiences of the Group 2 Peers were similar in that the themes of **purpose** and **hope** emanated from their responses. Several participants talked about being very focused on making changes in their lives so they could be more productive. Others commented on improving life for their families. For example, one participant stated,

“my life before recovery was miserable and sad all of the time and just dealing with a lot of trauma and emotions. I wanted a completely new life for myself so that’s what I started working towards and since I’ve been building that for myself, my children. I’m very committed to myself to make the changes necessary in my life.”

Another participant described the changes in her life since recovery as “*continued to strive to move forward and move beyond where I am even today so that’s what recovery is and that’s what recovery has done for me.*” Participants also talked about being more open, having more self-respect and dealing with their problems since entering recovery.

In terms of **hope**, most of the participants spoke of their belief in a better future, as well as their capacity to overcome obstacles in their lives and realize their dreams. For example, one participant offered the following description: “*I have experienced a 360 turnaround, got motivated, went to WRAP, want to go back to work, and wanted to be involved with people.*” Another participant stated, “*I have goals, dreams, and visions of what life can be like for me in the future. I have gumption and life has much more worth for me.*” This statement captures the feelings of purpose and hope for all the participants. Specifically, it speaks to their journey of healing, transformation, and recovery. Although the responses were overwhelmingly optimistic, the following comment represents their awareness of future challenges: “*my life is very fulfilling and it’s full and whole but I still have challenges with my mental health.*”

Group 1 Peers follow-up. Group 1 Peers who participated in the year three follow-up interview were asked to describe their recovery since the initial interview (approximately one year). All of the participants talked about a year of challenges and opportunities, which centered on the theme of **personal growth**. For example, one participant stated, “*the progress that we’ve made when you’re inside yourself but when you start telling it, it’s like wow, how have we done all this? It’s amazing.*” Another described his/her personal progress as “*Leaps and bounds – from being depressed and institutionalized to none of the symptoms.*” For most, personal growth included confidence to

take risks, confronting discomfort, and learning from their peers. The participants also noted that their growth was accompanied by a clearer understanding of the process of recovery. For example, *“it is an ongoing process, just going day by day and doing better working on my recovery.”* Several participants attributed their personal growth to the skills obtained through the trainings provided by ETCMHR. For example, participants talked about using the training and skills to *“...manage the stresses in my life with the up and downs”* and *“...to pull myself up.”* One of the most beneficial trainings was WRAP, to which they attributed their ability to maintain stability, grow, and *“learn to live and move through recovery.”*

Personal Growth

“The progress that we’ve made when you’re inside yourself but when you start telling it, it’s like wow, how have we done all this? It’s amazing.”

“It is an ongoing process, just going day by day and doing better working on my recovery.”

Life changes resulting from recovery. After talking about their lives before and after recovery, participants were asked to reflect on their responses and identify the differences.

Group 1 Peers. Each of the participants talked about how recovery had improved all aspects of his/her life and his/her potential for continued improvement. Their responses revealed a belief in a better future for themselves and their families. Each of them also talked passionately about his/her progress in recovery and gave credence to the impact of ETCMHR. The following statement exemplifies the aforementioned feelings:

I get excited when the coalition is going to meet. There was a stage in my life where I would stay in my house for two weeks and not get out, only when I had to, and now I look forward to getting out and being with society and people. And, I know there is not one in the coalition that I can’t call at any time, night or day, and they got time to listen to me and talk with me. It’s like having a bunch of brothers and sisters that I never had.

It is important to note that all of the participants credited ETCMHR for being where they are today.

Given the participants’ progress, it should not be surprising that the first theme to emerge from the analysis was one of **hope and confidence**. Specifically, participants believe that they can overcome the barriers and obstacles that will arise as they continue to pursue recovery. As one participant stated, *“I believe I will get better, even when I have a set back with stressors.”* In addition, several participants described a significant increase in confidence in their ability to sustain recovery and improve their lives. For instance, one participant stated *“I don’t consider myself as totally recovered, but I am in a process of making each day better than it was yesterday.”* As a result of their hope and confidence, several participants reported a tremendous improvement in self-esteem.

Hope and Confidence

“I believe I will get better, even when I have a set back with stressors.”

Personal Responsibility

“I feel more powerful, not power over others, just a sense of being more grounded and unafraid to make a decision.”

Self-Direction

“I am determined and I have a determination that I never had before to succeed in life and be part of something that is bigger than myself; and that is how my life has changed.”

The next theme that emerged was the importance of **personal responsibility** in recovery. Many participants talked about their personal responsibility for self-care and the recovery journey. For example, one participant stated “*I feel more powerful, not power over others, just a sense of being more grounded and unafraid to make a decision.*” Another participant stated “*in recovery, it is all about recovery; we all have within us the capability of doing it, it’s a matter of unlocking that potential that each individual has.*” Several participants talked about the importance of self-accountability and being more independent. Many participants commented that they had assumed more responsibility, were in control of their lives, and felt better, both emotionally and physically. Other participants commented on their past experiences and their new found understanding and meaning of the recovery process gained via identifying coping strategies and healing processes to promote their own wellness.

The final theme that emerged was **self-direction**. The Group 1 Peers talked about their determination and motivation to establish their path of recovery. As one participant stated “*I am determined and I have a determination that I never had before to succeed in life and be part of something that is bigger than myself; and that is how my life has changed.*” Participants appeared to recognize the importance of being in control of their recovery, as well as defining their own life goals and designing a unique path towards those goals. For example, one participant stated “*I am confident now. I don’t have to ask people’s opinion; I’m just kind of in charge.*” This particular statement truly captures the essence of the responses, which is a strong sense of control and understanding of their path to recovery. Responses from other participants who spoke to this aspect include: “*I am more responsible and I have what you call accountability*” and “*I’m taking the responsibility and getting out there for myself, I wasn’t doing that before and now I’m starting to branch out on my own and live my life.*” The participant who made the last statement went on to talk about getting out of bed, going to work, being motivated and responsible for his recovery.

Group 2 Peers. The participants’ responses were fairly consistent with those of the Group 1 Peers in that they spoke of their hope for the future and the progress they have made since entering recovery, as well as feelings of having at least partial control over their lives and the ability to define their life goals. Along these lines, the common themes that emerged were **self-direction, hope, and responsibility**. Specifically, they described the transition from a life void of direction and goals to one where they were making healthy choices for the betterment of themselves and their families. For instance, a participant indicated that her relationships with her children had changed immensely. In addition, she commented on her ability to “*set healthy boundaries*” in her relationships and to identify “*toxic environments.*” Other similar comments include “*my values of myself and moral have changed*” and “*my lifestyle has changed going from being an active addict to sobriety.*” Another participant described her life and ended with the following statement:

“The biggest aspect that has changed is me personally – the hope that I have. Hope for life to get better, hope for life to be worth living, hope for me to have dreams and reach those dreams and have them become a reality. I don’t sleep to avoid life, I engage life each day and it’s just worth living now where before when I didn’t have hope it wasn’t worth living.”

Another participant talked of his motivation, his hopes and his belief that life is going to continue to improve. He also commented on his desire and effort to make things better for him and his wife.

“I have a lot more hopes that I’m not gonna die from suicide. I have a healthier marriage now. I have my children back in my life. I pay bills. I’m learning to manage that. I have my license. I own a car. I do things in the community. I volunteer. I help other people in their journey. I speak on panels at conferences now. I paint. I put myself into life instead of withdrawing from it.”

The above statements portray how participants have developed their abilities related to personal responsibility, self-direction, and self-care. Most of the participants noted that their changes were substantial enough to be noticed and commented on by others.

Group 1 Peers follow-up. Participants described how their lives have changed over the past year. Many of them recounted their experiences by telling their stories as they related to the recovery process. Two themes emerged from their discussion, the first of which was **confidence** in their ability to help others. This theme represents growth in the participants’ belief in the recovery process and its ability to deeply impact one’s attitudes, values, feelings, goals, and purpose. The following statement captures one participant’s experience, as well as the experiences of others:

“Oh I think I’ve gained so much more confidence and I have gone through some depression this last year where I felt like ice water was going through my veins and I didn’t want to get up but I will recover from that and the confidence that I have gained is just amazing and I can speak to anybody on the same level and over the last year, it’s like it’s just flown by. It’s like, what can we achieve next?”

Another participant talked about recovery involving the development of a new purpose in one’s life that is centered on helping others, which occurs when one grows beyond the effects of their mental health issues. In other words, one’s focus shifts from survival to helping others. For example, the participant stated that when you gain confidence you acquire *“more passion for helping people recover.”* Another participant denoted the importance of helping others with this statement, *“helping others always helped me.”*

The second theme was **personal management skills**, which represents the participant’s ability to use the knowledge and skills learned during the recovery process to improve the quality of their lives. As one participant stated *“I’ve grown immensely and I’m about to get ready to go into a full-time job.”* He attributed his progress and skills to ETCMHR. In fact, many of the participants attributed their success to the skills and trainings, such as WRAP, that were acquired through ETCMHR. Others talked about their ability to manage their symptoms better, establish a strong support system, hold a job and be spiritually connected. One participant reported, *“I’m not like last*

“I’ve grown immensely and I’m about ready to go into a full-time job.”

year... *I did end up in a crisis unit and I realized then that I needed to take care of myself before everybody else.*" The discussions with the participants revealed that there are multiple pathways to recovery, which are based on an individual's unique strengths, resiliencies, and needs. Many of the participants identified recovery as an ongoing journey to achieving wellness and optimal mental health.

Unchanged aspects of life. In addition to being asked about changes since recovery, participants were asked to identify aspects of their lives that have not changed.

Group 1 Peers. Whereas participants offered various perspectives on how their lives have not changed, most of them talked about **managing issues related to their mental health**. For example, several participants indicated that they have the same amount of stressors. However, there was consensus that their ability to manage stress had improved. For example, a respondent offered the following comments: *"I still have my negative moments. I'm still hearing voices. I can handle it a lot better by using my tools."* Additionally, some mentioned their ups and downs in self-esteem and confidence, but commented on how their positive experiences in the recovery process help them to remain focused. In contrast, one participant stated *"All my life has changed. I'm healthier physically and mentally."* Some participants indicated their health issues continue to complicate their lives, but their recovery is going well. Another common comment among participants was that they were **no longer ashamed of their history**. For example, one participant expressed her thoughts on this via the following statement: *"I still think about the past, but I do not let it control me."* The participants' comfort with their individual histories exemplifies the significant degree of progress being made in their recovery.

Group 2 Peers. When the participants were asked about what aspects had not changed, many talked about periodic episodes of recurring **mental health symptoms** and the **management** of such. Whereas the general theme of the responses was similar to those of the Group 1 Peers, it differed in that there was also an underlying theme of realizing that symptom management often required help. Although the symptoms had not been eliminated and services were often difficult to access, participants reported substantial improvements in their ability to identify and manage stressors and recurring symptoms. They also reported improvements in knowing when and how to go about accessing treatment. For instance,

"I will tell you honestly right now I am going through the deepest depression I think I have gone through ever in my journey but it's because I know what I know and I'll share this with you. I'm fixing to go ahead and check myself into the hospital to adjust my medications so that I can continue to have the life that I have fought and worked so hard for."

Along these lines, another participant stated in the past I would have *"tried to kill myself but I have learned to advocate for myself, do what I need to do to make sure that I get adjusted."* It is important to note that most of the participants attributed the changes in their lives to the opportunities provided by ETCMHR.

Group 1 Peers follow-up. Participants presented various descriptions of how their lives have remained the same over the past year. The themes of concern about **mental health stability** and **support systems** appeared to best describe their lives. Most participants acknowledged that they still struggle with the challenges of managing their mental health symptoms. Whereas participants reported that the symptoms and stressors are still present, their ability to manage them

has improved and their positive experiences with recovery help them to focus on the important aspects of life. For instance, a participant stated she had *“more hope and enjoyed life so much better being in recovery.”*

In terms of **support systems**, most of the participants commented that their established support system continues to allow them to move through the recovery process. Some talked about spouses, friends, jobs, coworkers, peer support and the critical role of ETCMHR in keeping them on their journey to recovery. As one participant talked about support he stated, *“I probably would have committed suicide and I wouldn’t be here and I’m thankful for all the help and the support and the love that I’ve got from different people.”* Another participant stated, *“I’ve grown and it’s most likely because of the East Texas Coalition”*.

Supports and recovery strategies. The questions about progress in recovery and life changes were followed by a specific discussion about the supports and strategies the participants had available to continue their progress in the recovery process.

Group 1 Peers. The participants identified a number of supports and strategies. The two most frequently cited supports were **peers** who were associated with ETCMHR and **family**. For example, one participant stated *“I really, really, feel support and love from my buddies in the coalition.”* Many participants also mentioned family members and how being in recovery had improved their relationships with them. In addition, several participants mentioned various support groups in which they are involved. Many of these support groups were specific to their identified needs. However, the most frequently mentioned support group was ETCMHR.

In regard to strategies, each participant identified various strategies he/she thought were helpful to his/her journey in recovery. Several talked about knowing their limitations and setting boundaries. A couple of participants emphasized the importance of exercise, eating habits and maintaining their routines. All of the participants mentioned their WRAP. However, most of the discussions suggested that there was not a single strategy that would work in all situations, rather remaining active in recovery required a combination of strategies. For example, one participant stressed the importance of a multifaceted approach to a successful recovery. Specifically, when asked to identify her supports and strategies, she commented, *“I use my WRAP, I have a great job, I have a great home life, I have fantastic kids and I have fantastic coalition members.”* In other words, a successful recovery requires one to focus on and care for all facets of one’s life. The importance of the WRAP as a recovery strategy is demonstrated by another participant’s comment,

Importance of WRAP

“My core strategies are: hope, personal responsibility, education, and support, and self-advocacy. And I didn’t have any of those except for hope. And maybe a little support. And I just gave you the five key concepts of WRAP. WRAP is a lifestyle.”

“It gave me a sense of accomplishment. It gave me a sense of needing to value myself and take care of myself. It provided a guideline for what things were healthy to pursue and what things weren’t necessary...”

“I learned that I can take control of my life and I don’t have to be ruled by my emotions. And, that’s what really impacted me that it’s an action recovery plan.”

“My core strategies are: hope, personal responsibility, education, and support, and self-advocacy. And I didn't have any of those except for hope. And maybe a little support. And I just gave you the five key concepts of WRAP. WRAP is a lifestyle.”

Group 2 Peers. The responses of the Group 2 Peers were consistent with those of the Group 1 Peers in that they focused on their **social support network** and **WRAP**. In terms of social support networks, common responses included family, peers, jobs, and ETCMHR. Participants related that when they are struggling with their symptoms, the relationships with their peers allow them to talk to someone *“who have already been through it, who can walk me through and say this is... They don't tell me what to do but they say I've been through this and this. And, I can choose from what they're saying what is best for me.”* In most instances, the importance of a social support network and WRAP were intertwined:

“I can tell two weeks before the depression hits that I need to get prepared for it because it's gonna come anyway. I know a healthy place to go where I'll get my needs met and I can advocate for myself and be able to stand strong, have the support that I need while I'm going through it. Now, I would not have any of that without WRAP.”

Another example of the interrelationship and its importance follows:

“I have several supporters through WRAP and through the coalition group 2 or Take 2 is what we call ourselves. I rely on those supporters in my life. I have family members that are supporters in my life as well as I have my daily maintenance plan. On my daily maintenance plan there are in my WRAP people in place designated for a specific thing as well as my daily devotionals.”

Participants also commented on the benefit of WRAP to their recovery journey, for instance

“It gave me a sense of accomplishment. It gave me a sense of needing to value myself and take care of myself. It provided a guideline for what things were healthy to pursue and what things weren't necessary you know. Stay focused on the most important things that needed to be done.”

The above comments clearly demonstrate the importance of a strong support system and strategies, especially WRAP to the process of recovery.

Group 1 Peers follow-up. The participants identified a number of supports and strategies. The two most frequently supports cited were **peers** who were associated with ETCMHR and **family**. The following comment by one of the participants describes the importance of support:

“All I know is the first time I had recovery, it was eye-opening and awesome because that made me see that people can recover and you know dealing with depression all my life and not having many friends, and not the right support to know that I can change. I can do something productive, really impacted me because man, I was just so negative.”

A variety of strategies were identified, including being better organized, painting, spiritual beliefs, and support groups. For example, several participants commented on trying to stay *“real organized”* and another mentioned maintaining *“my spiritual life.”* The one strategy that all participants

“WRAP is just a good thing, for not just people with mental issues, but it's a good practice for everybody.”

identified as the most helpful in maintaining their progress toward recovery was WRAP. For example, in talking about WRAP, one participant stated *“I learned that I can take control of my life and I don’t have to be ruled by my emotions. And, that’s what really impacted me, that it’s an action recovery plan.”* Another participant noted that he uses his plan daily and that *“WRAP is just a good thing, for not just people with mental issues, but it’s a good practice for everybody.”*

Changes in perceptions of recovery. Given that most of the participants were at least one year into their recovery process, changes in their perceptions of recovery over the course of the process were of interest.

Group 1 Peers. The one theme that emerged reflects their realization that **recovery is possible**. Many of the participants talked about their past struggles with mental health issues and their previous belief that recovery was not possible. For instance, the following statement describes a participant’s perceptions before his involvement in the coalition:

“I think it is possible. There was one stage in my life when I really didn’t think recovery was possible. I didn’t think I had a choice but to be drugged all the time or just exist. I was at a point in my when I just did not have any hope of recovery.”

Another participant described her newly found meaning of recovery, which captures the sentiments of all the participants:

“I didn't know what recovery was. I thought recovery was for addicts, and, now I've realized, recovery means that you're living. You're recovering from whatever obstacle was in your way. It doesn't have to be a drug issue, it doesn't have to be the alcohol, and it can just be whatever's blocking you from living your life. Recovery means living. And, there's a whole world out there that is there to explore. It's an adventure, and every day, when you wake up and you're ready for the adventure. You're not hiding away anymore. Again, when you start living other people around you are gonna, they will want to start living, too. It's an exciting thing!”

In combination with a belief in recovery, many of the participants talked about how involvement in the coalition helped them find new meanings, hope, and purpose in their lives beyond their struggles with mental illness. If not for the coalition, their perceptions of recovery would be that it is not possible. As several participants stated, the *“coalition empowers me,” “gave me opportunities and resources”* and *“put me really living.”* Another participant described it as a belief that you have power and control in your life, including your mental health. For example, one participant talked about the need to learn as much as possible about his illness, medications and available resources. Several participants expressed the importance of taking responsibility for oneself, as well as advocating for oneself and others. Whereas there are common themes among the responses, it is important to remember that recovery is unique to each individual. This view is supported by a participant who equated it to a personal journey that is guided by the belief that you are going to get better. Along these lines, another participant described her recovery as a deeply personal process that required changing her attitude, values, feelings, goals and skills.

Group 2 Peers. The comments from the Group 2 Peers illustrated a variety of perceptions, but collectively they are tied by a theme of **knowledge and awareness** derived from experience. Several participants indicated they did not know the meaning of recovery. Others, based on previous

experiences with recovery, thought that it was not possible. And, most of them were apprehensive about it. For example, a participant offered the following pre/post views of recovery:

“I thought I didn’t have a future. I thought I’d be stuck. I didn’t believe that the WRAP program could make a difference. Maybe I’d just go through the motions you know.”

“I saw the difference in myself and I was changing and I was willing to accept what they was telling me and hearing other recovery stories you know there is hope in these stories of recovering if I’d just give it the chance. There is support.”

Another participant stated *“I was just surviving, no I wasn’t even surviving I was maintaining is the way to put it and now I’m living again.”*

Whereas they started in different places with varying perceptions, recovery has been a positive experience for them and brought them to a common understanding of recovery. The following quote captures the sentiments of the participants:

“The longer that I’m in recovery, the more I realize how possible recovery is, how available and how much it is applicable to more people’s lives than we realized. The more I’m involved in recovery, the more coping skills, the more perspectives, the more interactions I get of what works and doesn’t work and so the more understanding I have about recovery, the more I can share it with a broader scope of individuals who can apply it to their lives.”

Overall, their comments revealed that recovery is positive, possible, and a source of hope and support. Furthermore, recovery is an ongoing, personal, and versatile process that takes time. It is clear that an understanding of such has shaped the participants’ experiences and guided their process of recovery.

Group 1 Peers follow-up. Group 1 Peers were asked to reflect on the last year and talk about how their perceptions of recovery have changed. Most of the participants revisited the beginning of their journey, describing their struggles with mental health issues and feeling that things would never get better. Some talked about suicide and others commented on their belief in “God” and their “hope” for things to get better. All of them reminisced about the importance of their own unique journey. After listening to and thinking about their stories, including their triumphs and trepidations, two common threads emerged, **recovery is possible** and **recovery is personal**. The following quote exemplifies this,

“I perceive it as very possible. I do recognize that you have to take recovery for what it means - for what it says. Recovery for everyone is not the same, but we all have areas or levels of recovery we can – we can reach. You know I may have a person that is non-educated and depressed and down all the time, and recovery for them is just getting back to a happy life and having a purpose and enjoying it. They set their goal of ‘Well I want to be a doctor.’ Well that might be a little bit high, so recovery for some is a lot different. You know there are some that could be a doctor if they just got in there and worked at it. It’s all about choices but recovery is just meant everything to me.”

Recovery is Personal

“Recovery for everyone is not the same but we all have areas or levels of recovery we can – we can reach.”

“...it’s learning to accept where you are, and being happy where you are...”

“...people progress and recover at their own pace and it looks different for each individual.”

The idea that **recovery is personal** is significant to the participants because it allows for their own stories and experiences to support their journey to recovery. As one participant stated “*my recovery is mine and somebody else’s is theirs.*” Another stated “*recovery is to me, it’s not so much the step forward, it’s learning to accept where you are, and being happy where you are, and not pushing too far ahead and expecting too much of yourself so it’s doing things in the moment.*” Another participant described her perspective in this way “*it’s made me realize that people progress and recover at their own pace and it looks different for each individual.*”

One of the participants offered a point of view that was consistent with the previous statements, but took it a step further by noting the need for changes in the perspectives of those who deliver mental health services and the structure of the mental health system.

Specifically, the participant offered the following insights,

“They have to define it and they have to tell it in order to get support. There is no criteria both for not being in recovery or for being in recovery. Some people, it is ‘I’m sober today.’ For me, it’s ‘I’m sober for thirty-seven years.’ Both of them have lived so yeah it’s a very fluid word or concept. I don’t think the mental health system has a clue.”

Along these lines, another participant noted, “*my perception hasn’t changed but I know that as far as clinicians and doctors, we have to change their perception of recovery because they’ve got one mindset and they haven’t accepted the new paradigm shift of recovery yet.*” One more participant spoke to mental health system’s resistance to moving toward a recovery model,

“I think I respect the recovery model more and I’ve really had the opportunities to see it work and to see that’s it real and how much more I like it over this medical model. I like it a lot more. I think that I’ve always been that way but I think that I’ve been chastised for being that way just because of the environment. I’m glad it’s happening. I’m excited about it.”

Looking Forward

In addition to the impact of the recovery process upon participants, there was an interest in their perceptions of the future. Specifically, participants were asked about their goals for the future, resources needed to achieve their goals and the supports and strategies they have in place that could be used to achieve them.

Future goals. The first goal related item asked peers to identify their goals for the future. As for the Group 1 Peers during year three, they were asked to discuss any changes in their goals for the future.

Group 1 Peers. Whereas participants identified a wide range of individual goals for the future, their goals could be grouped into two categories: **continuing recovery** and **helping others**. Many of the participants stated they were “*doing it right now,*” suggesting they were maintaining

their commitment to recovery. A few participants stated they wanted to continue to grow and reach new levels of happiness. More specifically, several talked about becoming a CPS and teaching their first WRAP course. Others commented on continuing to teach WRAP courses and starting their own non-profit organization so they could better serve the community. A couple of participants indicated they would like to be hired as a CPS. There were also several discussions about convincing more people who worked in the mental health system to become a CPS. Finally, some of the participants spoke about getting more involved in painting and art related activities.

Several of the participants spoke about helping their families by being a better person and provider. Many of them expressed a desire to make a difference in people's lives through helping others and communities. For instance, several participants expressed their commitment to focusing on helping young people. Others offered similar comments, such as creating a safe haven for people with mental health issues, providing education, spreading the word about recovery, and helping *"people who have been in the cellar of their feelings like I was."* Additionally, participants conveyed their interest in encouraging people to take a greater interest in their health by eating better and participating in healthy activities, such as fitness groups.

Group 2 Peers. The participants identified a wide range of individual future goals, which could be grouped into two categories: **advanced training** and **education**. Many of the participants commented on their progress and desire to further develop their knowledge and skills. Some of the responses centered on acquiring more basic resources to support their job and assist in pursuing other opportunities. Along these lines, most of them talked about pursuing higher education and additional training (e.g., CPS, WRAP facilitator, peer advocacy). In terms of applying the additional training to practice, several wanted to increase the use of WRAP in mental health agencies and all mentioned expanding the recovery process in Texas. Finally, they all expressed their appreciation for the opportunities provided by ETCMHR and a desire to remain healthy and continue their recovery journey.

Group 1 Peers follow-up. Participants were asked to comment on how their goals have changed over the past year. In addition to identifying a number of individual goals, each of the participants commented on their future and mentioned continuing their journey to recovery. The goals were grouped into categories: **improving relationships** and **self-improvement**. Most of the participants commented on their progress and noted that they have shifted their attention to strengthening their relationships with family, friends and other support systems. Others spoke of improving their spiritual connection to a higher power. For example, one participant described her goals in this statement *"I'm trying to work on the relationship with my family. I'm trying to really go to my spiritual. I'm trying to be re-grounded in my spiritual thinking."*

In terms of **self-improvement**, participants commented on maintaining their recovery and engaging in activities to improve self. Interestingly, several participants talked about the importance of helping others to their personal self-improvement efforts. For instance, one participant stated *"it's not about me, but helping others."* And, for her, helping others involves creating opportunities for others to experience mental health recovery. Others spoke of a shift from part-time to full-time employment. All of the participants spoke of using their training to continue an

"...it's not about me, but helping others."

active lifestyle, stay healthy, and progress in their recovery. More importantly, all of the participants appeared to be realistic and well-grounded in their goal setting. Support of such is found in the following comments:

“Oh I set new goals every day. I set goals this week and as I take little baby steps and achieve my goals, and I don’t stop there. Recovery is not stopping. It’s a continual process and I set some goals a little bit higher and I try to reach those. As I reach those, I set more and it may be big goals, it may be little bitty goals.”

“It’s just a little of all kind of little goals and I don’t put a lot of pressure on myself. In setting myself a goal, I try not to cover too much on time limits because you know life happens. Life is good but life can be hard sometimes.”

Achieving goals. When discussing their goals, participants were asked to identify the strategies and supports necessary for goal achievement. They were also asked to identify the strategies and supports they currently had in place.

Group 1 Peers. Overall, the comments from the participants indicated that achieving their goals was dependent upon the following: receiving support, a sense of self, self-motivation, willingness to help others, desire to make a difference, staying healthy, patience and continuing their recovery. Most of the participants communicated a **need for support** from family, friends, community and the coalition. They also expressed their appreciation for the coalition and spoke about its essential role in their recovery process. Some of the participants commented on the need for additional resources, such as people with grant writing skills and additional funds to support people with mental health issues. Furthermore, they talked about continuing to use the knowledge and education they had received to continue their recovery. Finally, a few of the participants talked about maintaining their sense of purpose and the importance of their spirituality to achieving their goals.

As for strategies and supports that they already have in place, participants identified the following sources of support: family, friends, co-workers, support groups, peers, and ETCMHR. Once again, every participant mentioned **ETCMHR’s pivotal role** in their recovery and progress toward accomplishing their goals. Furthermore, most of them expressed their appreciation for the Hogg Foundation, especially for creating and supporting the creation of ETCMHR. Several participants noted the need for the coalition to continue its vital role in advancing mental health services for consumers. In terms of strategies, the most frequently mentioned strategy was their **WRAP**. The following participant statement expresses the value of the WRAP:

“WRAP is an individual program. It is a very good program for recovery because it gives the person the opportunity to take full responsibility of their own wellness. Make a plan, know your triggers, crisis plan, you have a post crisis plan and everything has a plan because in our situation we don’t know what [is] going to happen from day to day. So, we always tried to be prepared for whatever happens to keep us from going into mental state of mind.”

The above statement reflects the participants’ general perspective about the importance of WRAP to maintaining recovery and achieving goals. It is important to note that most of the participants felt that employing a multifaceted strategy is imperative to their success.

Group 2 Peers. As with the Group 1 Peers, the primary goal among the Group 2 Peers was to continue their recovery. In order to accomplish this and maintain balance in their health and wellness, they stated that they needed the following: support, prayers from others, training, and financial resources to pursue higher education. In regard to support, one participant offered the following description of his need for support:

“I need support and encouragement from people that believe in me and that is probably the biggest thing, is to have a support network of people that are encouraging me. Not demanding results, just encouraging me, giving me hope and believing me.”

“I need support and encouragement from people that believe in me and that is probably the biggest thing...”

Several participants expressed a desire to seek advanced peer support training and to become trainers. Along these lines, others mentioned improving their job opportunities via pursuit of a college degree, which they noted would be dependent upon availability of financial support. Finally, as with the Group 1 Peers, they expressed appreciation for support from their friends, family, community and ETCMHR.

The participants described a number of supports and strategies they had to assist them in achieving their goals. The two themes that emerged were **support networks** and the **tools or skills** learned while in recovery. The support networks were similar to those identified by the Group 1 Peers and included family, friends, co-workers, counselors, support groups, peers and ETCMHR. The following statement encompasses the extent of the support,

“I have the support of my family members. Then I have a job so that’s gonna help me financially. I have my old vehicle. I have the coalition for the WRAP training and the HOGG Foundation is funding that training for the WRAP facilitator training. I have members of Take 2 [Group 2 Peers] that are gonna be there and we can help support and encourage one another through the process and I have the people at my job that are pulling for us.”

As for strategies, participants mentioned that they must be multidimensional, which is consistent with the responses of the Group 1 Peers. The most frequently mentioned strategy was their **WRAP**, the value of which is demonstrated by the following statement:

“You know I’m not gonna lie. I was lost for a while and I thought all my answers was in that problem, but then I realized that the problem’s still there. So, when I was introduced to WRAP, I would just go through the motions you know, hear what they have to say, and that would be it. But then WRAP took everything out of my life, like this is what I needed. There is hope for me. I could have a future.”

“...But then WRAP took everything out of my life, like this is what I needed. There is hope for me. I could have a future.”

Participants also mentioned the importance of being yourself and recognizing your unique strengths. For example, *“I think it’s to be yourself and to show that everything you’re learning about recovery and about yourself that you’re able to share with other people to help them do the same.”* As with the Group 1 Peers, each participant expressed appreciation for the Hogg Foundation and ETCMHR’s vital role in their recovery and progress toward their goals.

Group 1 Peers follow-up. The Group 1 Peers spoke of their future goals and what they needed in order to achieve them. Several of them mentioned the need for financial resources to meet

their basic needs, such as housing and reliable transportation. Others commented on using their financial resources to help others and advance the recovery movement. In terms of a common theme, many of the participants spoke of the desire for **continuing education**, which they viewed as an avenue for advancing the recovery movement. For example, participants wanted to pursue certifications (e.g., CPS, WRAP Facilitator, etc.) and attend conferences, such as *Alternatives*. The following statement exemplifies the thoughts of participants concerning the importance of continuing education,

“I would like to continue going to Alternatives, meeting up with so many people of different backgrounds and stories and real life experience. Speaking about recovery is just an amazing adventure and I just appreciate all the people that have helped me in my recovery, especially the East Texas Coalition, and the WRAP, and stuff.”

In addition to continuing education, they also reiterated the importance of the Hogg Foundation, ETCMHR, and **WRAP**. All of the participants credited the Hogg Foundation and ETCMHR with making a substantial difference in their lives. For example,

“I would like to say that the Hogg Foundation has been instrumental in my recovery and I really appreciate what they’ve done. Stephany Bryan is great. Jim Lemon is great. I just can’t say enough of those two and Jim Lemon continues to be an influence in my life.”

As exemplified by the following comments, WRAP continues to be key tool in the participants’ recovery process.

“WRAP made me be so not auto-pilot and unpredictable and gave me some structure; that was a good thing.”

“I’d say I have to use my WRAP every day and especially during this time of year [early fall].”

The Group 1 Peers reported having a variety of supports and strategies in place, which can be grouped into the following common themes: **strong support network, resources, and more training**. The most frequent comment from participants was the importance of support from their jobs, family, friends, their spiritual beliefs, community, and ETCMHR. Several participants talked specifically about ETCMHR and its positive impact on their recovery and goal achievement. Along these lines, many stressed the importance of ETCMHR’s meetings as a vehicle for providing support and the need to continue such meetings. Examples of the importance of support and resources include,

“I’m surrounding myself with people that are supportive and encouraging and I’m not letting people that are negative in my life. I’m not letting them get in my head.”

WRAP

“WRAP made me be so not auto-pilot and unpredictable...”

“I’d say I have to use my WRAP every day...”

“...I’ve got all that and I use my WRAP.”

“...And it’s just all sorts of different things that WRAP has helped me with.”

“I got all my family support. I got the East Texas Coalition. I’ve got all that and I use my WRAP. Sometimes I use my E-CPR⁸ and one on one’s when people have been in emotional problems and that really helps out my job area.”

The most common resource was WRAP, which all of the participants identified as the single most important resource or tool for achieving their goals. Examples of such include,

“And I have to stop and think of my distraction activities and I have to stop and think about my support. And it’s just all sorts of different things that WRAP has helped me with.”

“I’ve had experience with major depression ever since I was 15 years old. So, you know my whole life I have dealt with that and so using recovery tools for that and using recovery tools for life stressors. You know, I have to have those tools or I’d probably be dead. I know that sounds dire but it happens.”

Finally, the participants reiterated the importance of additional training and education to remaining healthy and achieving their goals.

ETCMHR’s Impact on the Recovery Process

Given that ETCMHR was developed to assist with the implementation of peer support services and the recovery approach to mental health services in East Texas, there is a particular interest in the peer specialists’ view of ETCMHR. Specifically, participants were asked about ETCMHR’s impact on their recovery process and quality of life. They were also asked to identify the most and least helpful components of ETCMHR.

Impact on individual recovery. Group 1 and Group 2 Peers were asked several questions about their perceptions of ETCMHR, the first of which focused on its impact on their recovery. It is important to note that all of the responses to this question were consistent with responses to other related items.

Group 1 Peers. Everyone spoke of the importance of ETCMHR to their recovery process, through which three themes clearly emerged: **hope and purpose**, **support systems**, and **knowledge and skills**. It is interesting that hope is one of the ten fundamental components of recovery and viewed as a catalyst for the recovery process (Substance Abuse and Mental Health Services Administration [SAMSHA], 2006). Participants consistently mentioned that they found hope and purpose through their involvement with ETCMHR. For instance, one participant stated that *“since the coalition I have gained a sense of hope.”* Another participant offered the following perspective:

“I was having trouble with having hope. The coalition belief [sic] in me from the get go, accepted me and took me in as one of their own, and worked with me. I was a child of God that didn’t do anything. They believed in me and gave me hope. Just like family, support me in everything I do. Telling me I am a great guy and I’m so proud of you. It means a lot to me. I couldn’t have done it without them. It impacted my life so much, I want to make the coalition bigger.”

The sentiments expressed in the previous quote were common across the participants. The majority of them pointed out that ETCMHR had instilled hope through encouragement and showing

⁸ E-CPR - Emotional CPR

“They understand what I am feeling and they share their feelings with me that give me hope. Just knowing and seeing their recovery has lifted my hope in recovery.”

them that recovery was possible. An important aspect of this was providing opportunities to interact with others who had similar experiences. For example, one participant stated, *“They understand what I am feeling and they share their feelings with me that give me hope. Just knowing and seeing their recovery has lifted my hope in recovery.”* It is also likely that their hope stems from perceptions that ETCMHR’s efforts are changing societal views of mental illness and those who suffer from it. For example, a participant noted the coalition is *“all about recovery. It changes the view of mental health from something that is bad.”*

The next theme, the **support system**, further expands the understanding of the impact of ETCMHR on the participants’ recovery process. There was a complete consensus among participants that ETCMHR was the most renowned support system with which they have been involved. Many gave testimonials of how ETCMHR had impacted their lives and their recovery. The following statement conveys the thoughts of one participant:

“The coalition has formed such a bond with people. We have form [sic] friendships and bond [sic] with people. The ability to network with people so we do not feel like we are alone. When I talk about in the beginning I was alone, well I am not alone anymore. I have a network of people that cares about me and knows about me. That can help me out anytime I need help. That will be there for me in a minute if I need them.”

Other participants noted that ETCMHR *“has given me a family and self-confidence,”* has been *“the best group support ever”* and *“keeps me on the right track.”* Perhaps more importantly, the participants noted that their involvement with ETCMHR has motivated them to help and touch the lives of others.

The final theme centered on the **knowledge and skills** of recovery that each participant gained from and contributed to ETCMHR. Specifically, they talked about ETCMHR’s role in helping them to develop an understanding of recovery, as well as the knowledge and skills necessary for a successful recovery. Along these lines, they also expressed an appreciation for the bonds and friendships they had established with other members of ETCMHR. There was consensus among all of the participants that ETCMHR had given them the tools to be successful in their recovery. One of the most effective tools participants described and commented about was the WRAP. Many of the participants gave examples of how they are using their WRAP, some of which were presented earlier in this section.

Group 2 Peers. Many of the participants had an emotional response to this question and the discussion it generated was very similar to that of the Group 1 Peers. The participants were in complete agreement about the value of the relationship with ETCMHR. Specifically, it was clear that ETCMHR is the glue that has held them together as they moved through recovery. They attributed the following to ETCMHR: coming to believe that life could improve and that they could achieve a better quality of life. They also directly attributed their

“I’ve been in recovery but I’ve didn’t really get recovery until this coalition started because that’s when I started getting the education and that’s what I needed, the support I needed.”

newly found capacity to take control of their lives and overcome life's challenges to the knowledge and skills they had developed via involvement with ETCMHR. In examining the response, three themes clearly emerged from the responses: **hope**, **empowerment**, and **self-confidence**. The themes of hope and empowerment are illustrated by the following responses:

"It made me more aware that I have an illness and the help is there and all I have to do is ask for help."

"I do have a future because you know there is hope for me and my hope is a future."

"The information that I've been given through this process, I really feel that's empowered me to be an advocate for myself."

"I've been in recovery but I've didn't really get recovery until this coalition started because that's when I started getting the education and that's what I needed, the support I needed. I was just going through the motions of helping people but I wasn't really helping."

In terms of **self-confidence**, participants noted that involvement in ETCMHR had contributed to a greater degree of confidence in their abilities and capacity for change. As mentioned above, the coalition provided the context for personal growth. For example,

"I was introduced to WRAP before the coalition, but the coalition provided a way for me to connect to other peers who are going through some things, wanting to promote recovery, and take responsibility for their life."

"It has given me a network of individuals to communicate with and stay in touch with that help. We help promote recovery in each other. And, that's the biggest thing that it has done."

Group 1 Peers follow-up. During the follow up interviews, the Group 1 Peers were asked to reflect on the past year and talk about ETCMHR's impact on their recovery. The common themes that emerged from the comments were **support systems**, **strength**, **courage** and **hope**. In terms of support systems, most of the participants spoke of the support provided by ETCMHR and the essential motivating message for a better future. For example, one participant stated *"just watching everybody else grow has helped me grow and being connected to the people in the coalition, even though they're not there, I know they are there with me and I draw a lot of strength from them...."* Another mentioned the *"grant from the Hogg Foundation that supported trips, training and allowed us to connect with others was critical to our recovery."* Several other participants commented on the value of the face-to-face meetings and other aspects of the group that helped them in their recovery. Other commonly mentioned sources of support included friends, peer groups, family, counselors, and their communities. In contrast, a participant talked about a newfound interest in *"thinking about managing and improving mental health in various ways."* For example, she described the important role of peer specialists in the recovery process, which has not been embraced by many mental health professionals and providers in the region.

Strength, courage, and hope were typically mentioned together, all of which participants noted were necessary elements for sustaining one's recovery. In fact, each of the participants credited ETCMHR with being the catalyst for their recovery. Examples of such include,

"They pushed me to go forward and it gave me the strength to go forth and they have supported me the whole way through and they, in the past year, helped me try to go onto a full-time job."

“They have given me support and I have made a lot of friends, and other people working in the mental health field.”

“I have been given hope and courage to do things and not be afraid to step out there and speak up for mental illness and I’ve gotten most of my support and everything from the Hogg Foundation.”

A number of the participants spoke of the validation and sense of worth they found in recovery, which gave them the strength and motivation to continue their recovery even when they faced challenges. Finally, the following statements demonstrate the significance of a support system coupled with a sense of strength, courage and hope:

“My overall quality of life has been improved immensely. I am pretty much stress free right now. I don’t worry about too many things. I’m happy and a year ago, you know I still was having troubles, and sometimes I was unhappy and had symptoms and the coalition is the mold that brought me into the stability of recovery.”

“It shows me I have a strength base, a support system, and even if I’m not sure I can do something, I can look at my friends and see how they’ve done things and try to draw strength from their strength.”

Impact on overall quality of life. Group 1 and Group 2 Peers were asked to discuss the impact of ETCMHR on their overall quality of life.

Group 1 Peers. The responses to this question suggest agreement on the perception that the participants’ overall quality of life had improved as a result of their involvement with ETCMHR. The sentiments conveyed by the following statements echoed across responses, *“my whole life is better,”* *“I’m thinking and handle things better”* and *“I can enjoy myself and have fun again.”* In thinking about the aggregate of responses to this question, the common elements or themes were a sense of **purpose, confidence** and **empowerment**. As one participant noted, ETCMHR *“empowers them to understand that the illness does not define them.”* The idea of moving past definitions and labels is also echoed in the following statement: *“It is a whole new thing that opens my eyes so much into what I really want to do with my life. Before I never had a purpose, and now I do.”* Both of these statements represent a consistent belief among all the participants.

ETCMHR “empowers them to understand that the illness does not define them.”

“So my quality of life is a lot better because I’m more stable. And, I mean, even when I get sick I maintain.”

Not surprisingly, many of the participants revisited the themes that emerged from the responses to the previous question (**hope, confidence** and **support**), all of which were attributed to ETCMHR’s efforts to create a safe and secure environment in which they could share their recovery journey. Another participant commented that she has greater expectations for herself and a belief she can recover from her illness, both of which she attributed to her involvement with ETCMHR. Many of the participants gave very similar messages that indicated they believed they could recover, they were not alone, and that ETCMHR was the key to their recovery. For example,

very similar messages that indicated they believed they could recover, they were not alone, and that ETCMHR was the key to their recovery. For example,

“I don’t know if I can quantify it. But, I’ll tell you this much, my life’s a lot better today than it was a year ago. So my quality of life is a lot better because I’m more stable. And, I mean, even when I get sick I maintain. And, I don’t know where I would be today without the coalition. And, I don’t want to go there.”

It is important to note the majority of the “support” mentioned by the participants came from the relationships they have developed with other members of ETCMHR. For instance, all of the participants credited their success in recovery to the bonds among members and social networks established within ETCMHR. Many of them also mentioned the importance of the formal and informal activities and training to their recovery journey. Undeniably, the responses clearly suggest that ETCMHR has improved the quality of life for all of the participants.

Group 2 Peers. The Group 2 Peers’ responses demonstrated a clear belief that their quality of life had improved tremendously, and would continue to do so, because of their involvement with ETCMHR. As with their responses to the previous question, participants noted that ETCMHR had given them hope, purpose and/or support. For one participant, ETCMHR “*gave me life.*” The common themes that emerged from the responses were **support** and **skills**. According to the participants, one of the most important forces in their journey to recovery was the support system they found within ETCMHR. For some, the support was lifesaving. For instance,

“If I didn’t get into this coalition four years ago, and given the support and the trainings and the education and tools, I wouldn’t be where I’m at right now. If I was going through what I am going through right now without what I have had in the last four years...I most likely would be out there trying to kill myself.”

Many reported that involvement in the coalition has instilled greater expectations for themselves, as well as a stronger sense of self-efficacy. Participants also spoke of the skills they had acquired through involvement with ETCMHR (e.g., WRAP). They attributed their ability to manage the “ups and downs” to the skills and their support network. The importance of the trainings is exemplified in the previous quote, as well as the following one:

“I’m able to take responsibility, to manage my wellness by making decisions, by knowing when to step back, by saying hey I need this for myself, to speak my need, and to advocate for my needs”.

Group 1 Peers follow-up. The Group 1 Peers reported that they believed their quality of life had continued to improve over the last year, especially in terms of **self-confidence** and **independence**. In comparison to the first year interviews with this group, the increase in self-confidence and independence in their voices and responses was evident. The growth in self-confidence is evidenced by the following response:

“It’s just done nothing but made me feel a part of something bigger than myself and when you are a part of something bigger than yourself, it just makes you a better person, when you know that there are people out there that are supporting you, there’s just nothing better. Of course, my God is my mainstay,

but then having friends that are connected like the coalition is, it's just not a replaceable type thing in your life.”

Along with self-confidence, many of the participants talked about positive events in their lives, such as healthy relationships, helping others, gainful employment, financial stability, and confidence that life would continue to improve. Participants also spoke of an increase in their independence. For example,

“I’m happy every day now. I got a home. I get to work with people that have mental issues and you know I manage everything about what I do, my cooking. I’m not dependent on anybody anymore and like I say, if it hadn’t been for that, I probably would have committed suicide and I wouldn’t be here and I’m thankful for all the help and the support and the love that I’ve got from different people.”

The above quote is a very powerful expression that communicates this participant’s independence and improvement in the quality of his life.

Strengths/weaknesses of ETCMHR. Group 1 and 2 Peers were asked to identify and discuss the elements of ETCMHR that have been helpful in moving them toward their current place in the recovery process. They were asked to do the same for elements that had not been helpful in the recovery process.

Group 1 Peers. The ideas and suggestions offered by Group 1 Peers can be categorized into two themes, **support** and **education/knowledge**. In terms of support, many of the participants commented on the level of support that has helped them on their journey to recovery. One of the most important sources of support was ETCMHR, especially in terms of the relationships among peers. When asked this question, one participant responded, *“my relationships with others, I would say that’s number one.”* The participant also noted that all of the participants attribute the presence and strength of the relationships among peer specialists to the Hogg Foundation and its efforts. Specifically, the participant noted that the Hogg Foundation was responsible for creating an atmosphere where the relationships had the freedom to blossom. The importance of peer relationships to the recovery process was present in most of the responses to this question. In fact, several participants described the anticipation and excitement they felt as a result of meeting with their peers. The opportunity to have social meetings and share their stories was a tremendous benefit to their recovery.

“My relationships with others, I would say that’s number one.”

As for **education and knowledge**, all of the participants spoke about the importance of the training sessions to their forward progress with recovery. The participants identified a variety of topics, including mental illnesses, medications, best treatment practices and available resources. The training sessions that were identified as most helpful include the Respect Institute, Peer Support, and WRAP. Of these, WRAP was noted as being the most important training. Specifically, all of the participants pointed to the critical importance of WRAP and how helpful it was to their recovery process. It is also important to note that many of the participants spoke about the benefits of ETCMHR’s financial support for travel to trainings and meetings.

In terms of the elements that were least helpful, most of the participants responded by noting that all the elements of ETCMHR were extremely helpful and commented on the positive

nature of their overall experience. Some of the areas that participants suggested were the least helpful included working with people who do not appreciate and understand “*what we do.*” Along these lines, participants identified the Focus for Life training as having limited value. In fact, several suggested that it be eliminated. Another suggestion was to replace telephone conferences with face-to-face meetings, because the latter was believed to be of greater benefit. Finally, it was suggested that the “*politics of funding*” presented a barrier to success. Specifically, it was suggested that funding priorities should be determined by the needs of consumers rather than other factors.

Group 2 Peers. When presented with this question, the Group 2 Peers identified a number of elements that have been helpful in their recovery process. As with the Group 1 Peers, their responses can be categorized into two themes, **support** and **education/knowledge**. In terms of support, most of the participants spoke of the importance of ETCMHR’s role as a social support network to their recovery. The following quote demonstrates the importance of support and WRAP:

“By far the most important tool was having support. Healthy support around me and then having a wellness recovery action plan because that gave me greater insight and validated to me, it validated who I was in my voice, and where I was at in the world. That I wasn’t invisible and that I could do something. And, then all the other ones just added to it to strengthen what was built on that first WRAP.”

Education and knowledge involves the training opportunities and related information they gained about recovery and mental health, including recognizing and managing their mental health symptoms. Of all the training opportunities, WRAP appeared to be the most important. Most of the participants clearly believe that WRAP is a life changing tool that should be used by everyone. In fact, several participants articulated a vision where they could educate various groups about the strategic use of WRAP. The following quote truly captures the essence and importance of WRAP:

“WRAP has become very important to me – my maintenance of my recovery. And, I have a daily maintenance plan that I very much try to stick to every day. I was before a type of person that I refused to ask for help. I refused to speak to people about what I was going through because I didn’t want to feel like a burden or a buzzkill or whatever you want to call it. And, WRAP has helped me open up and be able to trust and rely on my supporters and to know I have people in place in my life that are moving towards their own wellness and recovery and some of them are further advanced in theirs, and can meet me where I am and tell me how they made it through these situations similar in their lives and it just really completely changed my whole concept of myself and the world. I don’t

WRAP

“...having a wellness recovery action plan because that gave me greater insight and validated to me, it validated who I was in my voice, and where I was at in the world.”

“And WRAP has helped me open up and be able to trust and rely on my supporters...”

“And, without the WRAP I could have never done the Respect Institute because I would have never know how to deal with those problems when they that came up.”

know how else to describe it. It's really indescribable with the limitations of words."

In a contrasting comment, one of the participants identified the Respect Institute as the most helpful element. However, he also noted that his attendance at the WRAP training was the key to his success with the Respect Institute training. Specifically,

"You know the Respect Institute was the biggest part for me. And, without the WRAP I could have never done the Respect Institute because I would have never know how to deal with those problems when they came up. They're like combined so well they're intertwined. I love them! I've dealt with feelings a lot. I've dealt with kid feelings you know? I've lived my whole life but I never felt how I felt at the Respect Institute. I finally did and I broke down there. Yeah I broke down like a little kid and I was like wow. I thought I'd dealt with all this but I never really did because I never felt it."

The Group 2 Peers expressed very few concerns about elements that were not helpful. In fact, most of the comments related to how helpful ETCMHR was in engaging them in productive activities and providing opportunities for growth and development. The handful of comments about unhelpful elements were limited to the Respect Institute, which stemmed from a belief that it limited participants' opportunities to share their experiences. Other aspects that were mentioned included adding new members to a group that was initially formed as a closed group and ETCMHR's inability to address the LMHA's resistance to shifting to a recovery orientation. Along these lines, there were some concerns related to the role of peer specialists in the recovery movement.

Group 1 Peers follow-up. During the follow-up interviews, the Group 1 Peers identified various elements that have helped them through the process of recovery. The responses can be categorized into two common themes: **support networks** and **training/skills**. Both themes convey the participants' progress and the influence of ETCMHR upon such. Whereas they frequently spoke of family, friends, and peers as sources of support, the most critical source of support appears to be ETCMHR's peers and staff. One of the most common comments was the critical importance of the face-to-face meetings and the support groups, both of which allowed them to interact regularly with their peers, build relationships, stay connected, and gain new knowledge. They felt that these experiences assisted them in gaining and maintaining control over their own destiny.

In terms of **training and skills**, most of the participants spoke of their struggles to understand, give meaning to, and cope with experiences in order to maintain wellness. As with the initial interviews, all of the participants identified the WRAP training and related skills as being the most helpful in moving them through the recovery process. Other commonly mentioned trainings included Respect Institute, E-CPR, CPS, and WRAP facilitator training. Participants were also overwhelmingly thankful for the resources provided by the Hogg Foundation, which funded their attendance at many of the trainings. The following statement summarized the overall thoughts of the participants about the value of their training:

"All of the trainings – any of the trainings that we were able to go to. And, oh there's so many because the trainings were so important to get us to where we are now and you know you think how am I gonna absorb all this stuff that we're learning and it all comes back at the time that you need it. You think gosh, I'll never learn all this stuff but you do. You don't realize it at the time but you do learn it all. And all the trainings have just been valuable."

When asked to identify elements that were the least helpful, participants identified several elements that can be grouped into three common themes: **administrative support, training, and sustainability**. Several participants were concerned about the lack of administrative support from some of the LMHAs, which they blamed for the loss of several peer members of the coalition. The resistance to shifting from a treatment orientation to one of recovery was also attributed to a lack of administrative support. Along these lines, a participant expressed frustration with “*caseworkers who think the certified peer specialist is going to take their jobs.*” In terms of training, several participants identified Focus for Life as the least productive training and attributed it with setbacks in their recovery process. For instance,

“...I don’t think we’re gonna be doing the Focus for Life ever again in the coalition and stuff because that set me back in the last year and that’s when I ended up going to the crisis unit and so I think the Focus for Life was definitely the least productive and the least helpful.”

Concerns around sustainability were linked to the participants’ perceptions of the importance of the financial and staff support provided by the Hogg Foundation. Many of the participants were worried that the nearing end of the funding cycle would limit their ability to meet regularly and attend trainings. The larger concern appeared to be of the unknown or how the role of ETCMHR may change as a result of the funding coming to an end.

RECRUITING PEER SPECIALISTS

Focus group meetings with Group 1 Peers were conducted for the purpose of gathering information to inform the development of a process for the identification and recruitment of consumers to provide peer-to-peer support services. The process was guided by the following overarching research question: What elements are important to the identification and development of consumers who are ready to deliver peer-to-peer support services? The research question was answered with qualitative data that was collected via the focus group sessions. The specific questions that were asked during the focus group sessions, as well as the methodology and results are detailed in the following sections. A discussion of the results and their implications is provided later in the report.

Methodology

Participants and Sampling

The participants were Group 1 Peers who were in attendance at an ETCMHR training event that was open to all 22 of the peer specialists involved with the coalition. The event was attended by 18 of the providers, all of who chose to participate in the focus groups. Demographic information for the participants is presented in Appendix E - Recruiting Peer Specialists.

Design and Data Collection

The focus group meetings took place during Year 2 in conjunction with a regional meeting of ETCMHR's peer specialists. Eighteen of the 22 peer specialists were in attendance and all of them chose to participate in the focus group meetings. The participants were split into two groups of nine by the Hogg Foundation Program Officer who was facilitating the regional meeting. She divided the groups based on her knowledge of the participants and their dynamics, the intended result being two balanced groups. The focus group meetings were held in separate locations at the same time and were facilitated based on a pre-established protocol. Specifically, participants were provided an overview of the purpose of the focus group, review of the consent form, and collecting demographic information from the participants (via written form). Participants were given 10-15 minutes to review and think individually about the following discussion questions:

1. How would you go about recruiting consumers to become members of a coalition such as this one?
2. What activities should be offered to assist consumers in making the transition to recovery and to providing peer-to-peer support?
3. What type of peer support are participants providing?
4. Do you think there are different skills or experiences that better prepare you to be a certified peer specialist versus a WRAP facilitator?
5. Are there different skills or recovery experiences that lend themselves to the peer being a good fit for offering a specific kind of peer support service (certified peer specialist, WRAP facilitator, etc.?)
6. What are the key elements of the recruitment process?
7. What are the key elements of the transition process from being a consumer to being a consumer who provides peer support services?

Once the participants were ready to discuss the questions, they were provided instructions for the “round robin” process that guided the group discussion. Specifically, the facilitator moved around the table giving each participant an opportunity to comment on the question at hand before moving on to the next question. Group discussion about the individual responses was encouraged.

Digital audio recordings of the focus group sessions were made and used to create a transcript for each session. Each session was attended by a recorder who took notes regarding their impressions of the process and discussion. The recorder and facilitator reviewed the session transcript prior to analysis. Once the transcripts were completed, the responses for each question were aggregated and reviewed in order to identify the most frequent ideas and suggestions. Responses were then grouped by common themes and reviewed again for consistency with the related theme.

Results

The primary purpose of the focus groups was to gather information that could inform the development of a process for identifying and recruiting providers of peer-to-peer support services. Specific attention was given to recruiting peer specialists, making the transition to being a peer specialist, and providing peer-to-peer support services. A summary of the common themes, as well as unique ones, for each of the questions are presented in this section. Where appropriate, examples of situations or events that illustrate the participants’ perspectives on peer support services are provided.

Recruiting Peer Specialists

Given ETCMHR’s focus on recruiting consumers and training them to provide peer-to-peer support services, one of the primary goals of the focus group was to solicit ideas from the current members about recruiting peer specialists.

Recruiting consumers for ETCMHR membership. Three themes emerged from the analysis of the discussion prompted by this question: **the need for a selection and screening process, multifaceted approach to recruitment** and **compensation** (full-time and part-time employment). The need for a selection and screening process for recruiting consumers to be a member of the coalition generated a fair amount of discussion across the groups. The comments under this theme centered on the need for stability and independence. One participant talked about the need for peer specialists to be involved in training, which would most likely require travel. The concern was that one would have to be far enough along in his/her recovery to be able to manage his/her wellness in an unfamiliar environment and away from his/her typical sources of support. Of particular importance is one’s ability to manage difficult situations away from home while remaining well. As a general side note, the same participant stated *“I’d have to really look at the stability and independence of a person before I’d try to invite them to join the coalition.”* The importance of ensuring one is stable in his/her recovery is demonstrated by the following comment:

“My opinion, when I first got to the coalition. It started off doing WRAP class, and everyone that I met had went through whatever they went through were well, were stable, were independent, were able to give input, good feedback on their recovery and stuff. And, it’s just a knowledge that if we’re trying to give this away, we have to have people involved with the same criteria so they can do the same thing we’re doing. We don’t want to get them into the coalition and

three days after they enter they crash and burn. We want them to be stable enough and independent enough to give back what others need for their health recovery.”

Another participant supported this point of view and suggested that consumers should express an interest in getting better themselves, as well as demonstrate a willingness to help improve the lives of others. In contrast, a different participant suggested that you may need to look past their surface characteristics and behaviors. Specifically, the participant noted that,

“...you can't judge a book by its cover because when I first started out in the job there were people I couldn't stand and I thought, oh God, I've got to deal with that person today, but now, as I've progressed and gotten to know them, they're my favorite people. So you've got to really have an open attitude.”

The second common theme across responses to this question was the use of a **multi-faceted recruitment process**. There were various suggestions as to the specific elements, including sending out invitations and recruiting through various avenues, including the mental health centers (LMHAs), drop-in centers, and current providers of peer-to-peer support services. For example, one participant suggested going to the LMHAs to provide an overview of the peer support program. Several participants discussed the importance of inviting potential peer specialists to the drop-in centers in order to observe the peer support culture, which most described as a supportive and stigma-free environment. Several others pointed out the importance of using peer specialists as recruiters, as well as friends and family members. Peer specialists could be the best advertisement since they frequently interact with consumers and are typically viewed as role models. These sentiments were consistent across responses and are exemplified by the following comment: *“that by many of them having a mental health diagnosis, they are able to recruit consumers by providing an example of how they can achieve well-being and help others in recovery.”* Several participants suggested recruiting peers that are already participating in support groups because they demonstrate that they are *“more amenable to help.”* Additional suggestions included the use of flyers, inviting potential specialists to ETCMHR meetings, and referrals from professionals (e.g., mental health service providers and physicians).

The final theme related to recruitment focused on **compensation** and **employment**, both full-time and part-time. The financial burden created by the limited nature or absence of compensation for involvement in the coalition was a common concern. As noted earlier in the section on participant characteristics, seven of the participants are employed full-time, seven are employed part-time, and the remaining four serve in a volunteer capacity. Whereas they stressed their commitment to ETCMHR and desire to remain involved, an inability to earn a living wage while doing so presented a substantial barrier. Furthermore, they were concerned that these circumstances would present a major barrier to recruiting new members. For example, participants stated most of the jobs are part-time, which limits who they can recruit. Although some people might be interested, they will not leave a full-time job and those receiving government benefits are fearful of losing their benefits.

Peer specialists stressed their commitment to ETCMHR and desire to remain involved. However, an inability to earn a living wage while doing so is a substantial barrier.

Key elements of the recruitment process. Participants' comments regarding the elements of the recruiting process were categorized into five themes: **communication, role models and mentors, empowerment and education, structure, and funding.** Participants suggested that communication regarding the recruitment of consumers should be by word of mouth. They felt that mental health employees could help with such efforts by talking to consumers who are interested in the program and/or are a good fit for it. However, participants noted that effective recruitment by mental health employees would be dependent upon their knowledge of the WRAP and CPS programs. Participants also noted that recruitment could easily occur through mentor or role model relationships among current peer specialists and consumers. Along these lines, a participant commented on the importance of “*live recovery*” and being an example that would encourage others to want to participate in peer-to-peer support services.

The next theme identified by participants was related to **empowerment and education.** Participants discussed the significance of having an “*empowering model*” that included education. One participant talked about finding consumers “*with a desire to recover*” and how combining such a desire with education can create an ideal candidate for peer-to-peer support services. Another suggestion was to focus on educating consumers in a manner that brings them to the realization that recovery is possible. Another participant added to this idea by suggesting that they take consumers “*to the training so they can get an understanding of the program.*” Finally, participants pointed out that creating drop-in centers throughout the communities would provide consumers with support services and create recruitment opportunities.

The fourth theme related to elements of recruiting consumers centered on the need for a formal **structure** to support the recruitment process. Several participants immediately noted the importance of educating consumers about the service delivery policies and procedures, especially those that are directly related to protecting consumers and important to administrators. These concerns are captured in the following quote, which describes the importance of understanding job expectations and related conflicts:

“It just seems like there’d be a lot of, as [removed participant’s name] was saying, if you’re connected with any agency or institution, there’s going to be rules, you’re going to have to keep that person out of trouble whether you like them or not, you need to know about them so that you don’t get yourself in a mess or ignore them and go on to your own things. I think they need someone in the beginning who can be there for them, when they first start this, just to answer questions and be available for support and help them deal with some of the things they’re gonna have to deal with between the administration and their job or their position.”

The final theme or element of the recruitment process emphasized the need for **funding** to support peer specialists in the fulfillment of their responsibilities. For example, participants noted that efforts to recruit peer specialists would require funding. Also, funding would be necessary for retention of those providers (e.g., funding for salaries, travel, and training). Along these lines, most of the participants were concerned about the stability of ETCMHR due to the lack of funding. The following quote describes a participant’s experience with recruiting a peer specialists and conveys the groups’ concerns regarding funding stability and recruitment:

“He’s one of the peers that I recruited for Peer Specialist. Let me tell you something that made me proud of him but it’s a fact. He told me the other day when I started to recruit him to come to the [removed name of the center] he told me his mother and his sister said whoa, whoa, do you want to go to work, if you do, you’re gonna have to give up your houses, maybe give up your housing and your assistance and the different programs that he’s in. The entitlement program. And I was proud of him because he turned to his mother and said, do you want me to be on entitlement the rest of my life? I was proud of him for saying that, but at the same token, working at minimum wage he’s never gonna be able to reach that total commitment, because he only can work part-time. He runs the risk of losing his entitlement.”

It is important to note that the above quote reinforces the earlier concerns about adequate compensation for peer specialists.

Transitioning to the Role of Peer Specialist

In addition to identifying the key elements of recruiting peer specialists, there was an interest in helping consumers make the transition to being a peer specialist. Specifically, the focus group members were engaged in a discussion with the goal of identifying the key elements of the process and activities that could assist in the transition.

Transitioning from consumer to provider. The participants generated a number of ideas related to key elements of the transition from being a consumer to a provider of peer support services, which can be organized into the following common themes: **hope**, **personal responsibility**, **learning from experience** and **support systems**. The theme of hope allowed participants to discuss their experiences and their transition from being a consumer to a consumer who provided peer support services. Many participants commented on their own recovery process and the challenges of achieving and maintaining recovery. One participant mentioned the importance of having “*hope even if you don’t believe it.*” Another participant described the magnitude of hope as “*trying not to doubt yourself.*” Additionally, participants noted that one of the keys to their transition was knowing that there is hope and that recovery is possible.

One of the most frequently identified elements was related to **personal responsibility**. Specifically, a substantial number of the participants spoke of the importance of personal responsibility to keeping oneself in recovery. For one participant, this meant that you could not continue to be in “*denial about your mental health diagnosis.*” Another participant talked about one’s responsibility for establishing and maintaining a “*feeling of competence and wellness.*” This sentiment was echoed by another participant, who noted the importance of personal responsibility and added that “*if you’re well, others will want to become well too.*” The theme of personal responsibility was also evident in other comments regarding personal growth, such as “*being willing to learn as much as possible.*” Finally, the discussion of personal responsibility also included a responsibility to help others through the process.

Participants conveyed a **sense of responsibility** to others through a variety of comments, including noting the importance of “*sharing what you’ve learned with other people*” and “*getting to a place where you can give help back.*” Whereas sharing with and helping others benefits consumers, it is also of great benefit to the peer specialists. Specifically, revisiting and sharing their experiences

serves to validate their progress in recovery. The importance of this is mirrored in the following comments: “*giving back does more for me than it does for others*” and “*I need this to maintain my own recovery.*” In summary, it appeared that most of the participants were in agreement that the provision of peer services was as much a part of the provider’s recovery as the recovery of the peers that he/she was assisting.

The last two themes evolving from the responses to this question are **support systems** and the **ability to learn from experience**. Many of the participants spoke about the value of a strong support system during the recovery process and their transition to a provider of peer support services. The majority of participants agreed that one of their strongest support systems was their peers. In early discussions, some participants equated their peers to family members on whom they could depend. In terms of learning from experiences, the participants felt that an important part of providing peer support services is the ability to learn from one’s experiences and the experiences of others. In fact, they equated the ability to learn from others’ experiences to the ability to be inspired by others. For example, one of the participants felt that an important element of learning is the ability to follow the examples set by those around you. Others talked about the importance of finding inspiration in peer specialists who have overcome substantial barriers to recovery, in some cases greater barriers than those faced by the participants. The key here is the ability to find hope in the successes of others.

Facilitating the transition. The responses to this question can be organized into two broader themes: **roles of peer specialists** in the LMHAs and the need for **treatment/support services**. Participants were fairly concerned about the need for more attention to the roles of peer specialists within the LMHAs. Within this theme, the primary emphasis was on the need to move peer specialists from volunteer to employee status and to create additional paid positions for peer specialists. It is important to note that many of the participants felt that providing opportunities for viable employment would assist the providers in their recovery efforts. Another concern related to roles within the LMHAs was the degree of autonomy granted to the peer specialists. There was consensus on the sentiment that peer specialists were typically told what to do rather than being allowed to participate in the decision-making process. This situation was viewed as being counter to their recovery and transition from consumer to peer specialist. Finally, both focus groups spent a substantial amount of time discussing issues arising from role conflicts. Specifically, they viewed the traditional approach to service delivery as inconsistent with the peer-to-peer support model. For example, they placed a great degree of importance on interacting with consumers in a variety of activities and being available to them outside of agency hours. To varying degrees, such behavior is frowned upon by the LMHAs. The concerns related to their relationships with consumers are reflected in the following quote:

“I have a working relationship with all my clients. And I know by how I feel, or how I did feel, and I guess the agency wants them if they have a problem in the middle of the night to call the hotline. Sometimes they have a relationship with me that they want to call me in the middle of the night to say I’m having a problem. And I don’t mind helping them. I don’t mind listening to them. But, I’ve also been told that there could be some legal problems with that. I

Giving Back

“Giving back does more for me than it does for others.”

“I need this to maintain my own recovery.”

think it's a shame that's it, I've got to say well you've got to call somebody you don't even know. And, I just think, that's a problem."

The majority of the responses to this question shared a theme of **treatment and support services**. Within this theme, the greatest emphasis was on the need for more group and one-on-one counseling services. Additional services that were viewed as important included support services (e.g., assistance with paperwork and attending training/conferences), recreational services, day treatment and group outings. More importantly, they spoke of the importance of “no pressure” social events and informal outings that provide opportunities for them to spend “quality time” with peers. Such events also provide an avenue for positive experiences that are so critical to peer support and the recovery process. Other activities that were identified as being important to engagement and empowerment included WRAP, facilitating groups, peer support groups, training and traveling to workshops. In fact, there was a complete consensus regarding the importance of WRAP to the group, even among those who had not yet completed the training. For instance, one participant talked about how WRAP activities help him maintain his stability during crises and avoid hospitalizations. Another participant commented on how WRAP training and listening to the recovery stories of others offer encouragement and support to peers.

The discussion of **treatment and support services** also highlighted the ability of peer-to-peer support services to “bring hope” to those who are institutionalized, which can be accomplished by providing such services in institutional settings and informing consumers about the process of accessing peer-to-peer support services once they are discharged to the community. Along these lines, a participant suggested the need for resource providers or someone else to provide a “peer hook-up.” The following quote elaborates on this suggestion:

“So, I think there's a real need for a peer hook-up, somebody to be there to kind of guide you back into society, guide you back in, because I had no idea what I was gonna do, where I was gonna go and whom to get the help from because I certainly, I didn't, you know, coming back I was expecting, well, he can go here for shelter, you can go here for food, you know. I didn't have any of those.”

A final comment, which was supported by many participants, was in regard to the critical need for consumers to participate in activities that add structure to their lives. The following quote captures the importance of this:

“I think having a club house or a place you could drop in and trying to restart structure in their lives by having group meetings, patient government, things like that inject a little structure into their lives and also around the house have chores that people can do, assign them a job to do, kind of get them back into the swing of things.”

Providing Peer-to-Peer Support Services

The final element focused on gaining an understanding of the types of peer support being provided by the participants. Participants were also asked to identify and discuss the knowledge, skills and experiences that they felt were imperative for a peer specialist to possess.

Peer support services. The intent of this question was to inform an understanding of the services being provided by peer specialists. In general, the services can be organized into the following categories: **personal**, **interpersonal** and **group support**. Although the participants voiced concerns and frustrations related to billing for the services they provide, the majority of them were enthusiastic about the opportunity to provide services. In terms of services, most of the

conversations about this topic focused on personal and interpersonal support. Specifically, the majority of the participants recognized personal and interpersonal support as the foundation for providing effective peer support services. For example, several participants spoke of the importance of offering support and encouragement and one equated this to a family that works together in order to help its members. A variety of examples were provided, including one that involved a participant providing peer support services to neighbors in his apartment complex and referring them to their case manager if the problem was out of the scope of his skills/knowledge. The participants also identified specific activities or skills that are imperative to the delivery of peer support services. Examples of such include listening to the concerns of patients, encouraging people “*where they are,*” providing non-judgmental emotional support, and assisting consumers with self-advocacy and support. Another participant talked about providing continuity of care from the hospital to the outpatient setting. Overall, the participants appeared to agree on the importance of personal and interpersonal support provided by peer specialists.

The second common theme among the responses was **group support**, which was exemplified through the participants’ emphasis on the importance of peer support groups, activities at the day treatment centers and occupational therapy/diversionary activities. For example, there was consensus on the perception that consumers’ involvement in activities that focus on a goal or project assist the consumers in redirecting their focus from the issues and challenges in their lives. Examples of such activities include art classes, painting and furniture building. It was noted that although these activities do not appear recovery related, they are very much a part of the recovery process. For example, they provide opportunities for healthy redirection of one’s attention, personal accomplishment, and building one’s self-esteem.

Although the final theme doesn’t speak directly to the types of services that are being delivered by the providers, it does impact the types of services and their delivery. Whereas the participants were able to clearly articulate the benefits of the services they provide and believe they are appreciated by the consumers, they **feel undervalued** by the larger mental health system. They attributed the mental health system’s negative perception of peer support services to their inability to bill for services and generate income. For example, a participant described the services they provide as “*not the right kind of service, because most of the services provided by peer support specialists are not billable.*” According to several participants, non-billable services provided by peer specialists include transportation, social support, organizing groups and crisis prevention. They also noted that they typically are not allowed to work overtime. One of the final comments on this topic was about the degree of difficulty associated with maintaining one’s own life and supporting the lives of others without a stable income.

Whereas the participants were able to clearly articulate the benefits of the services they provide and believe they are appreciated by the consumers, they feel undervalued by the larger mental health system.

Skills. Whereas this question was focused on the differences in the skills and experiences required for WRAP Facilitator and CPS, both groups engaged in a fluid discussion about the similarities and differences between CPS and WRAP Facilitator. Although their responses touched on the original question, neither group offered a definitive answer. The following quote best describes the participants’ perception of the differences between WRAP Facilitator and CPS:

“Well, the Certified Peer Specialist, the difference to me, WRAP teaches you about a wellness plan for yourself, it’s a daily maintenance plan you should figure out for every portion of your life, from your crisis, post-crisis, the whole nine yards. The peer specialist is a recovery model that’s transcending to change the whole system of the state and when I say it’s all about focusing on recovery and what did I do to recover, being the evidence, showing that recovery is possible if certain things are done. So, it’s a thin line drop, but I totally agree that to be effective as a Certified Peer Specialist, you need both.”

The discussion about these differences set a solid foundation for the dialogue around skills and experiences that serve to prepare one for these roles. Perhaps more importantly, it provided the participants an opportunity to think about how their lives had been impacted by exposure to these credentials and related training.

Through the course of the discussions, it became evident that there are some distinct differences, as well as similarities, between the WRAP facilitator and CPS. In terms of differences, a participant noted the certification process for WRAP facilitator is longer. Another participant stated that the skill sets varied between the two roles. For example, the participant stated that WRAP facilitators should be *“more open”* with a *“gushier personality.”* There was a general agreement among many of the participants that this difference existed. Participants also tended to agree on the following statement, *“WRAP was perceived as being an easier program to start with first because many only had the WRAP training.”*

The perception of WRAP as an easier program may be due, at least in part, to its openness to family member involvement. Another potential source of this perception is the broader scope and application of WRAP, which is exemplified by the following comment: *“WRAP can be for anyone, you can work a WRAP for work, you can work a WRAP for relationships and we’re all in recovery from something so I think WRAP, in my eyes, I see that as more open.”* One of the final comments in regard to WRAP was that it is *“more teachable to the ordinary person”* and available to everyone. On the other hand, the CPS credential is limited to those who have a diagnosable mental illness. Participant descriptions of CPS included the following: it is *“more closed off,”* aligned with the *“medical model”* of recovery, *“intense, geared toward psychiatric treatment”* and requires *“pouring so much of yourself out.”*

“WRAP can be for anyone, you can work a WRAP for work, you can work a WRAP for relationships and we’re all in recovery from something so I think WRAP, in my eyes, I see that as more open.”

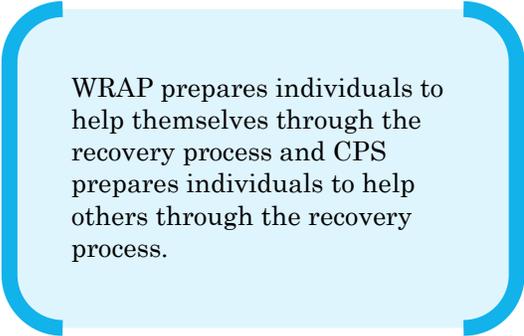
Despite the aforementioned differences between the WRAP facilitator and CPS, the participants were able to come to consensus about some similarities in the skills and experiences required for the two credentials. The following comment captures the essence of the similarities:

“A person has to be at a level where they can take responsibility for their own lives and be stable enough to handle the added responsibility or the added pressure of being either one of those. But, I certainly, I think either one of them, you have to have those same kind of things. I don’t know that they’re really different.”

Whereas the conversations did not result in specific characteristics, skills, or experiences, there was a general consensus that in order to be an effective peer specialist one must participate in the

following trainings: Respect Institute, Peer Specialist, WRAP, WRAP Facilitator and CPS. It is important to note that a particular order for these trainings was not identified and that the participants had taken a variety of pathways to their current position. In fact, several participants indicated that they were at different points of becoming a CPS or WRAP Facilitator, which limited their ability to respond to this question. Although the information gained from these discussions is invaluable, this topic should be explored further in order to determine the most appropriate process for participants to become a peer specialist.

Recovery experiences. Many of the participants recognized the importance of peer support services to consumers and most of their responses were related to either their own experiences with peer support services and/or their experiences with consumers. When looking at the aggregate of the responses, the following themes emerged: **different skills, recovery experiences** and **suggestions for improvement**. In terms of different skills, the respondents came back to the previous discussion about the differences between the WRAP facilitators and CPS. One participant described WRAP facilitators as having “*more open skills*” and being “*less threatening*.” Another compared and contrasted both programs by stating “*the CPS program helps people from the top down*” and the WRAP program helps people from “*the bottom up*,” with both leading to the same place. Specifically, WRAP prepares individuals to help themselves through the recovery process and CPS prepares individuals to help others through the recovery process. The overall group agreed with this statement by the participants either nodding or stating that this was a good comparison of the programs. However, as with the previous question, neither group identified specific skills.



WRAP prepares individuals to help themselves through the recovery process and CPS prepares individuals to help others through the recovery process.

Through the course of the discussions, it was apparent that one’s **recovery experiences** were a key element of being a good fit for providing peer support services. One participant indicated that in order for a CPS to effectively interact with consumers who were in active recovery, he/she would have to draw from “*deep emotions*” and life experiences. Another participant validated the importance of the recovery experience by stating “*being in recovery from a mental health illness helps him be a better PSS [peer support specialist]*.” It is important to note that some references to substance abuse treatment models were made during the course of the discussions. For instance, a participant noted that his experience with substance abuse recovery had helped him to become a better peer specialist. Another participant reported that the WRAP process was more helpful in addressing his substance abuse issues than the 12 step program. Finally, there appeared to be consensus among the participants that the CPS program better prepares one to work with consumers of mental health services.

The discussions about this question also generated suggestions for **improving the quality of the training programs**. For instance, one participant suggested that the CPS program training criteria should be modified to accommodate those who “*can’t read or write, but could become excellent PSS [peer support specialist]*” by placing the training on audiobooks. Another participant commented that individuals interested in the CPS program felt it was closed to them because they do not believe they can meet the academic criteria. Additionally, one participant voiced a concern that the peer specialist training is too aligned with the “*medical model*.”

OUTPUTS AND OUTCOMES FOR CONSUMERS

Hogg Foundation's expectations for the year one evaluation included the collection of output data by ETBHN and the LMHAs. Specifically, they were to collect data that would offer insight about the nature of the peer support services provided to consumers via ETCMHR. However, the data was not provided. This led to the inclusion of the following reporting expectations for ETBHN and the LMHAs in the year two evaluation plan:

- Level of consumer led activities at each participating organization
- Levels of consumer satisfaction at specified points in the implementation process
- Number of new peer providers identified, trained, and active in service delivery
- Amount of service provided by peer specialists at specified points in the implementation process (peer specialists includes CPS, WRAP facilitators, and other peer specialists who are involved in peer-to-peer support activities)
- Amount of Medicaid reimbursable services provided by CPS

In addition to output data, they were also expected to begin collecting outcome data for peer support services. Unfortunately, through the course of the year two evaluation, it became apparent that not all of the LMHAs were collecting output and outcome data. And, in cases where it had been collected, the format often did not lend itself well to analysis. This was especially true for outcome data.

In planning for the year three evaluation, it was decided that the emphasis should be on helping the LMHAs create a uniform approach to evaluating consumer outcomes. The logical first step was the identification of indicators of mental health and functioning, which would be followed by developing a uniform data collection process that could be implemented by all of the LMHAs involved with ETCMHR. Given that the TRAG (Texas Recommended Assessment Guidelines) was utilized by all of the LMHAs, it served as a starting point for examining the following potential indicators: risk of harm, support needs, psychiatric-related hospitalizations, level of functioning, employment, housing, co-occurring substance abuse, criminal justice involvement, schizophrenia algorithm (positive and negative symptom scores), bipolar algorithm, and major depression algorithm. Additional potential indicators included primary DSM diagnosis, GAF (Global Assessment of Functioning) score, service package, service type, number of interactions with a peer specialist, and the duration of such interactions.

Examining the TRAG data proved to be more difficult than expected. First of all, many of the LMHAs did not have a process in place to track the number and/or duration of peer interactions. For the LMHAs who were tracking this information, it did not "live" in the same database with the TRAG data, making it extremely difficult to examine. Fortunately, one of the LMHAs was in a position to extract the data for consumers who had received peer support services over a two year period. The methodology and results are reported in the following sections. A discussion of the results and their implications is provided later in the report.

Methodology

Participants and Sampling

One of the LMHAs had the capacity to extract data for all consumers who had received peer support services during a two year period ($N = 101$). All of the consumers who had two or more

treatment visits with a peer specialist were included in the analysis ($n = 96$). Initial diagnoses across the 96 clients included Bipolar I Disorder ($n = 33$), Major Depressive Disorder ($n = 37$) and Schizoaffective Disorder ($n = 26$). Consumers averaged 4.75 ($s^9 = 1.41$) visits to the center during the nearly one year ($\bar{x} = 338.75$ days; $s = 98.34$ days) that they received services. One of the services provided to consumers was peer support, which involved interactions with a peer specialist. The average number of peer interactions during the course of treatment was 8.89 ($s = 16.71$) and the average time in peer interactions was 11.06 hours ($s = 22.73$).

Measurement

The TRAG was designed to serve two functions, assess mental health needs of a consumer and assist in determining the appropriate mental health services. In terms of assessment, it examines the following nine domains: risk of harm, support needs, psychiatric-related hospitalizations, level of functioning, employment, housing, co-occurring substance abuse, criminal justice involvement, and depressive symptomatology. The TRAG is administered by a QMHP-CS (Qualified Mental Health Professional-Community Services) during a face-to-face visit with a consumer of mental health services. A detailed explanation of the TRAG, including assessment and scoring criteria is available in the *User's Manual for the Adult Texas Recommended Assessment Guidelines* (TDSHS, 2007).

Design and Data Collection

A pre-experimental design was employed for the purpose of identifying potential indicators of mental health and functioning that could assist in efforts to evaluate outcomes of consumers who receive peer support services. The data was extracted by the LMHA from the relevant databases and merged into an Excel file. The researchers then organized the data into a workable format and imported it to SPSS.

Limitations

The data analyzed for this aspect of the evaluation was provided by one of the 11 LMHAs that comprise ETBHN, which prohibits generalization of the data to the larger group. Generalizations are also limited by the lack of demographic information (e.g., age, gender, race/ethnicity, mental health crises, and psychiatric hospitalizations). It should be noted that the TRAG was replaced by the ANSA (Adult Needs and Strengths Assessment) in September 2013, which limits the utility of the results. Finally, the design does not control for threats to internal validity, making it impossible to conclude that involvement in peer support services is the cause of the observed outcomes.

Results

Exploratory Analyses

Exploratory analyses were conducted on the eight TRAG variables and the GAF scale to examine the impact of treatment across time. Difference scores were computed by subtracting a consumer's final visit score from their initial visit score. A positive difference score indicated the consumer had improved over the course of treatment and a negative difference score indicated

⁹ s = sample standard deviation

deterioration over the course of treatment. Difference scores were analyzed using paired samples *t*-test. The difference scores and results of the statistical tests are presented in Table 13.

Table 13- Initial, Final and Mean difference scores for each TRAG variable and GAF score

TRAG Variables and GAF Score	Initial Visit – Final Visit Scores	Mean Initial Visit Score	Mean Final Visit Score
Risk of Harm	.09	1.39	1.30
Support Needs	.03	2.20	2.17
Psychiatric-Related Hospitalizations	-.01	1.20	1.21
Level of Functioning	.25***	2.77	2.52
Employment	-.06	1.01	1.07
Housing	-.07	1.35	1.42
Co-Occurring Substance Use	-.16**	1.01	1.17
Criminal Justice Involvement	.07	1.23	1.30
GAF Score	-.32	50.58	50.90

* $p < .05$; ** $p < .01$; *** $p = .001$

Results of the exploratory analyses suggest that over the course of treatment the average consumer trended in the direction of a significantly lower level of dysfunction at his/her final visit as compared to the nearly moderate level of dysfunction he/she was experiencing at the initial visit ($\bar{x} = 2.52$ versus 2.77 , respectively). Conversely, consumers reported a negligibly higher rate of co-occurring substance abuse ($\bar{x} = 1.17$) at their final visit as compared to their initial visit ($\bar{x} = 1.01$). None of the other scales showed reliable change across treatment.

PSRS, BNSA, BDSS and QIDS

A second exploratory analysis examined the PSRS (Positive Symptom Rating Scale), BNSA (Brief Negative Symptom Assessment), BDSS (Brief Bipolar Disorder Symptom Scale), and QIDS (Quick Inventory of Depressive Symptomatology) changes across treatment as a function of initial diagnosis (Schizoaffective Disorder, Bipolar I Disorder, and Major Depressive Disorder). As seen in the Table 14, across treatment, there were no mean difference changes in PSRS or BNSA scores for consumers with the initial diagnosis of Schizoaffective Disorder (.42 and .27, respectively). Consumers initially diagnosed with Bipolar Disorder experienced a significant decrease on the BDSS score from their initial to last visit (17.48 and 15.09, respectively). Finally, consumers diagnosed with Major Depressive Disorder experienced a significant decrease on the QIDS score from their first to last visit (8.30 and 6.41, respectively). These analyses suggest that the constellation of services consumers received is related to their improvement, at least for the consumers initially diagnosed with Bipolar and Major Depressive Disorders.

Table 14- Initial, Final, and Mean difference scores for each PSRS and BNSA algorithm as a function of initial diagnosis

Initial Diagnosis	<i>n</i>	PSRS and BNSA Algorithm Scores	Initial Visit – Final Visit Scores	Mean Initial Visit Score	Mean Final Visit Score
Schizoaffective Disorder	26	PSRS – Schizophrenia Algorithm – Total Positive Symptom	.42*	6.46	6.04
	26	BNSA – Schizophrenia Algorithm – Total Negative Symptom	.27*	5.77	5.50
Bipolar I Disorder	33	BDSS – Bipolar Algorithm – Total Brief Polar	-2.39**	17.48	15.09
Major Depressive Disorder	37	QIDS – Major Depression Algorithm	-1.89**	8.30	6.41

* $p > .05$; ** $p < .05$

Peer Interactions and Facility Visits

Data collected regarding peer services delivered included the number of peer interactions as well as the duration of the peer interactions. As these variables were almost perfectly correlated ($r = .951$), only the number of peer interactions was included in the analyses. The number of facility visits a consumer made was also recorded. To examine the possible role that peer interactions and facility visits played in mean change (Initial – Final scores) score on the eight TRAG variables and GAF score, separate regression analyses were conducted for each of the eight TRAG variables. Regression results did not show that the number of peer interactions nor the number of facility visits were reliable predictors of mean changes observed on any of the eight TRAG variables or the GAF score ($ps > .05$). A similar pattern of results was obtained when number of peer interactions and facility visits served as predictors in regression analyses to predict changes on the PSRS, BNSA, BDSS, and QIDS (all $ps > .05$).

Frequency of Peer Interactions and Facility Visits

Since the overall results from examining the role of peer interactions and facility visits on changes in the TRAG variables, GAF score, and algorithms were inconclusive, a more focused analysis was conducted to examine whether those consumers with the greatest number of peer interactions showed any changes across the TRAG variables, GAF score and algorithms. Specifically, a regression analysis examined whether the number of peer interactions and facility visits were reliable predictors of the TRAG variables, GAF score, and algorithms for consumers falling in the upper quartile (25%) on number of peer visits (> 6). Results of this analysis showed that the number of facility visits was a significant predictor of changes in the TRAG variables of support needs ($\beta = .451, p < .05$) and psychiatric-related hospitalizations ($\beta = .445, p < .05$). Also observed was that the number of peer interactions was a reliable predictor in GAF change ($\beta = .476, p < .05$). Neither the number of peer interactions nor facility visits were reliable predictors for any of the algorithms (all $ps > .05$).

The final analyses examined mean differences across time for consumers in the upper quartile of number of peer interactions on the eight TRAG variables and GAF scale below. Difference scores (Initial – Final) were computed and tested. Results of these analyses are presented in Table 15. The only reliable difference was in the Housing TRAG variable. Given that the results of examining the role of peer interactions and facility visits on consumer functioning are inconclusive, additional research and consideration may be necessary.

Table 15- Initial, Final, and Mean difference scores for each TRAG variable and GAF score for clients in the top 25% of peer visits

TRAG Variables and GAF Score	Initial Visit – Final Visit Scores	Mean Initial Visit Score	Mean Final Visit Score
Risk of Harm	.13	1.38	1.25
Support Needs	-.13	2.00	2.13
Psychiatric-Related Hospitalizations	-.08	1.21	1.29
Level of Functioning	.21	2.50	2.29
Employment	.08	1.09	1.13
Housing	.29*	1.50	1.21
Co-Occurring Substance Use	.17	1.25	1.08
Criminal Justice Involvement	.13	1.21	1.08
GAF Score	.88	51.21	50.33

* $p < .05$

DISCUSSION

The purpose of this section is to provide a summary of the results as they pertain to the following aspects of ETCMHR and its efforts: the larger network, LMHAs, understanding recovery, recruiting peer specialists, outcomes for peer specialists, and consumer outputs and outcomes. Implications and recommendations for ETCMHR, service delivery, policy and future evaluation efforts are offered when appropriate.

East Texas Coalition for Mental Health Recovery

As demonstrated by the results, ETCMHR has played a substantial role in the peer specialists' recovery process. For example, it is credited with fostering a sense of hope and purpose among the peer specialists. Also, they view it as an invaluable source of support, knowledge and skills that are imperative to a successful recovery. As previously noted, there was a complete consensus among the participants that ETCMHR was the most substantial support system with which they have been involved. Another important role of ETCMHR is that it provides the peer specialists with an opportunity to help others or "*pay it forward.*" The bottom line is that they attribute their success with recovery and subsequent improvements in their quality of life to their experiences with ETCMHR. Along these lines, there is a deep sense of appreciation for the Hogg Foundation and their support of the coalition. The majority of the peer specialists who participated in the studies identified the Hogg Foundation as the primary catalyst for the coalition's development.

In terms of network development, the collaborative process appears to be healthy and functioning. Furthermore, the comparisons of the domains across the three evaluation years yielded no statistically significant differences, suggesting stability in the overall perceptions. As for individual items, changes observed since year one include an increase in the sense of importance about this effort/topic in year two, followed by a decrease in year three. Perceptions of the timeliness of the efforts followed the same trend. There was also a decrease in the year two scores related to members' orientation to the overall group's best interest and interest in obtaining a good decision from the group rather than improving their organization's position, both of which suggest an increase in self-interest among the members. However, the year three scores indicate improvement in these areas. Whereas year two brought improvement in the area of collaborative decision-making, especially in terms the members' ability to commit resources, the year three scores were lower than those of year one. Given that the ROC consists of the LMHAs' CEOs, it seems reasonable to assume that group members would have the authority to commit resources. Overall, the scores for items related to the Structure of the Collaboration, Collaboration Members, Collaboration Process, and Results of the Collaboration domain continue to suggest the presence of the elements necessary to building and maintaining trust, ownership, commitment and accountability. Due to the low response rate for year two, one should be cautious in drawing conclusions from trends in the data.

The evaluation results suggest that ETCMHR's members' shared history and relationships are a source of resiliency and strength. In fact, these characteristics appear to foster a positive environment and encourage progress. However, sustaining the progress, especially in terms of the coalition and the peer support provider network, requires more than a willingness to work together. One of the most critical elements is maintaining the peer support coordinator positions, which serve as the nucleus of the peer support provider network. Given that support from the Hogg Foundation is not indefinite, it is imperative that ETCMHR develop and implement a sustainability plan that supports the current structure of the peer support provider network through a diversified and stable

funding base. General recommendations that should be considered when planning for ETCMHR's future include:

- Maintaining the current level of participation of all the members of the ETCMHR
- Increasing and diversifying the representation of stakeholder groups in ETCMHR's membership
- Consider basing peer coordinator assignments on geographical location in order to reduce travel time and increase the frequency of meetings
- Actively involving peer specialists and LMHA staff in planning and decision-making related to ETCMHR
- Continuing to focus on evaluating and enhancing access to peer support services within the region
- Developing a public awareness campaign that focuses on ETCMHR's impact on the delivery of mental health services in the region
- Continuing to build the capacity of the local and state mental health systems for including consumers in the process of mental health recovery.

Consideration should also be given to advocating for changes in state policies that interfere with ETCMHR's mission and the overall transition of community-based mental health services to a recovery oriented focus.

Local Mental Health Authorities

The results from across the evaluation components have implications for the LMHAs. In terms of the degree to which the organizational cultures were conducive to the provision of peer support services, several concerns were identified. Responses from the year one snapshot of the peer specialists suggested that, more often than not, peer specialists were not included in treatment team meetings, treatment planning, assessment, and/or evaluation. The focus group discussions also raised concerns about the degree of involvement and autonomy given to peer specialists. For example, some noted that they were instructed on what to do and/or how to do things rather than being included in the decision-making process. Others noted feeling undervalued by staff. Responses to the narrative items that accompanied the AACP ROSE and RSA-R (years two and three) support the aforementioned concerns. For example, five of the eight (38%) year two participants and 11 of the 19 (58%) of the year three participants reported that they were not treated as a valued member of the treatment team. Whereas it is understandable that their involvement would be limited, especially in terms of diagnosis and advanced clinical interventions, peer support services are an important part of the overall intervention. As such, it seems reasonable to include the providers in the treatment planning and evaluation process. It is important to note that the participants for the focus groups and year one snapshot were all Group 1 Peers, who represented the LMHAs that were included in year one of the grant.

The results of the AACP ROSE and RSA-R, both of which examine the recovery orientation of an organization, are similar to the aforementioned results in that they suggest the need for improvement in the organizational environment of the LMHAs. In terms of the AACP ROSE (year two), the overall average score bordered on the cut point for "needs significant improvement" and "fair." In examining the subscales, the concerns appear to be related to the administrative, treatment, and supports domains. Whereas the structure of state funded mental health services in Texas and resulting structure of the LMHAs may not be conducive to some of the indicators measured by the AACP-ROSE (e.g., inclusion of recovery in the organization's mission and housing

options), most of the indicators are consistent with best practices and expectations for consumer involvement. In other words, the majority of the indicators appear to be consistent with the expectations for LMHAs.

The results for the RSA-R (year three) are consistent with those of the AACP ROSE in that they raise concerns around involvement of consumers and peers civic activities, service delivery, decision-making, evaluation and mentoring. Given the importance of mentoring to the recovery of the mentee and mentor, providing opportunities for such is important. Individual item scores also suggest a need for improving the holistic nature of treatment, especially in terms of personal needs and growth. It is important to note that Group 1 Peers tended to rate these items lower, suggesting that the concerns are specific to a subset of the sample rather than the entire sample. However, it is important to keep in mind the small sample size in years two and three neither allowed for an examination of individual LMHAs, nor comparisons among them.

Given the importance of ETCMHR's orientation to recovery and inclusion of peer specialists in appropriate aspects of service delivery, this element should be attended to in future evaluation efforts. The ability to examine the culture and recovery orientation of each LMHA would be especially beneficial. For instance, it could provide a baseline measure for gauging progress toward a recovery orientation and effectiveness of related organizational interventions. A study along these lines would ideally include representation from each of the LMHAs for each of the following stakeholder groups: administrators, staff, peer specialists, consumers and family members. Also, stakeholders should be selected from across programs, responses should be anonymous, and most, if not all, of the staff and consumers should be involved (Davidson, Tondora, Lawless, O'Connell, & Rowe, 2009). Employing the RSA-R for this purpose would also allow for the creation of a recovery profile for each LMHA, which takes a strengths-based approach to helping agencies improve their recovery orientation and assess progress toward such (Davidson et al., 2009). If ETCMHR chose to do so, the LMHA profiles could be compared to the profiles for other LMHAs and the overall system (ETCMHR), providing a sense of progress for the overall coalition. Whereas the RSA-R appears to be best suited for this study, the psychometrics for the measure have not been established. Therefore, future use should be preceded by an investigation of its psychometrics. Another possibility would be to use a modified version of the RSA that was developed by the Texas Institute for Excellence in Mental Health (University of Texas at Austin School of Social Work) in conjunction with instrument's authors. The institute has successfully utilized this version with LMHAs in Texas.

Understanding Recovery

The individual interviews with peer specialists yielded a tremendous amount of insight into the transformational nature of recovery. The common elements across their pre-recovery experiences were isolation, a fear of not improving or getting better, difficulty managing mental health symptoms, self-medication, misdiagnosis, poor life choices and unhappiness. All of these contributed to a sense of helplessness, hopelessness and, in some cases, thoughts of suicide. However, active involvement in recovery and related experiences provided them the knowledge, skills and confidence necessary to address their mental health concerns and improve their overall quality of life. For example, several mentioned that while their life stressors had not necessarily changed during recovery, their ability to handle them had improved substantially. Whereas the ability to manage life challenges and maintain an active recovery was credited to a variety of elements, WRAP was by far the most important one. In fact, the importance of WRAP was echoed across all aspects and years of the evaluation. The key elements of their recovery experiences were

hope, confidence, control, self-direction, personal responsibility, independence and empowerment. Simply, the participants went from believing that their lives would never improve to realizing that recovery is possible.

The individual discussions about recovery did result in the identification of several unexpected elements. The first such theme was the importance placed on opportunities created by recovery to “*pay it forward*” or help others through the recovery process. Specifically, through recovery they were “healthy” enough to manage their mental health concerns while assisting others through the recovery process. Another interesting, and somewhat unexpected theme, was the impact of the relationships developed through involvement with ETCMHR. Whereas the importance of the relationships in recovery was expected, the degree to which they affected the members was surprising. The relationships, commonly referred to as friendships, served as a source of encouragement, support and sense of belonging, as well as a vehicle for creating shared experiences. Participants equated the context of these relationships to a family and many noted that their success with recovery would have not been possible without the relationships they formed via ETCMHR. Finally, it is important to remain mindful that the concept of “healthy” is not limited to mental health. The individual discussions about recovery highlighted the importance of physical health, eating habits, nutrition, exercise, relationships and daily routines to one’s overall health. The importance of “*paying it forward*,” the relationships developed via ETCMHR, and the broader context of health also emerged in other components of the evaluation.

In planning for the current and future initiatives, the information gained in regard to the recovery process has several important implications. First of all, WRAP training appears to be one of the most important elements of the recovery process. In fact, WRAP training may prove to be helpful in teaching staff about the process of recovery and should be considered for inclusion when planning efforts to shift the orientation of the LMHAs toward recovery. Given the importance of opportunities to “*pay it forward*” and healthy relationships, ETCMHR and LMHAs should seek ways to encourage interactions among consumers and peer specialists, especially in the form of mentorship. Other contexts for relationship building to consider include family, friends, social groups and civic engagement. Furthermore, future efforts to develop peer specialists and related coalitions should include these elements. Finally, it is important to remain mindful of the point that “*recovery is personal*,” meaning that every individual is going to start recovery from a different place, with a different set of strengths and needs, and progress through the process via different paths at a different pace. Thus, service planning and delivery should be personalized and acknowledge the importance of physical health, housing, employment, personal growth, and other such aspects of achieving and maintaining recovery (i.e., holistic approach).

Recruiting Peer Specialists

The focus group sessions were fruitful in terms of developing an understanding of peer support services and the characteristics conducive to the provision of such services. The primary characteristic appears to be an active recovery marked by stability and independence. For example, there was consensus that one must be able to appropriately manage stressful situations that arise on a daily basis. Additional characteristics on which there was consensus include a commitment to one’s own wellness, a genuine interest in the health and recovery of others, and the ability to serve as a role model. In terms of role modeling, the emphasis was on demonstrating to others that recovery is possible and serving as an example of a person in an active and healthy recovery. Specific characteristics that were associated with a person in active recovery include a willingness to

take personal responsibility for his/her wellness, an ability to learn from personal experiences and those of others, and an ability to utilize support systems appropriately. Finally, one would need to be oriented to an education/empowerment approach. In other words, able to support and assist consumers in the development of the knowledge, skills and abilities necessary for successful recovery. An important aspect of this is the provider's ability to make the transition from being supported by others to being supportive of others. An inability to do so could create an unhealthy relationship between the peer specialist and consumer.

The information gained from the focus group sessions also included barriers to serving as a peer specialist. One of the key barriers was financial in nature. The peer specialists talked about needing to be compensated in a manner that allowed them to maintain a healthy lifestyle, which was not always the case with their positions. For example, most of the providers are either part-time employees or volunteers (uncompensated). Whereas this situation works for those who have another source of income (e.g., retirees), that is typically not the case for those who need employment related income and/or benefits. Unfortunately, finding a solution is impacted by a variety of factors, including whether or not the providers receive benefits from social insurance and/or public assistance programs. Part-time or full-time employment could render one ineligible for assistance, in which case the compensation and benefits from employment would have to cover the loss of eligibility. This is further complicated by the LMHAs' limited ability to capture reimbursement for peer support services. LMHAs can only be reimbursed for services that are provided by a CPS, which requires a lengthy training process. The peer specialists were also concerned that the perceived academic rigor of the CPS training process would exclude some candidates who otherwise had the potential to be peer specialists.

In considering the implications of these results, there are several points of interest. First of all, the recruiting process should include a component to assess a potential peer specialist's progress toward recovery and the aforementioned desired characteristics. The collection of information for this process should come from multiple sources, including the observations of peer specialists and LMHA staff, documentation of his/her progress and recovery, and the MHRM. Although the discussions about the recruitment process were fruitful, they did not result in the identification of specific knowledge and skills that are imperative for the provision of peer support services. This is a topic that could benefit from future research. In terms of training peer specialists, it was evident that WRAP, WRAP facilitator and CPS were important elements. However, concerns regarding the academic rigor of the CPS training and possible accommodations for such should be further investigated. Additional recommendations for training include:

- Develop a training that educates peer specialists about the practical and legal implications associated with their role as a peer specialist
- Develop a well-defined job description for those who deliver peer support services, inclusive of specific tasks and responsibilities
- Develop a related training that educates peers about the formal and informal guidelines for service delivery and fulfillment of their job responsibilities.

Finally, the coalition and LMHAs should work to identify solutions to the issues surrounding compensation of the peer specialists. Such efforts may very well include changes in state policies related to funding, billing and/or service delivery.

Additional recommendations for changes to the current recruiting and training process were offered by the Hogg Foundation's Program Officers, which are based on the lessons they have

learned through active involvement with ETCMHR. First of all, they recommend that voluntary activities and conferences be scheduled once a month so that the peer specialists are active, but not overwhelmed. Along these lines, they recommend that the first year activities focus on individual development in preparation for the second year, which would provide the content and instruction needed to become a successful peer specialist. The third recommendation is to offer WRAP or similar trainings to all consumers, but to only offer WRAP Facilitator and CPS trainings to those who actually want to engage in facilitation. Facilitator training may not be a perfect fit for everyone and consumers should have the ability to choose the degree to which they engage in the delivery of peer support services. The fourth recommendation is to provide basic facilitation skills training for individuals who are planning to attend WRAP Facilitator and/or CPS training. Although both of these trainings are in depth, they mostly teach content and not the skills needed to lead a group of diverse individuals. Finally, it is recommended that after peer specialists complete these trainings, they participate in communication and leadership trainings for the purpose of honing their facilitation and professional skills. All of the aforementioned recommendations are consistent with the information collected during years one, two and three.

Outcomes for Peer Specialists

The results of the MHRM provided a snapshot of where the peer specialists were in terms of their recovery. As previously mentioned, their overall mean scores for years two and three were higher than the normative mean scores for the MHRM, indicating a fairly high level of self-reported recovery. An examination of the domains and individual scores raised some questions worthy of additional investigation. For instance, the importance of eating nutritious meals to overall health would lead one to question why the peer specialists scored lower on this item for years two and three (2.44 and 2.61, respectively). Given the importance of activities that enrich one's life (e.g., physical, social, and recreational) to recovery, the factors related to the reported lack of money for such are of interest. Both of these questions could be addressed by the addition of narrative questions to future administrations of the MHRM. In fact, administration of the MHRM on an annual basis to peer specialists would allow for assessment of their progress with recovery. Depending on the design employed, it could also allow for conclusions to be drawn about factors that impact the recovery process of peer specialists.

Outputs and Outcomes for Consumers

Outputs

As noted earlier in the report, the evaluation plans for years one and two included an expectation that ETBHN and the LMHAs would collect data about the process or outputs related to the delivery of peer support services. Unfortunately, differences among the LMHAs' data collection processes and related elements delayed the creation of a uniform process. Given the importance of such information to evaluating efficiency, decision-making regarding service delivery and future attempts to replicate the coalition in other regions of Texas, ETBHN and the LMHA's should work together to implement a uniform process for evaluating outputs. Data related to the outputs that should be collected for each LMHA include, but are not limited to:

- Level of consumer led activities
- Levels of consumer satisfaction at specified points in the implementation process
- Number of new peer providers identified, trained, and active in service delivery

- Amount of service provided by peers (defined broadly; not limited to Certified Peer Specialists, but including WRAP facilitators, and peers involved in other types of peer-to-peer support activities) at specified points in the implementation process
- Amount of services provided by Certified Peer Specialists that are reimbursable.

Outcomes

The evaluation plans for years one and two also included an expectation for the collection of outcome data for consumers who received peer support services in hopes of developing a preliminary understanding of the impact of such services. However, through the course of the evaluation, it became apparent that not all of the LMHAs were collecting data and, in cases where it had been collected, the format did not lend itself well to analysis. Given various challenges to collecting outcome data, the emphasis in year three was on identifying potential indicators for which the LMHAs were already collecting data. Specifically, this involved examining data collected via the TRAG.

An exploratory analysis of the TRAG found that consumers experienced an increase in their ability to function over the course of treatment. Reported rates of substance abuse were also slightly higher at the end of treatment. Change over the course of treatment for the following measures was not statistically significant: risk of harm, support needs, psychiatric-related hospitalizations, level of functioning, employment, housing, criminal justice involvement and GAF (Global Assessment of Functioning) scale. Regression analyses indicate that the number of peer interactions and facility visits were not reliable predictors of mean changes on the aforementioned variables.

An analysis of symptoms related to the primary diagnosis revealed no mean changes on the PSRS and BNSA for a diagnosis of Schizoaffective Disorder. Those with a primary diagnosis of Bipolar Disorder experienced a significant decrease in scores on the BSDS. Those with a primary diagnosis of Major Depressive Disorder experienced a significant decrease in scores on the QIDS. Regression analyses indicate that the number of peer interactions and facility visits were not reliable predictors of mean changes on PSRS, BNSA, BSDS and QIDS.

A regression analysis of consumers falling in the top 25% for number of peer visits showed that the number of facility visits was a predictor of change for support needs, hospitalizations, and GAF score. For the same group, a regression analysis found that number of peer interactions was a predictor of scores for housing. Whereas the TRAG data analysis yielded interesting results, replacement of the TRAG by the ANSA limits their utility for informing recommendations for future efforts related to outcome research. Furthermore, it means that ETBHN and the LMHAs need to rethink their efforts to develop a process for collecting and evaluating outcome data.

The cornerstone of developing an evaluation of consumer outcomes is to identify the indicators of mental health and functioning and a process for collecting the related data that can be implemented by all of the LMHAs involved with ETCMHR. Given that the ANSA is utilized by all of the LMHAs, this might be a reasonable starting point. Furthermore, it appears to, at least in part, measure the four major dimensions of recovery: health, home, purpose, and community (SAMHSA, 2012). Inclusion of the following variables would improve the utility of the results: primary DSM diagnosis; number of crisis contacts (per month, quarter or year); the type, frequency and duration of contacts with peer specialists; and type, frequency and duration of other treatment interventions. Finally, the MHRM should be included as an indicator of the consumer's perception of his/her progress toward recovery. The assumption is that as one progresses through the recovery process, he/she would experience improvement across these indicators.

Regardless of the indicators that are selected, the related data should be collected by all of the LMHAs in the same manner, allowing for an examination of the data in an aggregate format. At the very least, the data should be collected for all consumers who receive peer support services. Doing so would provide some outcome related evidence for peer support services. The utility of this data could be improved by collecting it for all consumers of mental health services, which, when paired with an appropriate research design, would allow for greater control of threats to internal validity. Specifically, a comparison could be made between consumers of mental health services who do and do not receive peer support services. The results of such a comparison have the potential to lead to conclusions about the effectiveness of peer support services. However, this will most likely require a greater degree of uniformity in referral and delivery processes for peer support services, as well as data collection. Given the scope of such a project and the likelihood that some of the LMHAs will need more time to prepare for data collection, a reasonable starting point would be a pilot project involving one to three LMHAs.

CONCLUSION

The study sought to evaluate ETCMHR's efforts to develop and support the delivery of peer support services in the East Texas region. The evaluation generated information about the process of mental health recovery from the perspective of peer specialists, elements to consider when recruiting potential peer specialists, the current status of the peer specialists' recovery, the recovery orientation of the LMHAs, and ETCMHR's overall collaborative process. In addition to having specific implications for ETCMHR and the LMHAs, the results are important to the Hogg Foundation's future efforts to replicate the coalition in other regions of Texas. However, before moving forward with such endeavors, there are several unanswered questions that should be addressed. Topics for further exploration include the identification of knowledge and skills necessary for the provision of peer support services, effectiveness of peer support services in achieving positive outcomes for providers and consumers, efficiency of the delivery process for peer support services, and effectiveness of efforts to improve the recovery orientation of the LMHAs. Additional areas of concern highlighted by the study include the need for a sustainability plan for ETCMHR and collaborative efforts to advocate for changes in state mental health policies. In conclusion, the results suggest that ETCMHR is positively impacting consumers and progressing toward its desired outcomes, but there are still steps to be taken in order to ensure a bright future.

REFERENCES

- American Association of Community Psychiatrists. (2011). AACP guidelines for recovery oriented services. Retrieved from http://www.communitypsychiatry.org/publications/clinical_and_administrative_tools_guidelines/ROSGuidelines.aspx
- Bullock, W. A. (2005). Mental Health Recovery Measure (MHRM). In T. Campbell-Orde, J. Chamberlin, J. Carpenter, & H. S. Leff (Eds.), *Measuring the promise of recovery : A compendium of recovery measures (Volume II)*. Cambridge, MA: The Evaluation Center@HSRI.
- Bullock, W. A. (2009). *The Mental Health Recovery Measure (MHRM): Updated normative data and psychometric properties*. Toledo, OH: Author. Available online at <http://psychology.utoledo.edu/images/MHRM - Bullock - Updated Normative and Psychometric Data 12-09.pdf>.
- Campbell-Orde, T., Chamberlin, J., Carpenter, J., & Leff, H. S. (2005). *Measuring the promise: A compendium of recovery measures (Volume II)*. Cambridge, MA: The Evaluation Center@HSRI.
- Chrislip, D. & Larson, C. E. (1994). *Collaborative leadership: How citizens and civic leaders can make a difference*. San Francisco: Jossey-Bass Publishers.
- Cohen, S. & Hoberman, H. M. (1983). Positive events and social supports as buffers of life change stress. *Journal of Applied Social Psychology*, 13(2), 99-125.
- Cohen, S., Mermelstein, R., Kamarck, T., & Hoberman, H. N. (1985). Measuring the functional components of social support. In I. G. Sarason & B. Sarason (Eds.), *Social support: Theory, research, and applications*, pp. 73-94. New York: Springer Publishing.
- Cooper, H. S. & Avant, F. L. (2011). *Rural East Texas Health Network: 2010-2011 annual evaluation*. Nacogdoches, TX: Author.
- Cooper, H. S. & Avant, F. L. (2010). *Rural East Texas Health Network: 2009-2010 annual evaluation*. Nacogdoches, TX: Author.
- Cooper, H. S. & Avant, F. L. (2009). *Rural East Texas Health Network: 2008-2009 annual evaluation*. Nacogdoches, TX: Author.
- Cooper, H. S. & Avant, F. L. (2007). *Rural East Texas Health Network: 2006-2007 annual evaluation*. Nacogdoches, TX: Author.
- Davidson, L., Tondora, J., Lawless, M. S., O'Connell, M. J., & Rowe, M. (2009). *A practical guide to recovery-oriented practice: Tools for transforming mental health care*. New York: Oxford University Press.
- O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (2005). Recovery Self-Assessment (RSA). In T. Campbell-Orde, J. Chamberlin, J. Carpenter, & H.S. Leff, *Measuring the promise: A compendium of recovery measures, Volume II*, pp. 91-96. Cambridge, MA: Human Services Research Initiative. Available online at <http://www.power2u.org/downloads/pn-55.pdf>.

- Omni Institute. (1992). *Working together: A collaboration profile*. Author: Denver, CO. Available online at www.omni.org/instruments.php.
- Omni Institute. (n.d.). *Working together: A collaboration profile. A companion to the assessment tool*. Author: Denver, CO. Available online at www.omni.org/instruments.php.
- Streeter, C. L. & Rivaux, S. (2002). *Working Together: A Profile of Collaboration*. Report submitted to the Georgetown Safe Schools/Healthy Students Initiative. Austin, TX: School of Social Work, Center for Social Work Research at The University of Texas at Austin.
- Streeter, C. L., Rivaux, S., and Lee, S. (2002). *Safe Schools/Healthy Students Initiative. Evaluation of Outcomes: Final Report*. Final Report submitted to the Georgetown Safe Schools/Healthy Students Initiative. Austin, TX: School of Social Work, Center for Social Work Research at The University of Texas at Austin.
- Substance Abuse and Mental Health Services Administration. (2006). *SAMHSA advisory. SAMHSA issues consensus statement on mental health recovery*. Retrieved from http://www.samhsa.gov/news/newsreleases/060215_consumer.htm.
- Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working definition of recovery: 10 guiding principles of recovery*. Rockville, MD: Author. Publication ID: PEP12-RECDEF.
- Texas Department of State Health Services. (2007). *User's Manual for the Adult Texas Recommended Assessment Guidelines (Adult-TRAG). Version 3.1*. Austin, TX: Author.

APPENDIX A - ETCMHR DEVELOPMENT PROCESS

Demographic Information for Participants

Year One

As mentioned in the report, ten of the twelve potential participants chose to participate in this study (83.3% response rate). It is important to note that three of the ten respondents did not complete the demographic information sheet. Three of the respondents were female and four were male. The average age of the respondents was 60.86 ($n = 7$, $SD = 5.490$). Seven of the respondents had earned a graduate or professional degree. In terms of ethnicity, six of the respondents self-identified as White/European and one self-identified as African-American. Seven of the participants were employed full-time with benefits by either a public agency (six respondents) or other (one respondent). One of the respondents reported being licensed as a clinical psychologist and the other six indicated that they did not possess a license.

Year Two

Five of the twelve potential participants chose to participate in this study (41.6% response rate). Three of the respondents were female and four were male. The average age of the respondents was 50.67 ($n = 3$, $SD = 18.01$). In terms of ethnicity, four of the respondents self-identified as White/European and one self-identified as Latino/Hispanic. All five of the respondents had earned a graduate or professional degree and were employed full-time as an administrator of a public agency (three respondents) or other (two respondents). Two respondents reported being licensed, one as a LMSW-AP and one as a LCSW. The other three respondents indicated that they did not possess a license.

Year Three

Eight of the thirteen potential participants chose to participate in this study (74% response rate). It is important to note that ten instruments were returned, but two were excluded because they were not completed by the organization's representative to the ROC. All eight of the respondents were male. The average age of the respondents was 59.88 ($n = 8$, $SD = 8.27$). In terms of ethnicity, six of the respondents self-identified as White/European and two self-identified as African American. All eight of the respondents had earned a graduate or professional degree and were employed full-time as an administrator of a public agency (five respondents) or non-profit agency (three respondents). Two respondents reported being licensed, one as a LPC and one as a MD. The other six respondents indicated that they did not possess a professional license.

APPENDIX B - RECOVERY ORIENTATION OF ETCMHR

Demographic Information for Participants

The year two participants were all members of the Group 1 Peers. Five of the participants were female (31.3%) and 11 were male (68.8%). The average age of the participants was 53.31 ($SD = 11.28$, $min = 27$, $max = 72$). As for professional licensure, one of the participants reported having two professional licenses, Licensed Marriage and Family Therapist (LMFT) and Licensed Chemical Dependency Counselor (LCDC), with the LMFT as the primary license. The AACP ROSE includes an item that solicits the participant's roles, which may include more than one of the options provided. The options and responses are as follows: consumers- 68.8% ($n = 11$), family member of a consumer- 12.5% ($n = 2$), peer- 68.8% ($n = 11$), clinician- 0%, administrator- 0%, staff- 31.3% ($n = 5$), and other- 12.5% ($n = 2$).

The year three participants consisted of 16 Group 1 Peers and 15 Group 2 Peers. In terms of the overall group, 21 of the participants were female (67.7%) and 10 were male (32.3%). The average age of the participants was 49.13 ($SD = 12.93$, $min = 27$, $max = 73$). As for professional licensure, one of the participants reported having two professional licenses, Licensed Marriage and Family Therapist (LMFT) and Licensed Chemical Dependency Counselor (LCDC), with the LMFT as the primary license. Other participants reported possessing the following licenses: one registered nurse (RN), two teachers, and one other. Additional characteristics for year two and year three participants are presented in the following figures and tables.

Figure 5– Participants' Highest Degree

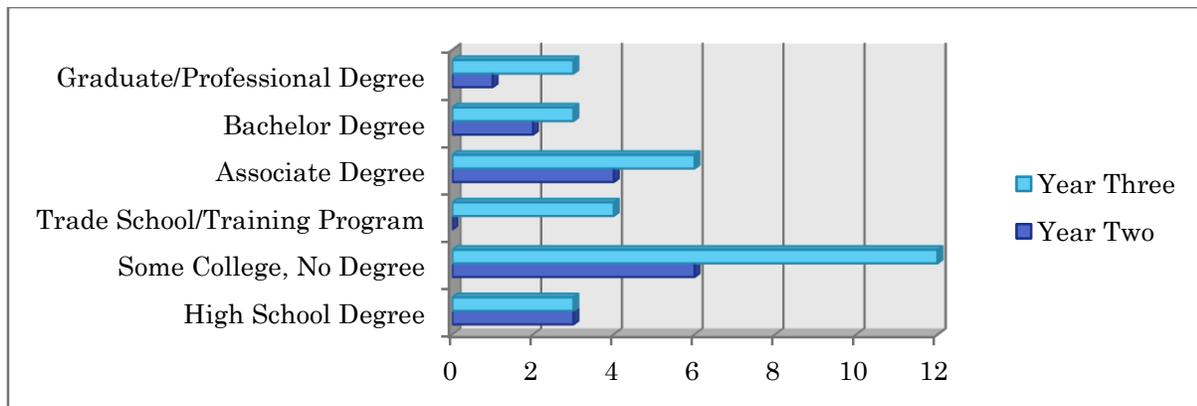


Figure 6– Participants' Ethnicity

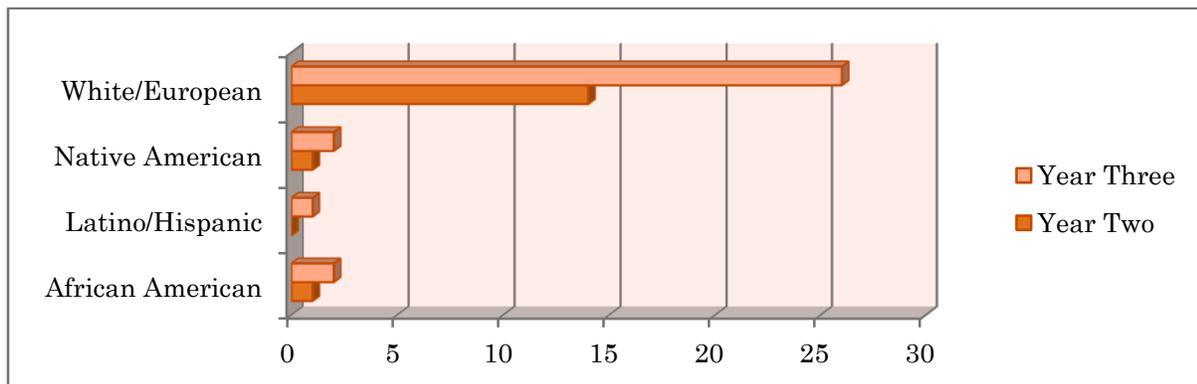


Figure 7 Populations Served by Participants

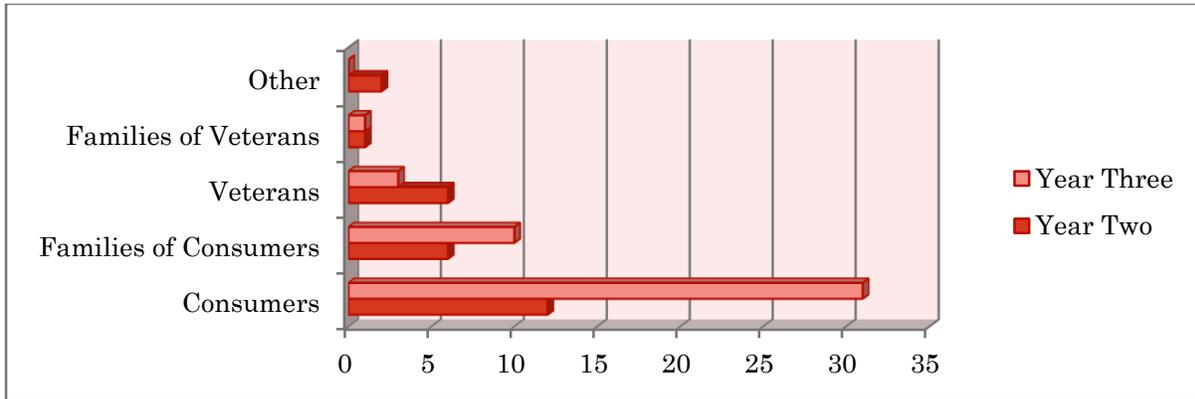


Figure 8- Primary Population Served by Participants

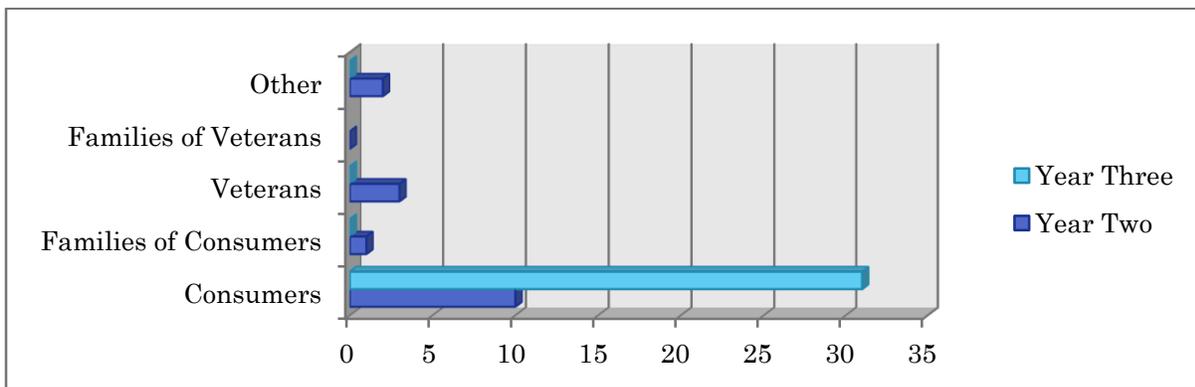


Figure 9- Participants' Employment Status

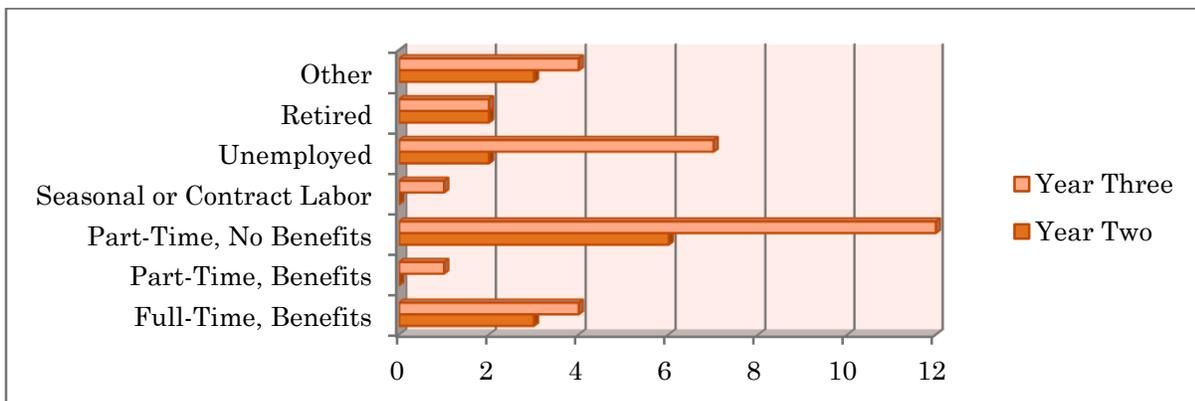


Figure 10- Participants' Employer (LMHAs)

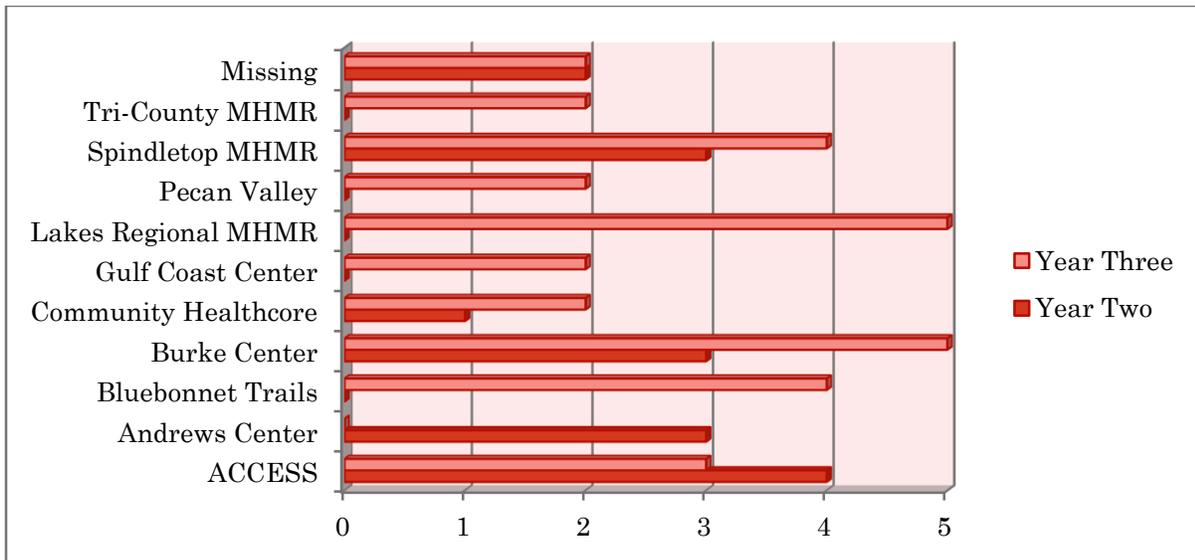
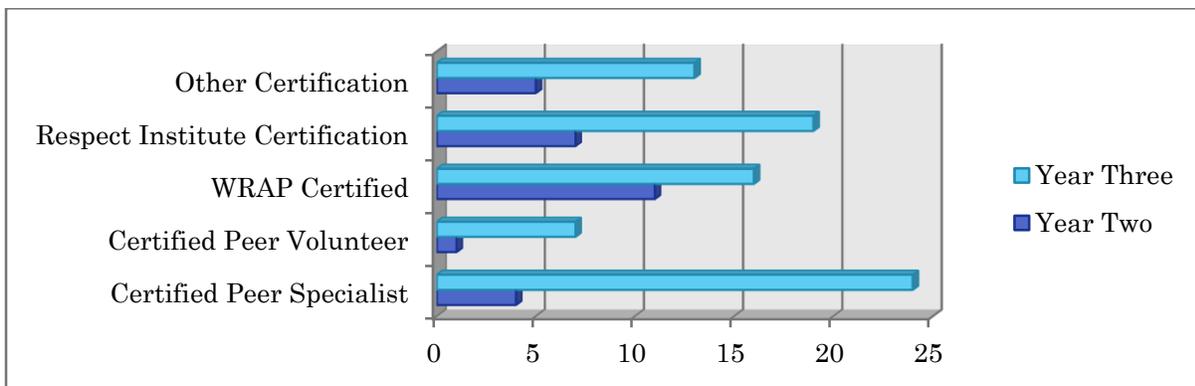


Figure 11- Peer Support Related Credentials¹⁰



Results

AACP ROSE

Table 16- AACP ROSE- Mean Sums and Mean Scores for Domains

Domain	Sums		Scores	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
Administration (Items 1 - 11)	30.13	8.07	2.74	.734
Treatment (Items 12 - 29)	48.94	13.83	2.74	.763
Supports (Items 30 - 40)	31.06	8.61	2.82	.782
Organizational Culture (Items 41 - 46)	19.81	5.24	2.83	.749

¹⁰ The conceptualization of certifications and trainings in the evaluation data collected may not fully reflect the current names of those trainings. For example, demographic questionnaires used the term “WRAP Certified.” However, completion of a 3 day WRAP training is typically referred to as “completed.”

Table 17- AACP ROSE- Mean Scores for Individual Items

#	Item	\bar{X}	<i>SD</i>
1	Promotion of recovery is included in organization's mission and vision	3.31	.946
2	Consumers are well represented in organization's internal review and strategic planning processes	2.81	.981
3	Community members interested in mental health settings are recruited and retained to participate in organizational oversight and development	2.56	.892
4	Consumers are compensated for participation in administrative activities (committees, quality improvement, etc)	2.38	.806
5	Agency employs persons in recovery and persons with disabilities as mentors and counselors	3.00	.966
6	There are significant opportunities for consumers and service providers to interact outside clinical relationships	2.50	.966
7	Service providers are knowledgeable about recovery principles and recovery promotion	3.25	1.07
8	Consumers are enlisted to participate in training of service providers	2.81	.834
9	Consumers are well represented and respected in quality improvement processes	2.63	.957
10	Outcome indicators are developed with consumer participation	2.50	.966
11	Outcome indicators are available to and make sense to consumers	2.38	.885
12	There is comprehensive array of services available to meet all identified needs	2.69	.946
13	All clinical services encourage the use of self-management principles	2.56	.892
14	Advance directives/crisis plans are encouraged and respected by the organization	2.75	1.13
15	A process is in place to assist consumers to develop advance directives	2.50	.966
16	A process is in place to assure review and implement advance directives during periods of incapacitation	2.31	.793
17	Organization is sensitive to cultural issues and provides services that meet cultural needs	2.81	.911
18	Staffing patterns reflect community's ethnic/racial/linguistic profile	2.81	1.22
19	Treatment planning is a collaborative process between consumers and providers	2.75	1.00
20	Consumers are provided adequate information about service options to make decisions regarding their service plans	2.73	1.10
21	Choices made by consumers are respected by providers	2.81	.911
22	Recovery management plans are developed that emphasize individual strengths and choice	2.81	1.17
23	Co-occurring disorders are treated at the same time and by the same clinicians	2.53	.743
24	A screening process is in place to assure detection of co-occurring disorders	3.06	.854
25	Organization meets competency standards for treating persons with co-occurring disorders	3.12	.885
26	Organization has program to reduce or eliminate the use of coercive treatment	2.81	.911
27	Attempts are made to engage and empower persons on involuntary treatment status	2.75	.931
28	Staff has been adequately trained to de-escalate volatile situations and to avoid seclusion and restraint	2.88	.957
29	Debriefing occurs following all episodes of seclusion or restraint if it must be used	2.56	1.15
30	Organization facilitates consumer participation and leadership in advocacy and peer support efforts/organizations	3.50	.516
31	Organization has an active liaison with local advocacy and peer support groups	3.13	.885
32	Consumers consistently indicate satisfaction with access to services	2.94	.998
33	Family members are engaged and educated to support recovery efforts	2.75	1.13
34	Opportunities exist for family members to be involved in treatment planning and organizational development	2.62	1.03
35	Family members are represented on committees and are involved in staff training	2.44	1.15
36	Consumers are encouraged and supported in pursuit of employment and vocational skills	3.19	.911
37	Development of educational and employment goals are emphasized in recovery plans	3.06	1.06
38	Individual placement and support guides vocational activities	2.75	1.07
39	Tolerant housing is available to those who cannot maintain sobriety or stable recovery	2.38	1.31
40	Consumers are satisfied with housing options available	2.31	1.25
41	Consumers feel respected by service providers	2.87	.885

#	Item	\bar{X}	<i>SD</i>
42	Consumers feel welcomed and valued	2.88	.885
43	Providers communicate with consumers honestly and sincerely	3.00	.966
44	Documentation is an open process that consumers may have easy access to if desired	2.69	1.14
45	Consumers are informed of their rights and responsibilities	3.13	.957
46	There is an equitable process through which service consumers and providers can resolve conflicts or disagreement	2.94	.998

RSA-R

Table 18- RSA-R - Mean Scores for Domains

Domain (items)	Group One		Group Two		All ¹¹	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
Life Goals (3, 7, 8, 9, 12, 16, 17, 18, 28, 31, 32)	3.30	.639	3.78	.528	3.55	.621
Involvement (22, 23, 24, 25, 29)	2.82	1.04	3.13	.772	2.97	.913
Diversity of Treatment Options (14, 15, 20, 21, 26)	2.93	.913	3.69	.592	3.29	.852
Choice (4, 5, 6, 10, 27)	3.45	.877	3.48	.501	3.46	.706
Individually-Tailored Services (11, 13, 19, 30)	3.11	.802	3.54	.529	3.32	.689
Invite (1, 2)	3.46	.853	3.65	1.05	3.56	.942
Overall (All items)	3.09	.725	3.63	.525	3.35	.681

Table 19- RSA-R - Mean Scores for Individual Items

Item	Group One		Group Two		All	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
1 Staff make a concerted effort to welcome people in recovery and help them to feel comfortable in this program.	3.15	1.07	3.92	1.12	3.54	1.14
2 This program/agency offers an inviting and dignified physical environment (e.g., the lobby, waiting rooms, etc.).	3.77	.927	3.36	1.08	3.56	1.01
3 Staff encourage program participants to have hope and high expectations for their recovery.	3.31	1.18	3.67	1.16	3.48	1.16
4 Program participants can change their clinician or case manager if they wish.	3.30	1.42	2.90	1.45	3.10	1.41
5 Program participants can easily access their treatment records if they wish.	3.40	1.35	3.09	1.14	3.24	1.22
6 Staff do not use threats, bribes, or other forms of pressure to influence the behavior of program participants.	4.67	.651	4.15	1.14	4.40	.957
7 Staff believe in the ability of program participants to recover.	3.36	1.03	4.00	.913	3.71	.999
8 Staff believe that program participants have the ability to manage their own symptoms.	3.50	.707	3.42	.996	3.45	.858
9 Staff believe that program participants can make their own life choices regarding things such as where to live, when to work, whom to be friends with, etc.	3.36	.809	3.67	.778	3.52	.790
10 Staff listen to and respect the decisions that program participants make about their treatment and care.	3.23	.725	3.83	.835	3.52	.823
11 Staff regularly ask program participants about their interests and the things they would like to do in the community.	3.15	.899	4.08	.954	3.62	1.02

¹¹ All participants (Groups One and Two)

Item	Group One		Group Two		All	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
12 Staff encourage program participants to take risks and try new things.	3.08	.954	3.73	1.01	3.38	1.01
13 This program offers specific services that fit each participant's unique culture and life experiences.	2.92	1.24	3.27	1.35	3.09	1.28
14 Staff offer participants opportunities to discuss their spiritual needs and interests when they wish.	3.08	1.12	4.00	.739	3.52	1.05
15 Staff offer participants opportunities to discuss their sexual needs and interests when they wish.	2.80	1.23	2.86	.900	2.82	1.07
16 Staff help program participants to develop and plan for life goals beyond managing symptoms or staying stable (e.g., employment, education, physical fitness, connecting with family and friends, hobbies).	3.08	1.04	4.23	.927	3.65	1.13
17 Staff routinely assist program participants with getting jobs.	2.91	1.30	3.89	.782	3.35	1.18
18 Staff actively help program participants to get involved in non-mental health/addiction related activities, such as church groups, adult education, sports, or hobbies.	2.80	.422	3.67	.778	3.27	.767
19 Staff work hard to help program participants to include people who are important to them in their recovery/treatment planning (such as family, friends, clergy, or an employer).	3.09	.944	3.58	1.08	3.35	1.03
20 Staff actively introduce program participants to persons in recovery who can serve as role models or mentors.	2.92	1.17	3.92	.954	3.44	1.16
21 Staff actively connect program participants with self-help, peer support, or consumer advocacy groups and programs.	3.08	1.04	4.31	.751	3.69	1.09
22 Staff actively help people find ways to give back to their community (i.e., volunteering, community services, neighborhood watch/cleanup).	2.83	1.03	3.58	.996	3.21	1.06
23 People in recovery are encouraged to help staff with the development of new groups, programs, or services.	2.92	1.31	3.75	1.14	3.33	1.27
24 People in recovery are encouraged to be involved in the evaluation of this agency's programs, services, and service providers.	2.58	1.24	3.33	1.23	2.96	1.27
25 People in recovery are encouraged to attend agency advisory boards and management meetings.	2.92	1.62	2.64	1.21	2.78	1.41
26 Staff talk with program participants about what it takes to complete or exit the program.	2.73	1.27	3.10	1.10	2.90	1.18
27 Progress made towards an individual's own personal goals is tracked regularly.	2.83	1.03	3.55	.688	3.17	.937
28 The primary role of agency staff is to assist a person with fulfilling his/her own goals and aspirations.	3.08	1.24	3.83	1.27	3.46	1.29
29 Persons in recovery are involved with facilitating staff trainings and education at this program.	2.62	1.39	3.00	1.28	2.80	1.32
30 Staff at this program regularly attend trainings on cultural competency.	3.00	1.20	3.43	.535	3.20	.941
31 Staff are knowledgeable about special interest groups and activities in the community.	3.20	.919	3.55	.820	3.38	.865
32 Agency staff are diverse in terms of culture, ethnicity, lifestyle, and interests.	3.70	.949	4.18	.751	3.95	.865

APPENDIX C - A SNAPSHOT OF THE PEER SPECIALISTS

Demographic Information for Participants

Year One

The year one participants were all members of the Group 1 Peers. Eight of the respondents were male (80%) and two were female (20%). The average age of the respondents was 54.1 ($SD = 7.666$). In terms of race/ethnicity, one respondent self-identified as African American (10%) and 9 respondents self-identified as White/European (90%). The results for the remaining demographic categories are presented below (see Figure 12 through Figure 15).

Figure 12- Respondents' Highest Level of Education

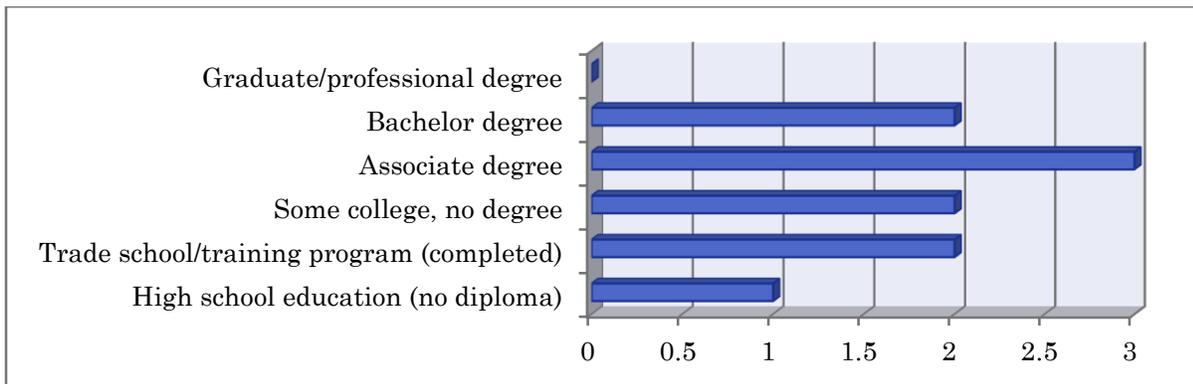


Figure 13- Respondents' Primary County of Residence

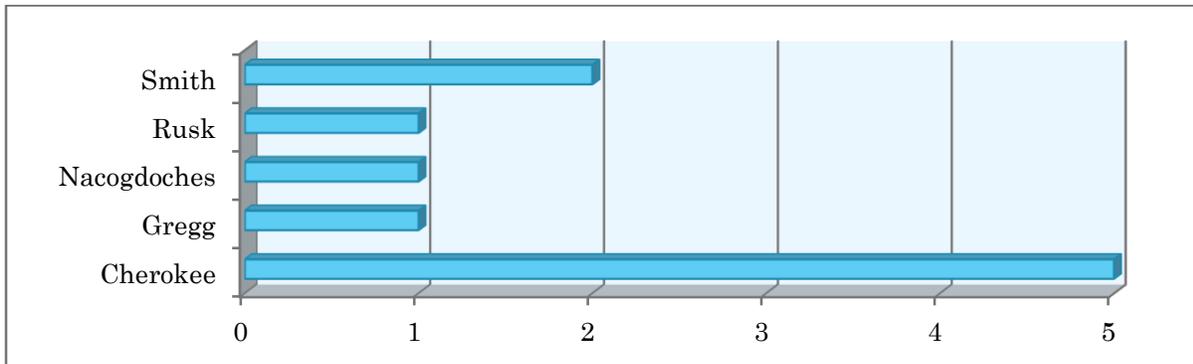


Figure 14- Respondents' Primary County of Employment

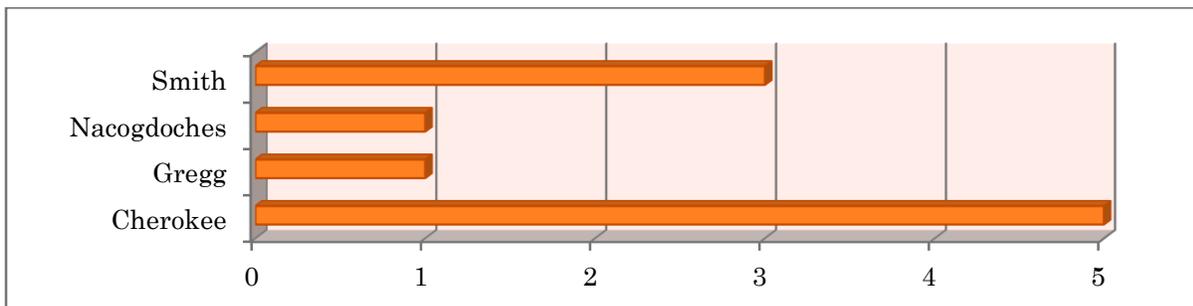
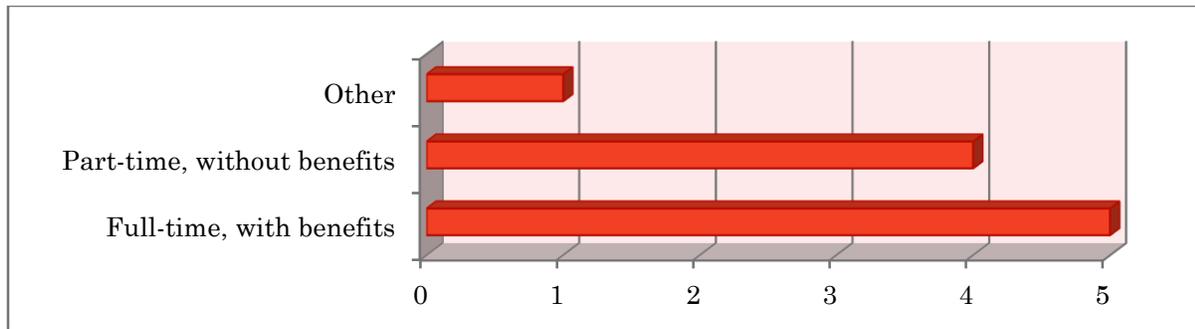


Figure 15- Respondents' Employment Status



Years Two and Three

The year two participants were all members of the Group 1 Peers. Five of the participants were female (31.3%) and 11 were male (68.8%). The average age of the participants was 53.31 ($SD = 11.28$, $min = 27$, $max = 72$). As for professional licensure, one of the participants reported having two professional licenses, Licensed Marriage and Family Therapist (LMFT) and Licensed Chemical Dependency Counselor (LCDC), with the LMFT as the primary license. The AACP ROSE includes an item that solicits the participant's roles, which may include more than one of the options provided. The options and responses are as follows: consumers- 68.8% ($n = 11$), family member of a consumer- 12.5% ($n = 2$), peer- 68.8% ($n = 11$), clinician- 0%, administrator- 0%, staff- 31.3% ($n = 5$), and other- 12.5% ($n = 2$).

The year three participants consisted of 16 Group 1 Peers and 15 Group 2 Peers. In terms of the overall group, 21 of the participants were female (67.7%) and 10 were male (32.3%). The average age of the participants was 49.13 ($SD = 12.93$, $min = 27$, $max = 73$). As for professional licensure, one of the participants reported having two professional licenses, Licensed Marriage and Family Therapist (LMFT) and Licensed Chemical Dependency Counselor (LCDC), with the LMFT as the primary license. Other participants reported possessing the following licenses: one registered nurse (RN), two teachers, and one other. Additional characteristics for year two and year three participants are below (see Figure 16 through Figure 22).

Figure 16- Participants' Highest Degree

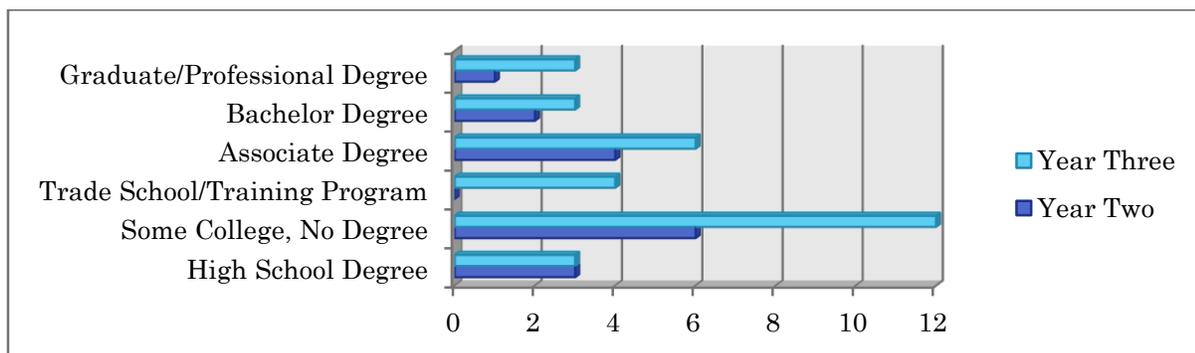


Figure 17- Participants' Ethnicity

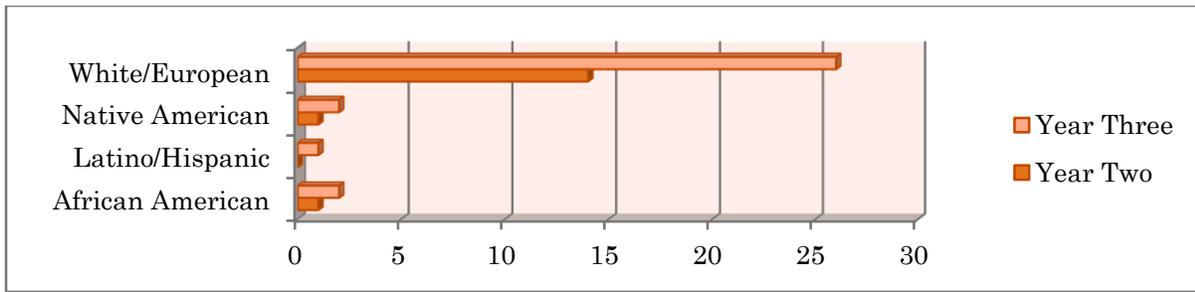


Figure 18- Populations Served by Participants

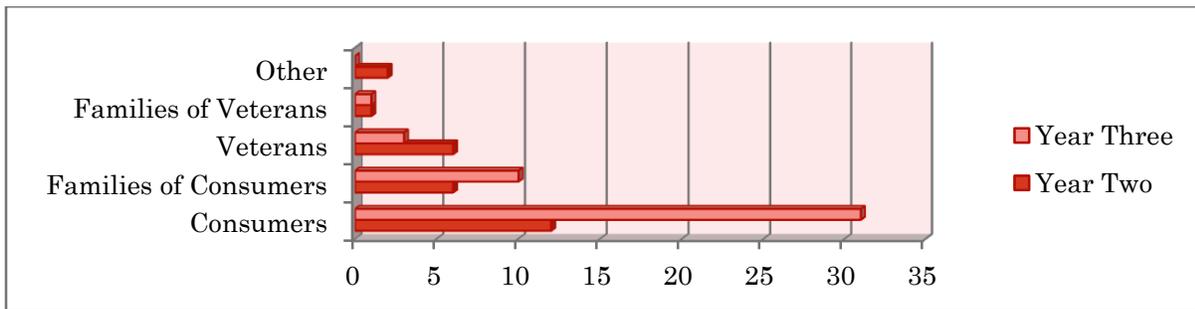


Figure 19- Primary Population Served by Participants

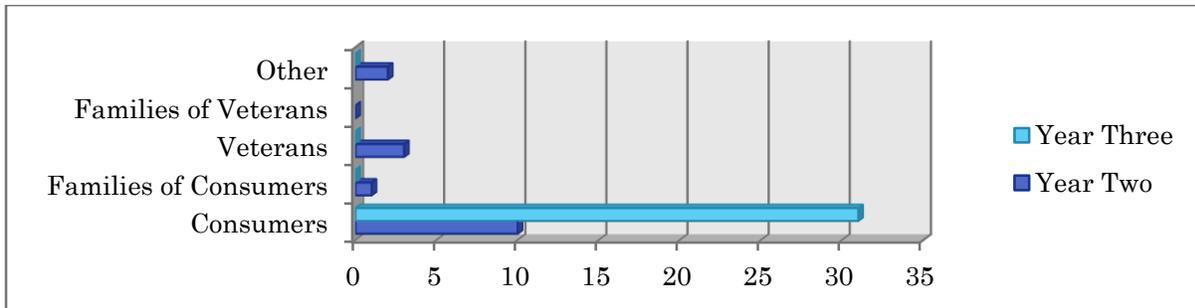


Figure 20- Participants' Employment Status

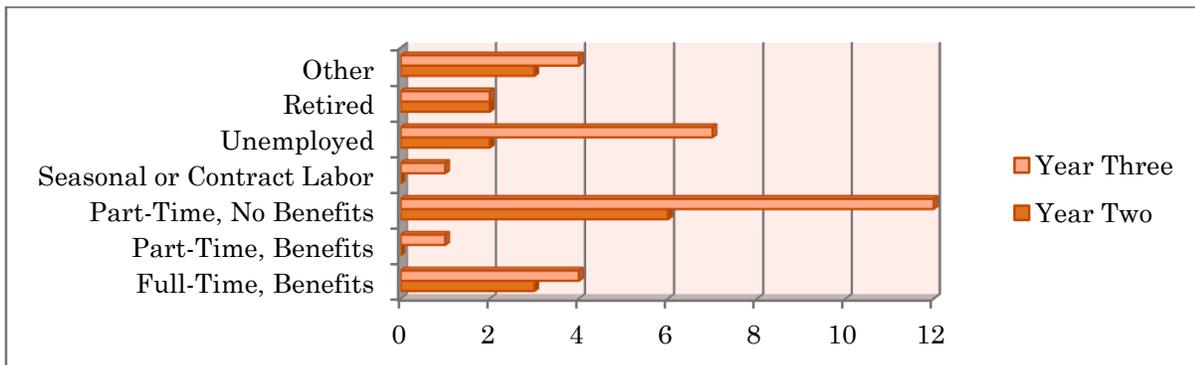


Figure 21- Participants' Employer (LMHAs)

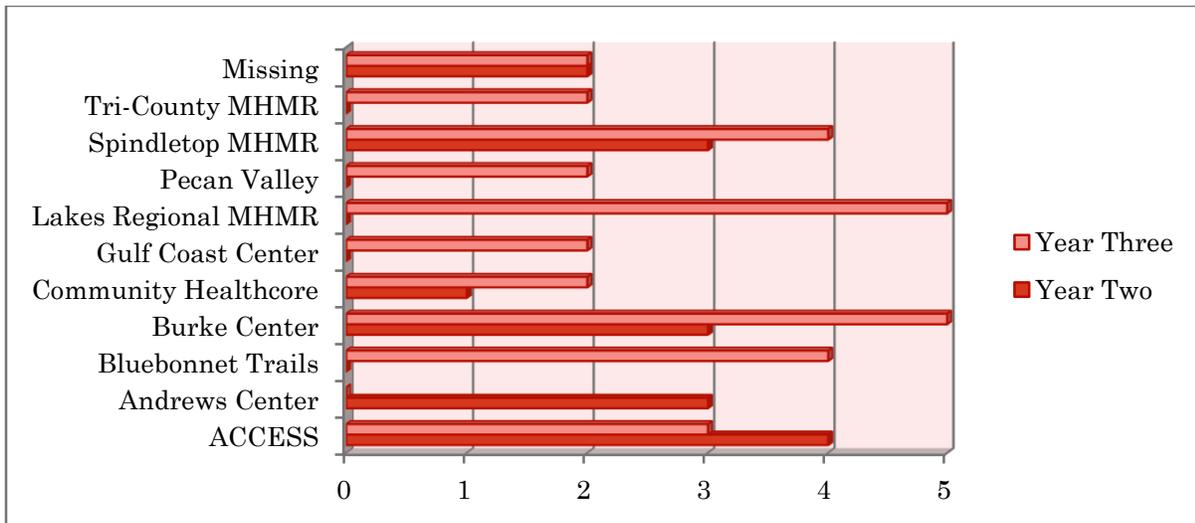
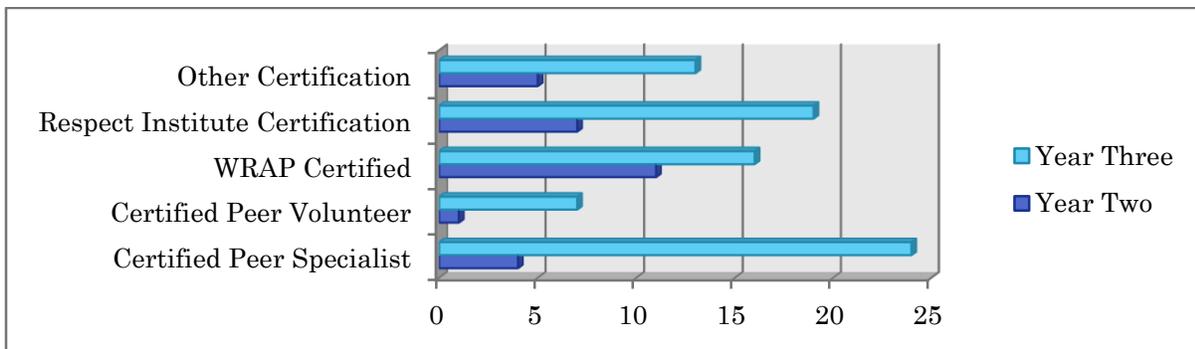


Figure 22- Peer Support Related Credentials¹²



¹² The conceptualization of certifications and trainings in the evaluation data collected may not fully reflect the current names of those trainings. For example, demographic questionnaires used the term “WRAP Certified.” However, completion of a 3 day WRAP training is typically referred to as “completed.”

Results

Table 20- MHRM- Mean Scores for Individual Items

Item	Year Two		Year Three	
	\bar{X}	<i>SD</i>	\bar{X}	<i>SD</i>
1 I work hard towards my mental health recovery.	3.75	.447	3.71	.783
2 Even though there are hard days, things are improving for me.	3.31	1.01	3.55	.850
3 I ask for help when I am not feeling well.	2.75	1.13	3.00	1.03
4 I take risks to move forward with my recovery.	3.25	.856	3.06	1.09
5 I believe in myself.	3.19	1.11	3.23	.990
6 I have control over my mental health problems.	3.25	.856	3.10	.908
7 I am in control of my life.	3.44	.512	3.23	.990
8 I socialize and make friends.	3.38	.719	3.39	.558
9 Every day is a new opportunity for learning.	3.69	.479	3.55	.850
10 I still grow and change in positive ways despite my mental health problems.	3.38	1.03	3.61	.803
11 Even though I may still have problems, I value myself as a person of worth.	3.37	1.09	3.26	1.09
12 I understand myself and have a good sense of who I am.	3.13	1.03	3.29	1.01
13 I eat nutritious meals everyday.	2.44	1.15	2.61	1.12
14 I go out and participate in enjoyable activities every week.	2.88	.885	3.03	.795
15 I make the effort to get to know other people.	3.19	.834	3.29	.693
16 I am comfortable with my use of prescribed medications.	3.25	.856	3.48	.570
17 I feel good about myself.	3.19	1.17	3.06	.998
18 The way I think about things helps me to achieve my goals.	3.25	.931	3.35	.839
19 My life is pretty normal.	2.81	1.17	2.68	.979
20 I feel at peace with myself.	3.00	1.21	3.00	.894
21 I maintain a positive attitude for weeks at a time.	2.94	1.34	3.16	.860
22 My quality of life will get better in the future.	3.44	.727	3.52	.890
23 Everyday that I get up, I do something productive.	3.13	.885	3.10	.870
24 I am making progress toward my goals.	3.31	.873	3.35	.839
25 When I am feeling low, my religious faith or spirituality supports my recovery.	3.44	.629	3.23	.990
26 My religious faith or spirituality supports my recovery.	3.44	.629	3.16	1.04
27 I advocate for the rights of myself and others with mental health problems.	3.31	.873	3.61	.615
28 I engage in work or other activities that enrich myself and the world around me.	3.13	1.15	3.29	.973
29 I cope effectively with stigma associated with having a mental health problem.	2.94	1.06	3.06	.892
30 I have enough money to spend on extra things or activities that enrich my life.	2.31	1.35	2.23	1.26

APPENDIX D - RECOVERY EXPERIENCES OF THE PEER SPECIALISTS

Demographic Information for Participants

Group 1

Five of the participants were female (55.6%) and four were male (44.4%). The average age of the participants was 51.75 ($SD = 13.51$, min = 38, max = 73). As for professional licensure, two of the participants reported holding a professional license (one Licensed Professional Counselor and one teacher). One of the participants reported having two professional licenses, Licensed Marriage and Family Therapist (LMFT) and Licensed Chemical Dependency Counselor (LCDC), with the LMFT as the primary license. Additional characteristics are reported in Figure 23 through Figure 29.

Group 2

Four of the participants were female (80%) and one was male (20%). The average age of the participants was 43.60 ($SD = 11.61$, min = 27, max = 56). As for professional licensure, one of the participants reported having a teaching certificate. Additional characteristics for the participants are presented reported in Figure 23 through Figure 29.

Figure 23– Participants’ Highest Degree

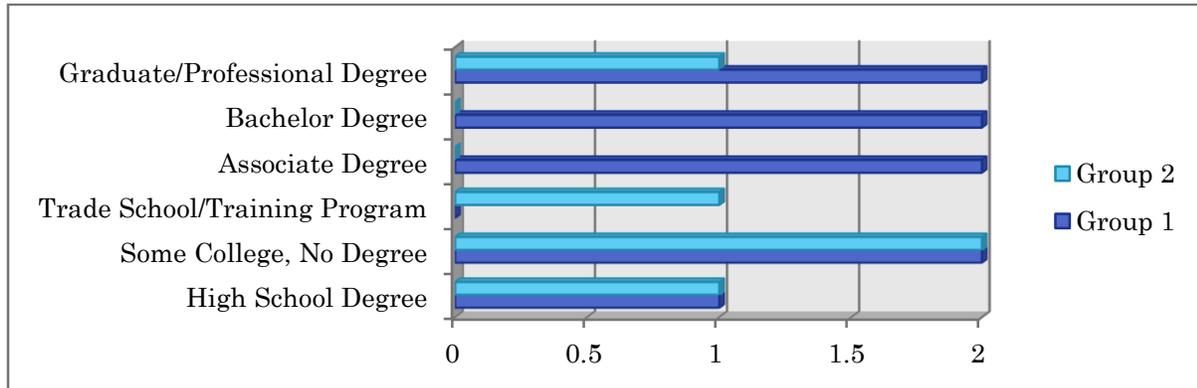


Figure 24– Participants’ Ethnicity

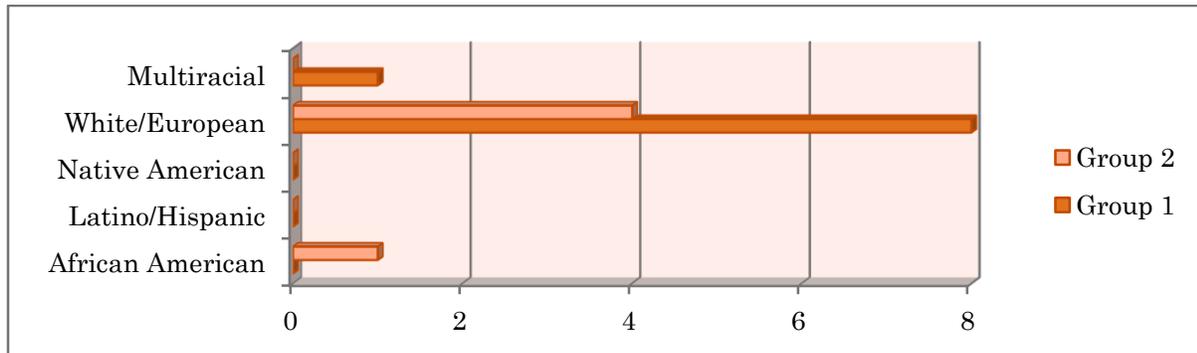


Figure 25– Populations Served by Participants

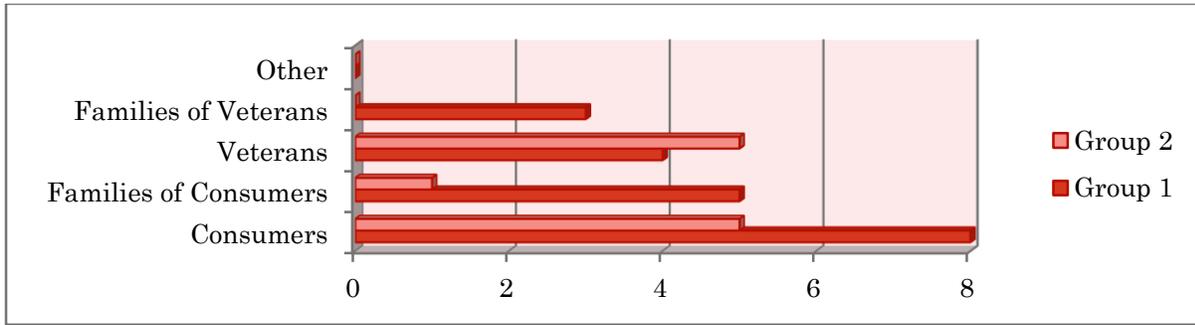


Figure 26– Primary Population Served by Participants

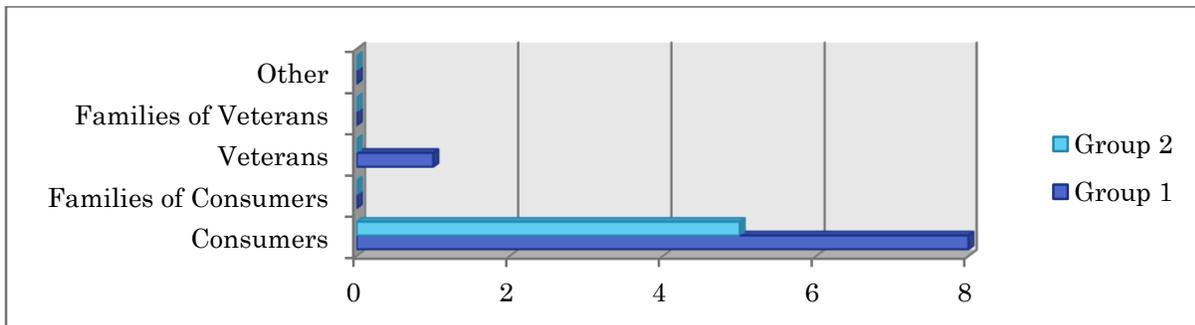


Figure 27– Participants' Employment Status

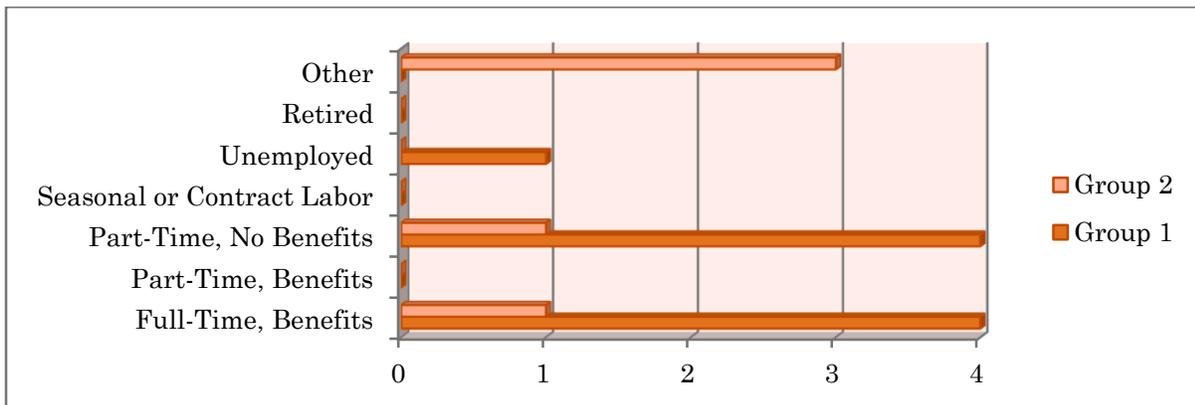


Figure 28– Participants’ Employer (LMHAs)

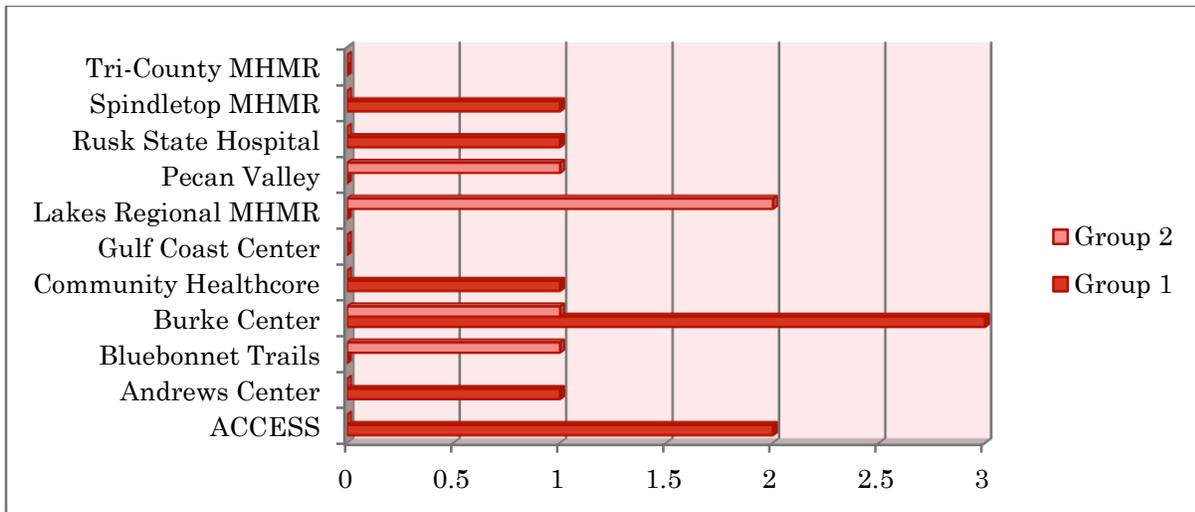
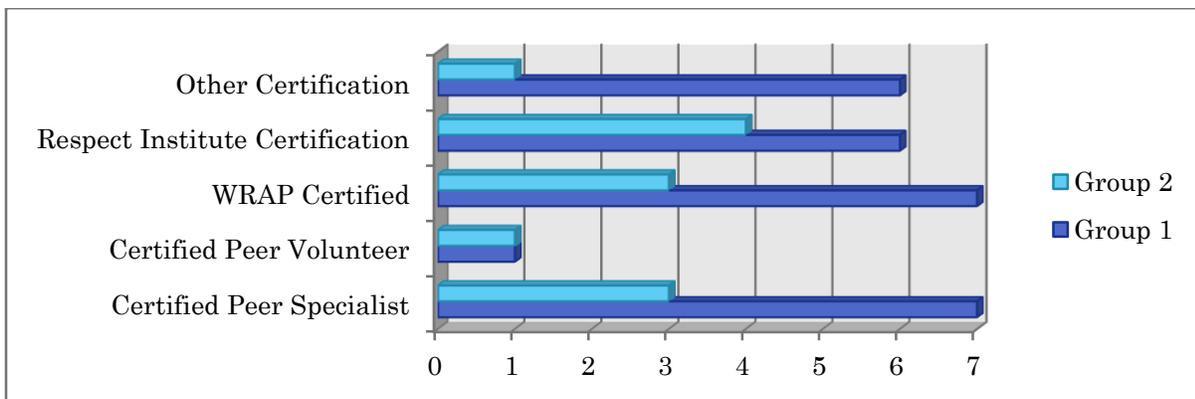


Figure 29– Peer Support Related Credentials¹³



Interview Questions

Year Two - Initial Interview with Group 1 Peers

1. What was your life like before you began the recovery process? What is your life like now that you are in recovery?
2. What aspects of your life have changed? What aspects haven't changed?
3. How has the coalition (ETCMHR) impacted your recovery process? How has it impacted your overall quality of life?
4. What specific elements of the coalition (ETCMHR) do you believe were the most helpful in moving you toward your current place in the recovery process? What elements do you believe were the least helpful?

¹³ The conceptualization of certifications and trainings in the evaluation data collection may not fully reflect the current names of those trainings. For example, demographic questionnaires used the term “WRAP Certified.” However, completion of a 3 day WRAP training is typically referred to as “completed.”

5. What supports/strategies do you have in place to maintain your progress?
6. How have your perceptions of recovery changed over the course of the recovery process?
7. What are your individual future goals?
8. What do you need to achieve these goals?
9. What supports/strategies do you have in place to achieve these?

Year Three - Initial Interview with Group 2 Peers

1. What was your life like before you began the recovery process? What is your life like now that you are in recovery?
2. What aspects of your life have changed? What aspects haven't changed?
3. How has the coalition (ETCMHR) impacted your recovery process? How has it impacted your overall quality of life?
4. What specific elements of the coalition (ETCHMR) do you believe were the most helpful in moving you toward your current place in the recovery process? What elements do you believe were the least helpful? *If WRAP is not mentioned, ask about it.*
5. What supports/strategies do you have in place to maintain your progress? *If they do not mention WRAP, follow up with the following questions: Are you currently using your WRAP (yes or no)? Why or why not?*
6. How have your perceptions of recovery changed over the course of the recovery process?
7. What are your individual future goals?
8. What do you need to achieve these?
9. What supports/strategies do you have in place to achieve these?

Year Three - Follow-up Interview with Group 1 Peers

1. How would you describe your process of recovery over the past year?
2. What aspects of your life have changed over the past year? What aspects of your life have remained the same over the past year?
3. How has the ETCMHR impacted your recovery process over the past year? How has it impacted your quality of life over the last year?
4. What specific elements of ETCMHR do you believe were the most helpful in moving you toward your current place in the recovery process? What elements do you believe were the least helpful? *If WRAP is not mentioned, ask about it.*
5. What supports/strategies do you have in place to maintain your progress? *If they do not mention WRAP, follow up with the following questions: Are you currently using your WRAP (yes or no)? Why or why not?*
6. How have your perceptions of recovery changed over the past year?
7. Have your individual future goals changed over the past year? If so, how have they changed?
8. What supports/strategies do you have in place to achieve these?
9. What do you need to achieve these?

APPENDIX E - RECRUITING PEER SPECIALISTS

Demographic Information for Participants

Individual Characteristics

Nine of the participants were female and nine were male. The average age of the respondents was 49.94 ($SD = 11.88$, min = 25, max = 72). Two of the respondents had at least a high school diploma or GED (11.1%), three had some college without a degree (16.7%), four had earned an associate's degree (22.2%), five had earned a bachelor's degree (27.8%), and four had earned a graduate or professional degree (22.2%). In terms of ethnicity, 16 of the respondents self-identified as White/European (88.9%), one self-identified as African American (5.6%), and one self-identified as Native American (5.6%).

Employment Related Characteristics

All of the participants reported working directly with consumers of mental health services, 6 reported working directly with families of consumers (33.3%), five reported working directly with veterans (27.8%), two reported working with families of veterans (11.1%), and two reported working with populations other than those mentioned (11.1%). Of the populations served, 16 of the respondents identified consumers of mental health services as their primary service population (88.9%), one identified veterans (5.6%), and one identified families of veterans (5.6%). Seven of the participants were employed full-time with benefits, seven were employed part-time without benefits, one was unemployed, one was retired, and two reported their employment status as other. Sixteen of the respondents reported their county of employment, which are as follows: Cherokee (6), Gregg (1), Jefferson (4), Nacogdoches (3) and Smith (2). In terms of related certifications, five of the participants were certified peer specialists (27.8%), two were certified peer volunteers (11.1%), 14 had completed WRAP training (77.8%), and eight had a Respect Institute Certification (44.4%)¹⁴. Four of the respondents held a professional license or certification (one Licensed Marriage and Family Therapist, one Licensed Chemical Dependency Counselor, one Licensed Bachelor Social Worker, one Licensed Master Social Worker, one Licensed Clinical Social Worker, and one teacher). Of the two respondents who reported holding more than one license, one's primary license was as a Licensed Marriage and Family Therapist and the other's primary license was as a Licensed Master Social Worker.

¹⁴ The conceptualization of certifications and trainings in the evaluation data collected may not fully reflect the current names of those trainings. For example, demographic questionnaires used the term "WRAP Certified." However, completion of a 3 day WRAP training is typically referred to as "completed."

For More Information:

H. Stephen Cooper, Ph.D., LCSW
Associate Professor of Social Work
Stephen F. Austin State University
School of Social Work
PO Box 6104, SFA Station
Nacogdoches, Texas 75962
(936) 468-2845 • scooper@sfasu.edu

