Enabling Change: MassHealth Expansion of Enhanced Peer Support in Child Behavioral Health

ENABLING CHANGE:

MASSHEALTH EXPANSION OF ENHANCED PEER SUPPORT

IN CHILD BEHAVIORAL HEALTH

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Abstract

There is an unmet need in mental health services for youth and young adults ages 14-25 years in the United States, with only 20-35% receiving needed treatments (NIMH, 2017). Transition Age Youth (TAY) are older adolescents, ages 16-24 years, that are particularly at risk for mental health crises when transitioning from child to adult social services or from child services to complete independence. This vulnerable population faces challenges across diverse social systems, including poverty, education, justice system, housing, and unemployment. To expand efforts to address gaps in the continuum of mental health care and to improve mental health outcomes for TAY, the Massachusetts Medicaid and Children's Health Insurance agency (MassHealth) in partnership with the Massachusetts Department of Mental Health (DMH) developed a treatment innovation: the Young Adult Peer Mentor (YAPM) therapeutic intervention model. In the YAPM intervention, young adult peer support staff utilize their lived experiences from the successful management of their own mental illness to assist youth with similar mental health challenges through therapeutic mentoring techniques.

The DELTA Project provided a broader knowledge base for the MassHealth statewide implementation of the YAPM model by examining the MassHealth Providers' interest in and organizational readiness to implement the YAPM peer support intervention. Data was collected through electronically administered surveys to staff and through key stakeholder interviews. The Project findings showed that education and advocacy were vital for organizations to

understand the valuable role of peer support staff. Unfortunately, the stigma of mental illness remains an issue among mental health professionals working with young adult peers. Training and support were reported as being critical to the successful integration of the YAPM model. Fidelity of the YAPM model was essential to its sustainability in organizations. Interest and organizational readiness surveys, educational materials, an executive summary, and an issue brief were developed as deliverables to MassHealth.

The key leadership lesson learned from the DELTA Project was that when facing an organizational challenge, one must continually self-assess, learn from unanticipated experiences, and believe that flexibility of perspective, flexibility of thought, and a willingness to compromise can lead to the right solution.

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List of Abbreviations

CASRA ……..…….	California Association of Social Rehabilitation Agencies
CBHI ……..…….	Children's Behavioral Health Initiative
CHIP ……...…	Children's Health Insurance Program
CMHI ……..……	Children's Mental Health Initiative
CMS ……..……..	Centers for Medicare and Medicaid Services
CPS ……..……...	Certified Peer Specialist
DELTA ……..…….	Doctoral Engagement in Leadership and Translation for Action
DMH ……..…….	Department of Mental Health
DrPH ……...…	Doctor of Public Health
HHS ……..…….	Department of Health and Human Services
MSDH …….....	Mississippi State Department of Health
SAMHSA ……..…	Substance Abuse and Mental Health Services Administration
SED ……..……..	Serious Emotional Disturbances
STAY …….	Success for Transition Age Youth
TAY ……..…….	Transition Age Youth
YAPM ……..……..	Young Adult Peer Mentor

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Introduction

Background

Transition Aged Youth (TAY), typically defined as those youth and young adults from 16 to 24 years of age, are at risk for a wide range of healthcare, housing, justice system, employment, educational, and developmental challenges as they transition from child to adult health and social services. Of those youth and young adults needing mental health services in the United States, only 20-35% receive needed treatments (National Institute of Mental Health [NIMH], 2017). Some of the alarming statistics in the state of Massachusetts are that over 800,000 young adults have "aged out" of state child services. Poverty claims over 16% of these "aged out" youth and young adults (Marchand, Pirk, Putnam, & Savir, 2016). In addition, this vulnerable population is at greater risk for failing at school, engaging with correctional authorities, and developing a dependency on social assistance services (Department of Mental Health, 2010). Because they perceive that their needs have changed, TAY themselves often perceive a mismatch between the services offered to them as children and those available to them as adults. They represent a particularly vulnerable population for continued care if they exhibit mental illness or disabilities or have experienced foster care, juvenile justice engagement, or homelessness. Further, those youth with serious mental health problems may be at a higher risk for developing serious mental health crises as they age out of child mental health services, and they may experience difficulties in access to and benefits from the most effective therapeutic intervention strategies (Delman & Klodnick, n.d.). Mental health issues are of particular concern because disruption in the continuum of care can exacerbate these challenges. This vulnerable group continues to face the challenge of the stigma of mental illness and other major physiological, social, economic, and psychological changes in their lives once they leave child

health and social services (Delman & Klodnick, n.d.; Marchand, et al., 2016). These are significant challenges which cannot be ignored. They must be addressed not only for the TAY population, but for the community and state as well. Responses to this growing problem must be met by community and state agencies.

Given the depth of the challenges to the TAY population, the state of Massachusetts faces the dilemma of a health, economic, social, and educational overlapping cluster of formidable challenges to its governmental integrity, financial solvency, and concerned commitment to the well-being of its vulnerable TAY population (Norton, 2017; Norton & Murphy, 2017; The Associated Press, 2017). The need for more effective health care options, particularly in mental health services, for TAY is critical given the growth of the target population. Problematic issues in mental health services provided by state and federal governments for the TAY population include the following highlights: (1) commitment to enhancing the quality and effectiveness of therapeutic intervention program strategies put in place as treatment options for the mentally ill; (2) commitment to fostering the development and retention of an effective and supportive mental health workforce; and (3) commitment to fiscal responsibility as motivation to support the cost-benefits associated with the most effective mental health services and policies of the state of Massachusetts. Thus, finding solutions to this dilemma threatening these diverse critical areas of life can make a difference in the lives of one of Massachusetts' most vulnerable populations. Attention to the specific challenges involved in the delivery of mental health services may offer a template for addressing other life challenges faced by TAY. Implementing change in the delivery of health care services through an innovation in the delivery process is one solution to a growing TAY problem for the state of Massachusetts.

Role of MassHealth in State Response to TAY Crisis

Organizational structure and the MassHealth responsibilities. MassHealth as the Medicaid and Children's Health Insurance Program (CHIP) authority for the state of Massachusetts operates with the mission to "improve the health outcomes of our diverse members, their families and their communities, by providing access to integrated health care services that are sustainable, while they promote health, well-being, independence and quality of life" (Harris, 2013). The organizational structure of MassHealth encompasses the Medicaid program and the Children's Health Insurance Program (CHIP) for the state of Massachusetts. It serves just under 2 million members, spending approximately $13 billion in FY 2015 (Bump, 2017). MassHealth is a state government entity that must adhere to all Massachusetts government policies and budget restraints. MassHealth also reports to its federal parent agency, the Centers for Medicare and Medicaid Services (CMS), that is housed in the Department of Health and Human Services (HHS). In addition, the mental health division of MassHealth must consider recommendations from the federal mental health agency, the Substance Abuse and Mental Health Services Administration (SAMHSA).

The Children's Behavioral Health Initiative (CBHI) was created as an organized reform effort to address the issues that gave rise to the *Rosie D. v. Romney* class action lawsuit, which sought assistance for children with serious emotional disturbance (SED). It is important to note that the *Rosie D.* lawsuit compelled the state of Massachusetts to provide intensive home-based treatment for children with severe psychiatric disabilities and led to a strong reform policy that affects current program planning (Center for Public Representation, 2006; Mental Health Legal Advisors Committee, 2012)

MassHealth programming attempts to remedy TAY crisis. Numerous attempts have been made by the state of Massachusetts to address the TAY crisis. One response is the *Department of Mental Health Transition Age Youth Initiative*, which lists over 10 programs on the official website for the state's Health and Human Services Departments and Divisions that focus on transition aged youth. The Department of Mental Health (DMH) also provides online access to the *Young Adult Resource Guide* and other resources and tools to address the health, education, homelessness, legal, and economic problems faced by transition aged youth (Massachusetts Department of Mental Health, 2010*).* Some of the many state-funded services provided for transition aged youth and young adults include several which address those developmental life challenges that make this group a vulnerable population in need of life-changing solutions. The *Home for Little Wanderers* represents one model of services which form a system of different programs serving youth from birth to 22 years of age by focusing on youth who have "aged out" of many of the state's children's programs for treating mental illness and behavioral problems. The program offerings include (1) Peer Mentors as part of the MassHealth and Department of Mental Health intervention initiative; (2) support for academic, clinical, social, vocational, and daily living challenges for those TAY choosing higher education career options; (3) life skills curriculum facilitating successful adjustment to daily living; and (4) on-site Life Coaches for support in achieving goals and in following life skills curriculum (The Home for Little Wanderers, 2015).

Within MassHealth itself, the Child Behavioral Health Initiative (CBHI) has piloted innovative mental health care strategies by implementing a young adult peer intervention model, where youth who have recovered from past mental illness are trained as peer coaches with additional therapeutic counseling responsibilities. The Success for Transition Age Youth and

Young Adults (STAY) grant has been a prominent example of how state agency/department partnerships can address the unique needs of transition age youth (ages 18-21yrs for this grant). The STAY grant's goal was "to enhance the system of care for all Transition Age Youth within the CBHI system by increasing access to behavioral health care that is young adult driven, culturally responsible, and meets the specific needs of youth transition to adulthood and to demonstrate positive outcomes as a result of enhancements" (DMH & CBHI, 2014).

The vision of CBHI is to utilize the Young Adult Peer Mentor (YAPM) therapeutic intervention model to provide the best continuum of mental health care for transition age youth. It is the contention of CBHI that the enhanced Young Adult Peer Mentor intervention model will provide the most effective treatment strategy for this vulnerable population. The statewide implementation of the innovative YAPM model at MassHealth Provider organizations would bring that vision to fruition.

Challenges Facing Statewide Implementation of Young Adult Peer Mentor Intervention

Gap in knowledge base for implementation planning. Encouraged by the positive outcomes from the grant-supported pilot study Success for Transition Age Youth and Young Adults (STAY), MassHealth is currently planning to encourage the expanded use of the Young Adult Peer Mentor therapeutic intervention model from pilot MassHealth Provider sites to other MassHealth Providers. Administrators/supervisors, support staff, and clinical staff would be the primary agents at the MassHealth Provider organizational workplace settings who would have the responsibility of implementing this therapeutic innovation statewide. In their joint efforts to improve mental health outcomes and to facilitate the recovery of Transition Age Youth, MassHealth (Medicaid agency) and the Massachusetts Department of Mental Health (DMH) found that they lacked sufficient, relevant information on the current attitudes and perceptions of

those Providers who would be implementing the newly developed innovation in therapeutic intervention, the Young Adult Peer Mentor (YAPM) model. With the additional, relevant data from MassHealth Provider staff, MassHealth proposed that it be better able to evaluate the probability and progress of adoption of the Young Adult Peer Mentor intervention model by MassHealth Providers.

Role of organizational culture in adoption of YAPM model. For a smooth transition from limited peer support programs or none being used at a Provider site or community service agency, MassHealth had to develop and implement a program to effectively engage Provider staff in its plan for improvement in mental health care. In this way staff would invest in and share the commitment of the Provider organizational structure in adopting this innovative intervention model. That researchers have developed instruments for the evaluation of the adoption process represents the established acknowledgement of the workplace environment as a social system that is very important in the determination of acceptance or rejection of the adoption of an innovation in policy and practice (Glisson, 2002; Rogers 2006). More specifically with respect to the YAPM model, the organizational workplace setting would be a significant variable which could facilitate or hinder the adoption of this therapeutic innovation. For example, important questions in the evaluation would definitely include, "How ready is the organizational culture is to adopt this therapeutic innovation? How willing is the culture to change?"

The organizational readiness for the change of treatment focus in the numerous intervention programs conducted by MassHealth Providers had to be addressed if there was to be a successful adoption of the YAPM intervention model of peer support by Providers. Examining mental health organization staff (adopter) preferences and inclination to change could help gauge

the likelihood of innovation adoption and stability in an organization based on its social context (Glisson, 2002). Concluding, Glisson (2002) proposes that the organizational context of the mental health services affects the adoption of innovations in treatments, how they are implemented, whether they are sustained, and their effectiveness.

Statement of the Problem

The mental health, economic, education, housing, unemployment, and justice system challenges facing those youth and young adults transitioning (TAY) from child to adult social services present a pressing need that had to be addressed by the state of Massachusetts through its designated Medicare agency (MassHealth). Of particular concern was the mental health crises experienced by youth and young adults (TAY) which may often be intensified by these same challenges. MassHealth (Medicaid agency) and the Massachusetts Department of Mental Health (DMH) partnered in the response to these crises in mental health services to this vulnerable population by implementing an innovation in peer support therapy, the Young Adult Peer Mentor (YAPM) therapeutic intervention. The statewide success of their joint response to this crisis required a greater pool of detailed information than was currently available about the MassHealth Provider organizations who would be implementing the therapeutic innovation.

DELTA Project Role in MassHealth Solution to TAY Crisis

Goals and objectives. The purpose of developing the DELTA Project was to facilitate the goal of MassHealth to increase the statewide use of the Young Adult Peer Mentor (YAPM) therapeutic intervention model among MassHealth Provider organizations. The DELTA Project goals and objectives provided the information needed by MassHealth and the Department of Mental Health about the perceptions and experiences of MassHealth Provider staff regarding adoption of the Young Adult Peer Mentor (YAPM) therapeutic intervention model.

The following goals and objectives guided the strategies that were planned as DELTA Project action outcomes: (1) to examine the organizational readiness for adopting the innovative Young Adult Peer Mentor therapeutic intervention model of peer support, (2) to address gaps in the education/knowledge base for MassHealth Providers related to the YAPM model, and (3) to document MassHealth mechanisms of funding the YAPM intervention.

Theoretical framework. The Diffusion of Innovation Theory model of change was used as the theoretical foundation for the issues addressed by the DELTA Project. Its use provided explanations for how much support or hindrance existed within the workplace culture for the social system change which could, in turn, predict the success or failure of adopting the innovation in therapeutic intervention, the YAPM model. A key factor in implementing this therapeutic treatment innovation was the assessment of the workplace culture that would be responsible for adopting the new treatment. Founded on the training of youth who have recovered from past mental illness to act as mental health peer mentor coaches on the mental health services team, YAPM's is to train these peer mentors to engage in counseling responsibilities and sharing of their own lived (mental illness journey) experiences to help other youth with mental health problems.

DELTA Project summary. The proposed DELTA Project provided valuable deliverables reflecting the organizational needs communicated by MassHealth for DELTA Project action outcomes to its own intervention planning strategies: (1) Survey and interview data showing Provider staff's levels of interest in and readiness for an innovative change in client treatment strategies through implementation of the YAPM therapeutic intervention model of peer support; (2) Education materials deliverables to enhance the dissemination and application of YAPM (brochures, PowerPoint, and presentations) by MassHealth in its statewide

implementation; (3) Issue brief of funding mechanisms used by MassHealth for implementation and sustainability of the Young Adult Peer Mentor therapeutic intervention model of peer support; and (4) Executive Summary of survey and interview response outcomes. The information provided by the DELTA Project could greatly assist MassHealth in its progressive plan to enhance the effectiveness of mental health services for transition age youth. Additionally, the findings could be applied to other models of peer support in mental health and substance abuse clinical programming that are addressed by MassHealth.

Analytical Platform

Review of Related Literature

Importance of the public health crisis of Transition Age Youth (TAY).

Transition Age Youth (TAY) range from 18 to 24 years old and experience unique life challenges moving from pediatric to adult social services or complete independence. Massachusetts has approximately 800,000 Transition Age Youth; MassHealth as the state Medicaid agency is responsible for addressing health care needs of this vulnerable population during their critical transition time. There is a risk of poverty for many Transition Age Youth since this population has a fourteen percent unemployment rate, and there is the possibility of school failure with a low likelihood of higher education enrollment. Severe health conditions can develop, and mental illness is of particular concern as Transition Age Youth navigate serious issues in adolescence while forming an identity. Throughout adolescence, Transition Age Youth may engage in riskier behavior without a strong sense of self or resilience that most youth would have already developed (Delman & Klodnick, n.d.; Marchand, et al., 2016).

Mental illness can become more severe in response to many of the challenges Transition Age Youth face, and therefore a continuum of mental health care is critical for this population. MassHealth offers mental health services for Transition Age Youth and has observed a lack of engagement by Transition Age Youth during their move to adult services. There is a belief among TAY that child services are not sufficient and adult services are not appropriate for adolescent needs. The perception of incompatible care along with the stigma of mental illness places Transition Age Youth in problematic positions where TAY do not seek care during difficult life transitions, putting themselves at risk for mental health crises (Delman & Klodnick, n.d.; Marchand, et al., 2016). It is imperative that MassHealth innovate mental health care for

Transition Age Youth and models of Peer Support intervention offer promise for this critical public health problem.

Historical perspectives of peer support models in mental healthcare.

The practice of integrating peer support into mental health services has historical roots dating back to the early 1700s with Physician Philippe Pinel and contemporaries incorporating recovered mental health patients as staff in psychiatric health services (Davidson, Bellamy, Guy, & Miller, 2012; Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services, 2017). Pinel's integration of peer staff into clinical practice was inspired and facilitated by former patient Jean Baptiste Pussin, who employed peer staff in the hospital he supervised in order to deliver more humane treatment. Pussin believed ex-patients had empathy and a unique insight into patient experiences (Davidson et al., 2012; Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services, 2017). The peer support initiatives initiated by Pinel and Pussin were the beginnings of the Moral Treatment Era in modern psychiatry, where oppressive practices of beating and chaining the mentally ill were countered by supportive care respectful of a patient's dignity. In the Moral Treatment Era, people were seen as individuals suffering from a treatable disease who were worthy of compassionate care (Carron & Saad, 2012).

The nineteenth and early twentieth century asylums continued in civilized attitudes toward patient care, although there was a paternal approach that focused on submission. Patient voice became more prominent in the 1970s and 1980s with galvanized consumers creating a movement that advocated for recovery-focused care through legislation, practice innovation, and government programs. The resulting peer support movement built on patient respect and patient empowerment also capitalizes on youth and community involvement in determining effective healthcare (Davidson et al., 2012; Hendry, Hill, & Rosenthal, 2014; Mental Health Coordinating

Council, 2009; Pinches, 2009; Philadelphia Dept. of Behavioral Health and Intellectual Disabilities Services, 2017; White, 2009). The past two decades have shown growth in peer support practices, creating a peer support workforce that numbers in the thousands (Chinman, George, Dougherty, Daniels, Ghose, Swift, & Delphin-Rittmon, 2014; Davidson et al., 2012; Miyamoto & Sono, 2012; Pinches, 2009). A significant step was the recommended integration of peer support services into behavioral health by President George Bush's New Freedom Commission for Mental Health in 2003 (Office of the Assistant Secretary for Planning and Evaluation, 2017). A few years later, peer support services were approved as an evidenced-based practice for Medicaid reimbursement in 2007 (Office of the Assistant Secretary for Planning and Evaluation, 2017). These advancements of peer support as a practice offer an opportunity for additional innovation in mental health care. One particular area of interest for adolescent populations is technology use. Viable mobile interventions have been investigated for conditions such as depression, anxiety, eating disorders, substance abuse, and even some severe mental health problems (Berry, Lobban, Emsley, & Bucci, 2016). As technology use increases in modern times, it has become common for social networks to be utilized by individuals to self-select and form groups for emotional and psychological support (Naslund, Aschbrenner, Marsch, & Bartels, 2016). Although mobile technology in psychological treatment is still being developed and explored as a practice, there are opportunities for peer support to be further integrated into clinical care with technological advancements (Naslund et al., 2016). Thus, MassHealth and the Department of Mental Health's focus on adolescent mental health presents opportunities for greater technological innovation in adolescent mental health care.

The historical background of peer support integration into mental healthcare delivery is relevant to the DELTA Project because the development of peer support roles and development

of the peer support movement illustrate shifts in provider and patient attitudes toward people who have experienced mental health challenges. While harmful attitudes, perceptions, and beliefs still exist about people with mental illnesses, history shows an improvement in valuing the patient voice and acknowledging patient authority in individual health decisions. MassHealth's investment in advancing peer support work for mental health interventions demonstrates the health system's recognition of the value of patient voice as payers are willing to financially support advancing the Young Adult Peer Mentor innovation among a vulnerable population of youth. The DELTA Project will be able to support MassHealth at this juncture in developing health systems of patient centered and culturally competent community based care.

Development of peer support practice in modern mental health services.

Involving individuals in patient care who themselves have shared life experiences with the patients they serve uniquely personalizes mental health treatment, but there are broad misunderstandings of peer support that can make its expected outcomes unclear (Miyamoto & Sono, 2012). These peer support services can be integrated informally by involving informal peer community support or formal hired roles (Brown, Ehrlich-Jones, Fisher, Gabriele. Hino, Kowitt, Perez, Tang, & Thompson, 2014; Simons, Hendricks , Lipper , Bergan, & Masselli, 2016). Peer support staff can be described as "consumer-clients", "peer providers", "peer mentors", "young adult peers", "therapeutic mentors", or "peer coaches" ; these varied descriptions communicate nuanced interpretations of the peer support role. Different job definitions for peer support roles include "youth with 'lived experience' who have personally faced the challenges of coping with serious mental health conditions" (Mann & Hyde, 2013, p. 4); staff who "[offer] and receive help, based on shared understanding, respect, and mutual empowerment between people in similar situations…" (Jackson, Walker, & Siebel, 2015, p. 3);

as well as "individuals in recovery from mental health and/or substance use issues who strategically share their lived experience with clients to inspire hope, provide emotional support, and aid in developing a recovery plan" (Delman & Klodnick, n.d., p. 12). What is common across interpretations of peer support practice is the expectation of shared experiences with mutual understanding and respect that provides hope and inspiration for recovery (Delman & Klodnick, n.d.).

The DELTA Project focuses on formal peer support roles as a therapeutic mentoring practice in MassHealth. Within the Centers for Medicare and Medicaid Services, the peer specialist role takes the form of a "Therapeutic Mentor". Therapeutic mentors are staff "…with 'lived' experience of psychiatric or co-occurring mental health-addictions diagnosis, mental health disability, extreme emotional states, or trauma who are trained and certified to use their lived experiences to help others drive their life and recovery in meaningful ways." (Transcom, 2012, pp. 25). Therapeutic mentors employed by MassHealth involve intervention with "structured, one-to-one, strength-based support services between a therapeutic mentor and a youth (up to the age of 21) for the purpose of addressing communication, daily-living, and social needs", assisting clients in the following:

- Interpersonal communication, conflict resolution, problem-solving
- Relating appropriately to other children, adolescents, and adults in recreational and social activities pursuant to a behavioral-health treatment plan developed by an outpatient or in-home therapy provider in concert with the family and youth whenever possible, or pursuant to an Individual Care Plan (ICP) for youth with Intensive Care Coordination (ICC).

(Child & Family Services., n.d.).

MassHealth and the Massachusetts Department of Mental Health developed Young Adult Peer Mentoring as a subspecialty practice within therapeutic mentoring. The core elements of the Young Adult Peer Mentoring therapeutic intervention model are:

- Practicing cultural responsiveness
- Building relationships and collaboration
- Supporting young adult vision and goals
- Role modeling
- Promoting self-care
- Demonstrating safe, professional, and ethical behavior

(The Young Adult Peer Mentor Practice Profile Group, 2017, p. 14).

Young Adult Peer Mentors are trained in the core elements to share their life experience "with purpose and intent" in order to "inspire hope and motivation" with youth clients (The Young Adult Peer Mentor Practice Profile Group, 2017, p. 5).

The rationale for peer support in mental health care services.

Evidence of effectiveness of peer support intervention model. The Research and Training Center for Pathways to Positive Futures at Portland State University found various forms of peer support to improve health; the kinds of support available included "one-on-one coaching and advocacy, facilitating groups, promoting young people's active participation in treatment and in meetings with professionals, helping young people navigate services or undertake activities in the community, coordinating community events for young people, publicly sharing personal stories of hope and recovery, engaging in discussions around public policy and legislative activities, and encouraging young people to participate in systems activism" (Jackson et al., 2015, p. 7). The assortment of strategies and formats reveal the range

of options available for peer support intervention. Peer support use has been associated with improved outcomes of increased behavioral and emotional strength as well as greater satisfaction with health care services (Jackson et al., 2015, p. 8-9; MassHealth, CBHI, DMH, 2017). Youth clients are more engaged when they are satisfied and see positive outcomes; this improved engagement in services results in fewer hospital and emergency room stays, decreased occurrence of substance abuse, and increased hope and self-confidence (Mental Health America. 2016; Davidson et al., 2012). Outcomes from integrating peer support models in mental health care are promising for Transition Age Youth whose unique mental health needs dictate engaging and innovative healthcare delivery. Implementation of peer support strategies must be supported with appropriate policy.

At the national level, policy initiated by the Centers for Medicare and Medicaid Services (CMS) included the 2004 Real Choice System Change in Mental Health Transformation grant that was created "to promote recovery throughout the mental health service system with a particular focus on developing the role of Certified Peer Specialist and peer-operated services statewide" (Transcom, 2012). CMS was joined by the Substance Abuse and Mental Health Services Administration (SAMHSA) in promoting peer support services that are a "coordinated, community-based approach to care for children and adolescents with serious mental health challenges" (Joint CMCS and SAMHSA Informational Bulletin, 2013, pp. 1-2, 4). Policies that support this approach are desirable because of the observed clinical results (Joint CMCS and SAMHSA Informational Bulletin, 2013) :

1) Reduced cost of care
2) Improved school attendance
3) Improved clinical and functional outcomes

4) Decreased contacts with law enforcement

5) Increase in behavioral and emotional strength

At the state level, the current impetus for innovation by MassHealth is twofold: (1) there are requirements for financial accountability to address growing responsibilities as a public payer of health care, and (2) there are requirements for efficacy in treatment outcomes to address the vulnerable population of Transition Age Youth. MassHealth undertook an extensive reform process in July of 2016 as part of a Section 1115 Demonstration Project Amendment and Extension Request to address agency expenditures that represented almost 40% of the Massachusetts state budget (Executive Office of Health and Human Services, 2016). The restructuring of MassHealth included strategies to address care management, the opioid crisis, community partner involvement, and long term services.

Role of DELTA Project. The DELTA Project supported MassHealth and the Department of Mental Health by defining peer support treatment plans in mental health and substance abuse intervention that reflect national funding for peer support programs (MassHealth, CBHI & DMH, 2017). The four-year Success for Transition Age Youth (STAY) grant was funded by SAMHSA and provided funding for peer support pilot programs as a primary component of success with Transition Age Youth (Pratt, Nowers, & Henry, 2016a, 2016b). Young Adult Peer Mentors, as a part of peer support strategies, are a dynamic illustration of CBHI's values, which are illustrated in its commitment to provide child-centered, strength based, culturally responsive, and continually improved care.

Implementation of effective peer support models in mental health services.

Variables that may support successful YAPM implementation. In a toolkit for employing Young Adult Peer Mentors, the Transitions to Adulthood Center for Research at

University of Massachusetts Medical School highlights the need to first understand the goals for peer support particular to an organization, then review that vision as implementation proceeds (Delman & Klodnick, n.d.). The way in which peer support services are integrated into health care delivery matters. Health system factors and organizational dynamics can have a profound impact on the success of peer support practice. The Massachusetts Transformation Committee (Transcom) was a partnership of state agencies, peer-operated service providers, and payers who worked together to implement a Centers for Medicare and Medicaid Services (CMS) grant in Massachusetts that focused on peer-operated services and Certified Peer Specialist roles (Transcom, 2012). The Transcom committee reported research findings that peer support specialist role integration was facilitated when organizations were "taking steps to help peer specialists feel included within the team, [giving] support for integration from the mental health agency or program, making ongoing coaching and mentoring available, establishing opportunities for training, education and advancement, and [when peer support specialists were] regarded as an equal and a colleague by co-workers" (Transcom, 2012, pp.25-26).

Variables that may hinder successful YAPM implementation. Conversely, Transcom (2012) also found factors that hindered peer support integration, including "lack of understanding of the role of the peer workforce among peers, supervisors and colleagues; feeling in conflict with others on treatment team; job duties which do not match ethics and values of peer role; not being able to apply skills learned in training; dealing with stigma, self care/boundaries, and system issues of [solitude]; [difficult] paperwork language; [and the] recovery model not [being] embraced" (Transcom, 2012, pp. 30-32). Additional issues of confidentiality and unclear role definition also present concerns (Transcom, 2012, p.26). Confidentiality is a concern given the nature of peer relationships and the age of peer staff.

MassHealth's Young Adult Peer Mentor Practice Profile sets forth the ideal practice for confidentiality in order to train peer mentors in client relations. Peer Mentors are directed to adhere to legal and professional policy guidelines regarding health information of youth clients. Peer Mentors are expected to meet with youth clients one-on-one, unless supervisors give permission to include others and there is a reason for others to attend client meetings. Peer Mentors must also recognize that confidentiality expectations for their own lived experience disclosure are different as a staff member compared to patient confidentiality expirations. As staff, peer mentors recognize any sharing of lived experience could be shared with others (The Young Adult Peer Mentor Practice Profile Group, 2017).

Recommendations for implementation.

Peer Support program implementation, therefore, requires proactive policies to increase likelihood of success. Davidson et al. (2012) provide the following recommendations:

(1) Clear job description and role clarification;

(2) When creating or proposing peer support positions, include non-peer staff, organization leaders, and those in recovery;

(3) Identify and value contributions peer support staff make;

(4) Have senior administrator as advocate or "champion" for peer support staff;

(5) Training in specific job duties and skills for peer support staff;

(6) Supervision for specific job skills, performance, and support rather than peer support staff's clinical status; and

(7) Provide training and education for non-peer staff on issues of "…disability and discrimination legislation and its implications for hiring and the provision of reasonable accommodations, expectations of peer staff, ethics, boundaries, adopting

person-first language and a respectful attitude toward all coworkers, and ways of resolving conflicts in the workplace, including how to talk openly about issues of power and hierarchy within the organization" p. 127.

The recommendations on implementation shed light on possible solutions to challenges MassHealth has observed in implementing Young Adult Peer Mentoring among Providers. Clear job descriptions, training, and supervision of peer staff, peer staff supervisors, and co-workers of peer staff can ensure that peers are adequately supported for optimal work performance and maximum engagement of youth clients. Identifying the value of peer support staff and securing administrative 'champions' for peer support roles can provide a workplace culture where peer support staff feel capable and empowered to perform at their best and provide the best service for their youth clients.

Organizational readiness: Considerations of organizational context and change.

The role of the workplace setting. The organizational context and organizational change are worthy of exploring to further examine the theme of organizational readiness. Researchers who have evaluated peer support programs recognize that the workplace culture is one of the key factors in determining the readiness of a service agency to embrace peer support as an intervention model (Simons et al., 2016). Organizational culture can be defined as "a system of shared values, beliefs, and norms that governs how people behave in organizations" (Delman & Klopnick n.d., p. 28). The young adult peer provider can represent an innovation which challenges the mental health provider culture. As such, the innovation may require changes in the organizational culture, which may result in acceptance or resistance from that culture (Delman & Klopnick n.d.). Barber (2010) reported that within the nursing home workplace, staff who were willing to adopt a new change initiative indicated in their responses

that the key variables supporting their readiness to change were the relationship with supervisors, organizational commitment, and organizational support.

As reported by research studies, the workplace culture often becomes the key social context in defining the possibility of successful implementation and sustained operation of a peer support program. The optimal culture of a mental health services workplace that includes peer support services can be summarized by the following descriptions: collaborative in working with all levels of client staff, based on a relationship of mutuality of reciprocal giving and taking, non-hierarchical with valued input accepted by all positions on the healthcare team, and empowerment and choice-oriented beliefs in self-determination of all (California Association of Social Rehabilitation Agencies, 2014). Trusting relationships with other mental health providers in the workplace have been identified as contributing to the success of a peer support therapeutic intervention (Delman & Klodnick, n.d.). This social context becomes critical to the peer support worker facing the misconceptions and myths often held by other non-peer mental health providers. Other workers may have the misconception that those with mental illness cannot get better, that they are dangerous, or that they cannot be employed for any great length of time. This stigma often attached to mental illness can contribute greatly to the resulting behaviors of fellow mental health providers. The successful peer support intervention program is more likely to occur in the workplace setting which accepts diversity, addresses workplace stigma, and understands the experience and culture of today's young adults in its workforce (Delman & Klodnick, n.d.). The workplace culture must value the lived experience of the peer provider as members of the healthcare treatment team in the mental health setting (Simons et al., 2016). Thus, the perceptions, attitudes, social interactions of other mental health delivery team

colleagues with respect to peer providers represents a social system which does influence the effectiveness and sustainability of peer support programs.

Business as model for defining influence of organizational culture. Research from the business field on organizational structure and behavior has provided a lot of information about the characteristics, operations, and influences of organizational culture. Organizational context can include "culture, climate, structure, and work attitudes" that contribute to the service quality, treatment outcomes, and overall effectiveness of mental health services (Glisson, 2002, p. 233). Organizational culture can be understood as "the normative beliefs and shared expectations in an organizational work unit" (Cooke & Szumal, 1993). The organizational context can provide an environment where innovation is supported or hindered because adoption of new practices can be supported or hindered by contextual factors. For child mental health services, the social context can be a critical factor for peer support staff. "Interpersonal relationships, social norms, behavioral expectations, individual perceptions, attitudes, and other psychological factors" comprise the social context in the organizational setting that affects how an employee will carry out their job and interact with their surroundings (Glisson, 2002, p. 234). An effective organization will take these factors into account when planning, enforcing, or changing policies and practices, when hiring or terminating employees, when rewarding employee productivity, or when evaluating success or failure outcomes.

Innovation and the organizational culture in the mental health services. An environment where innovation succeeds predictably exists within a social context where the culture is supportive. The Diffusion of Innovation Theory by Everett Rogers (Rogers, 2003), is an adopter-based explanation of how innovation spreads or is stopped/hindered in its adoption. Examining adopter preferences and inclination to change can explain the likelihood of

innovation uptake and stability in an organization, based on its social context (Glisson, 2002). The DELTA project, therefore, sought to examine MassHealth Provider attitudes toward the Young Adult Peer Mentor therapeutic intervention model in order to understand how the implementation of the model could be improved for increased adoption by Providers. Successful implementation, as reviewed, demands that the workplace setting be supportive of innovation. The readiness to adopt innovation can become a critical factor in assessing the probability of success of the proposed innovation. Robinson (2009) notes that in applications of Rogers' theory, peer conversations and peer-to-peer interactions represent networks of communication which definitely influence the adoption of an innovation. An understanding of the current social context, the organizational culture, and individual preferences toward innovation will provide insight into an organization's readiness for innovation. Applied to the introduction of a peer support intervention model in the mental health services setting, the YAPM model can be viewed as an innovation which could cause a response filtered by the social context of the mental health provider's staff. Glisson (2002) proposes that the organizational context of the mental health services workplace environment affects the adoption of innovations in treatments, how they are implemented, whether they are sustained, and their effectiveness. How the workforce in a specific organizational setting approaches their work, interacts with others, and interprets their work setting has been found to depend upon variables such as interpersonal relationships, individual perceptions, attitudes, and social norms (Glisson, 2002). Significant to the mental health field, researchers propose that knowledge of the organizational intervention strategies used in business and industry can be used to develop organizational cultures that improve the performance and effectiveness of mental health services (Glisson, 2002).

In his research of the relationship between attitudes of mental health providers and adoption of evidence-based practices, Aarons (2004) found that organizational change occurred when new evidence-based practices in mental health services were implemented. Whether or not new treatments, interventions, or practices were adopted was influenced by the attitudes of providers towards the adoption. Aarons (2004) developed a 15-item objective measure, the Evidence-Based Practice Scale (EBPS), to empirically assess the provider-innovation adoption relationship. There is a need to better understand the attitudes of providers towards innovation in mental health systems, particularly with efforts to implement effective interventions in community-based therapeutic environments (Aarons, 2004). Rogers' (1995) Theory of Diffusion of Innovation provided an explanation for how providers' attitudes toward a new practice/innovation resulting in the organizational factor into the adoption of that innovation (Aarons, 2004). Examining the influence of the mental health services workplace further, Aarons and Sawitsky (2006) later found that the organizational culture and climate in the workplace can affect the staff acceptance of or resistance to innovation. Constructive organizational cultures can be described as having organizational norms of achievement and motivation, encouraging social interactions with others, exhibiting individualism and self-actualization, being humanistic, and offering support. Constructive cultures have more positive attitudes toward adoption of innovative mental health practices. In contrast, defensive cultures could be described as more approval and consensus seeking, more conforming, and more dependent and subservient. The research conclusions were that organizational culture includes factors such as client outcomes and staff's work attitudes, perceptions, behaviors, and service quality, which operate to influence provider attitudes towards organizational change and adoption of innovation in mental health services (Aarons & Sawitsky, 2006).

Evaluation of innovation in peer support programs for mental health service providers. In implementing peer support programs for existing mental health service providers, the organizational change that would occur with the adoption of an innovative intervention model must be addressed (Chinman, Young, Hassell, & Davidson, 2006). The recovery-oriented peer support model provides a team approach to facilitate the recovery of those with mental health problems. Assessing the ability of an organization to adopt a change often requires that there has to be a quality improvement approach. Evaluating the readiness to change should reveal the potential barriers to implementing new procedures, structures, and processes within the organizational context. Several staff characteristics offer a key index of the organization's readiness to change: (1) provider's belief that new innovation represents an improvement strategy that will make the care of patients easier; (2) collaborative relationship between provider and organization's leadership; (3) provider encourages evidence-based and leading clinical practices; and (4) provider willing to be leader in implementing innovation and in promoting innovation to other providers in the organization (U.S. Dept. Health and Human Services, n.d.).

Guidelines for a mental health service environment that will be supportive of the Young Adult Peer Mentor model must take into account the organizational readiness of the workplace to support this innovation in therapeutic interventions. Identifying those factors which facilitate or hinder the success of the innovation emphasizes the importance of recognizing the powerful influence of the social context of the workplace setting. It is equally important to know the attitudes of the Provider's staff toward this innovation in order to estimate whether or not the innovation will be successfully adopted in a specific organizational culture (Aarons, 2004; Delman & Klodnick, n.d.; Glisson, 2002). The National Association of State Mental Health

Program Directors propose that for successful integration of the peer workforce in mental health workplace settings, the first step is an assessment of the whether the workplace would be accepting of peers as members of the health care services staff (Jorgenson & Schmook, 2014). There should be training of non-peer staff to ensure that negative attitudes, stigma about mental illness, and discrimination do not exist. A safe place for workers with a history of mental health problems would then be created (Jorgenson & Schmook, 2014). The workplace culture must be an environment of respect, encouragement, and integrity.

Theory of Change

Overview.

The Diffusion of Innovation Theory characterizes how change occurs in a population or organization (Rogers, 1995, 2003). It was a useful model for the DELTA Project because it can be broadly applied to understanding variables that influence the process of change within a group or organization, including the characteristics of those making the decision of whether to adopt an innovation. The application of the Diffusion of Innovation Theory in other discussions of the process of adoption of healthcare innovations also supported its selection as an appropriate and meaningful theoretical framework for the DELTA Project (Barber, 2010; CASRA, 2014; Fleuren, Wiefferink, & Paulussen, 2004; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004; Lien & Jiang, 2017; Wong, Soon, Zed, & Norman, 2014). Research had indicated that one of the most critical variables which influences adoption of an innovation in practice or policy for an organization is the level of organizational readiness for change within that workplace culture. From the Diffusion of Innovation Theory, key components of the change process can be delineated which are relevant to the DELTA Project: the innovation, adopters of the innovation,

communication that influences change, the time to change, and the social systems where change occurs (Rogers, 1995, 2003).

Components of the change process.

***Innovation*.** The nature of the innovation affects the likelihood that it will or will not be adopted by the organization or group. Robinson (2009) proposed five considerations for adoption of innovations: (1) relative advantage measuring improvement of practice – perception that the innovation is better than what it replaces, (2) comparison that the innovation is compatible with existing values, past experiences, and needs of possible adopters – perception that the innovation matches what the adopter "is", (3) simplicity and ease of use – perception that the innovation is not difficult to understand or apply, (4) ability to experiment – perception that the innovation is triable and, thus, less risky, and (5) observable results – seeing the innovation "in action" (Robinson, 2009).

Adopters. The target population making the decision of whether or not to adopt the innovation can be grouped by five different preferences and attitudes toward change itself that influence the likelihood of effectively adopting an innovation. Common groupings of adopters are as follows: (1) Innovators - create change as time and energy invested in new innovative experiences; (2) Early Adopters - need little persuasion for an innovation that gives them a social/economic edge as "trend setters" who are quick to adopt innovation once benefits are known, they follow innovators with positive results; (3) Early Majority - pragmatists needing firm proof of benefits, avoiding risks, and looking for simple, better ways to do what they already do; (4) Late Majority - respond to effectiveness of innovation, but are not risk takers and are uncomfortable with new ideas; they are influenced by fears, opinions, and criticisms of laggards; and (5) Laggards - adverse to risks and respond to tradition, fear, and social pressure

(Robinson, 2009). Rogers proposes that each category is represented differently in the population of possible adopters: (1) Innovators, 2.5%; (2) Early Adopters, 13.5%; (3) Early Majority, 34%;(4) Late Majority, 34%; and (5) Laggards, 16%. The designation of categories of adopter types can assist in focusing intervention efforts and strategies, given the influence of the adopter's perspectives and attitudes on whether an innovation is accepted easily or with difficulty (Robinson, 2009).

Communication, time, and social systems. Communication has varied importance across the designated adopter categories of the Diffusion of Innovation Theory (Robinson, 2009). Innovators and Early Adopters respond to creativity around the innovative idea. These responses make marketing and mass media efforts ideal for communication with these two types of adopters. In contrast, peer networks have been found to have greater influence for Early and Late Majority adopter groups (Robinson, 2009). The Early Majority and Late Majority groups are more sensitive to evidence of success and prefer trusted sources, making peer networks with face to face interactions more important as variables influencing the adoption process (Robinson, 2009). In applications of Rogers' theory, Robinson (2009) proposes that peer conversations and peer-to-peer interactions represent networks of communication which definitely influence the adoption of an innovation. Time (or more specifically constraints in time) may influence the spread of the adoption of the innovation. Social systems provide the context for change. System structure, system resources, and system culture are a few of the many considerations that influence population behavior and should be considered in evaluating organizational responses to innovation (Robinson, 2009). The organizational culture or workplace setting is a social system which defines change as social interactions impact perceptions, interpretations, and behavioral outcomes. Peer to peer

conversations and peer networks form a critical foundation for social processes underlying the decision to adopt the innovation. It is those individuals who are trusted and have themselves adopted the innovation who can more forcefully attest to the benefits of the innovation, "people whose lived example is the best teacher of how to adopt an innovation" (Robinson, 2009, p. 3).

Variables impacting applications of the theory of change to the DELTA Project.

Applying the Diffusion of Innovation Theory - The Innovation. As components of the DELTA Project, the surveys and interviews of staff at MassHealth Provider sites allowed for determination of the organization staff's interest in and level of knowledge about the YAPM therapeutic intervention model. The surveys and interviews allowed respondents to indicate experiences with or knowledge of peer support interventions, especially the YAPM program. They could also report their own willingness to work with peer mentors as fellow members of the mental health services team.

Applying the Diffusion of Innovation Theory - The Adopters. Initially, it was anticipated that a diverse pool of MassHealth Provider organization staff would be involved in the DELTA Project. This adopter pool was projected to have included clinical, support, education, or training directors; supervisors who would hire and manage peer mentors participating in the YAPM model implementation; and administrative staff who would work with and/or support the YAPM model peer mentors at the Provider site. However, the surveys administered to MassHealth Provider organizations did not provide a clear profile of the positions, duties, and responsibilities of the respondents.

Applying the Diffusion of Innovation Theory - Communication, time, and social systems. Communication, time, and social systems are components of the organizational culture of a mental health services site. Survey and interview questions with a communication

focus examined what factors influence staff knowledge and attitudes about peer mentoring and peer support at Provider services sites. The time component was explored by examining the commitment of time and ability to change within organizational cultures and, specifically, within MassHealth practices and policies. Social systems proved to be an encompassing issue, overlapping into questions which focused on the MassHealth guidelines and policies for hiring/employment, training, valuing peer members of mental health services team, handling discriminatory practices, and developing and defining operating practices for departments and divisions where peer support staff would be participating in the YAPM program. The evaluation of the impact of social systems also included examination of the supervisory and administrative boundaries formed in dealing with the peer mentor who is part of the mental health services delivery team, as well as being an employee who may require at some time those same services. Compelling questions were prepared to obtain critical information from Provider organization staff in order to define other relevant variables: (1) depth of knowledge about the model, (2) level of experience with implementing or being a part of a peer support intervention model, (3) probability of the greater effectiveness of the YAPM model when compared to other treatment models, (4) role of peer support workforce in the community-based treatment recovery system when compared to the medical model treatment system, and (5) concerns held by community service staff and leadership staff.

Process of change and its impact.

One expectation of an anticipated outcome is that the most favorable environment for change to occur is through a collaborative process. For change to have the best probability of implementation, it is important to gain "buy in" and ownership in the beginning from those individuals who will ultimately use the findings and deliverables of the DELTA Project. I

focused on these “end users”, as identified by my DELTA Project advisor, because prior research suggests they are crucial to the adoption of innovations.

My DELTA Project had accepted the role of contributing to the information base for current and future programming of an innovative therapeutic intervention to be developed and implemented jointly by MassHealth and the Massachusetts Department of Mental Health. At this critical moment in planning for MassHealth, the DELTA Project was to become a valuable instrument in the development and evaluation process of the anticipated statewide transition of treatment programs, particularly for the TAY population. Now and in the future, findings from the DELTA Project could alter current training and policy efforts by MassHealth and the Department of Mental Health with regard to the peer support workforce. In closing, the expectation was that the outcomes from DELTA Project would assist in developing ways to sustain innovative change at the staff level in Provider organizations, thereby supporting for MassHealth in its efforts to expand the peer support intervention model in child behavioral health provider settings.

Methods

DELTA Project Plan Development

Overview.

The DELTA Project goals and objectives were developed to address the primary challenges and supporting mechanisms to the statewide implementation of the Young Adult Peer Mentor (YAPM) intervention model by MassHealth. The following goals guided the strategies that were planned as DELTA Project action outcomes: (1) to examine the organizational readiness for adopting the innovative Young Adult Peer Mentor therapeutic intervention model of peer support, (2) to address gaps in the education/knowledge base for MassHealth Providers related to the YAPM model, and (3) to document the MassHealth mechanisms for funding the YAPM intervention model, expanding the agency institutional knowledge base in this intervention programming and sharing the experiences with other Medicaid payers. The process of planning the DELTA Project followed a progression which began with the academic instruction focus of the DELTA Project supporting a more empirical approach in the initial planning. Later, applying leadership concepts and willingness to balance the organizational needs of the host organization (MassHealth) with the DELTA Project academic requirements led to positive relationship-building discussions with the host organization. The negotiated compromise led to modifications of initial action outcome strategies to address the DELTA Project goals and objectives. All parties were confident that the action strategies ultimately executed were the right strategies to implement in addressing DELTA Project goals and objectives for this particular host organization.

Initial strategic plans for implementing the DELTA Project.

Addressing organizational readiness for implementing YAPM intervention.

Strategies to address the first goal focused on a series of self-assessment developmental tools to be created and administered to staff at MassHealth Provider sites. These developmental tools would have included multiple surveys developed by researchers conducting research in the impact of organizational readiness, mental health support staff perceptions of peer support mental health services team members, training and competence of peer support mental health services team members, and the anticipated degree of support in the respective workplace culture for the peer support mental health services team members. The actual readiness development tools (surveys/checklists) were not to be confidential and were to be shared among Providers. The Provider would have had the option of administering the organizational readiness development tools or modified versions to administrators, hiring managers, or clinical staff at MassHealth Provider sites before implementing a clearly defined peer support program (Appendix B).

Organizational readiness instruments which had not been created in the planning of the DELTA Project were to be subject to the legal/usage policies accompanying the use of that specific readiness instrument with permission from the author(s) before administering them to MassHealth Providers.

Addressing gaps in the education/knowledge base of MassHealth Providers.

The second goal was addressed by creating multimedia materials for MassHealth Provider education/training programming in various forms (PowerPoint, brochures, workshops, etc.). MassHealth communicated a desire to promote the YAPM peer support model among Providers and a wide range of stakeholders in various positions associated with the organization.

Workforce training, recruitment/hiring, presentation of Provider programs, and clinical implications offered an array of applications for using these educational materials for a wide range of staff, from administrators and clinicians to mental health services teams.

Addressing MassHealth funding mechanisms for YAPM intervention.

Meeting the third goal focused on preparing an issue brief presenting the summary of funding mechanisms used by MassHealth to start-up and sustain the YAPM therapeutic intervention model. The diverse funding efforts of MassHealth and the Massachusetts Department of Mental Health (DMH) to address the state response to mental health challenges among its young adult population promoted a peer support therapeutic intervention model. With the issue brief, these diverse efforts could then be reviewed and critically evaluated by other states with similar Medicaid guidelines and similar mental health and substance abuse problems among its youth and young adults.

DELTA Project Plan Modifications

Organizational interest and readiness for implementing YAPM intervention: Modifications.

After presentation to the host organization of the initial action outcomes planned in the DELTA Project, MassHealth decided that the DELTA Project must first narrow its focus to examine more specifically the organizational interests of Provider staff who would be directly implementing the innovative Young Adult Peer Mentor intervention model at their respective Provider sites. This decision by the host organization was project development in real time as MassHealth re-evaluated its most urgent needs and communicated the required modification and corresponding changes in the DELTA Project planned action strategies. In response to what appeared to be a decision based on the urgent need for immediate, practical answers to questions

posed to Provider sites, MassHealth had made a pragmatic shift in the DELTA Project planned action strategies. Those strategies had been planned to meet the comprehensive, academic, empirically-guided focus of the DELTA Project doctoral curriculum experience. MassHealth acknowledged that the assembly of organizational readiness development tools in the initial DELTA Project planning had been a great idea for a self-assessment by MassHealth Providers. However, for the development tools to be more informative for MassHealth Providers, MassHealth concluded that there would need to be extensive research, piloting, and testing investigative efforts that the DELTA Project was not equipped at this time to address. MassHealth communicated its intent to keep all data collection "in house", with no parties outside its organization being responsible for the collection and retention of the modified action outcomes strategies proposed for the DELTA Project. The Harvard University Office of Human Research Administration authorized an IRB "Notification of Determination – Not Research" designation, indicating that the DELTA Project did not require additional review after its evaluation of those activities described in the IRB submission as MassHealth's in- house responsibilities within DELTA Project action outcomes strategies (Appendix A).

Thus, after consultation with MassHealth CBHI directors and program managers, it was decided to move away from an academic-focused approach of examining implementation of evidence-based practices in mental health services. The revised priority of the DELTA Project focus would be to ask questions that were more specific about the perceptions or experiences of the MassHealth Provider site staff in working with other employees (YAPM colleagues on mental health services team) who would have disclosed their mental health status. The action outcome strategies in response to this goal were modified to the administration of two selective

surveys: (1) organizational interest and organizational readiness for adopting the YAPM peer support model and (2) a series of semi-structured stakeholder interviews.

The Peer Interest Survey 2017. The survey provided information from responses of staff concerning the size and client base of the MassHealth Provider organization, organizational history in therapeutic mentoring intervention, staff willingness to participate in YAPM meetings and training, and staff beliefs that the YAPM intervention model would be helpful for their clients, was worth the investment for expanding the pool of intervention strategies offered to clients, and could integrate smoothly into their intervention practices (Appendix C). The organizational interest survey for peer support also provided an opportunity to understand which Provider organizations would most likely be willing to engage in additional planning in support of the statewide implementation of the Young Adult Peer Mentor therapeutic intervention model.

Readiness Follow-up Survey 2017. At the time of the DELTA Project initiation, there was no standard way to examine the workplace culture of MassHealth Provider organizations in order to compare MassHealth Provider resources and to evaluate and estimate their organizational capacity to create the optimal environment for the successful implementation of the Young Adult Peer Mentor intervention model. The Project goal of examining organizational readiness for an innovative peer support treatment strategy was achieved by creating a second assessment instrument for MassHealth, the Readiness Follow-up Survey (Appendix D).

***Semi-structured Stakeholder Interviews*.** The stakeholder interviews were developed to obtain information about peer support therapeutic interventions from diverse sectors of mental health clinical services. Those sectors included research, academia, advocates

in the field, the peer mentor supervisors, and center directors in the field. Interviews provided an expanded pool of respondents for reporting of relevant, and perhaps contrasting, mental health treatment experiences in addition to information gathered in the surveys.

Gaps in the education/knowledge base of MassHealth Providers: Modifications.

The educational materials created for the DELTA Project deliverables provided a broad umbrella of Project outcomes designed to meet the specific needs of MassHealth. The educational materials focused on a range of staff respondents, not just clinicians. The expanded range of staff targeted by the educational materials reflected the acknowledgement and realization that understanding the challenges of implementing a new therapeutic intervention directly impacted Provider planning. Diversified educational programming and training were needed at multiple levels at MassHealth Provider sites where peers participating in the YAPM application would be working.

It had been assumed that there would be a need for advocacy in promoting the YAPM intervention model among MassHealth Providers when the Project was started, as well as when program sustainability was addressed. The pilot project which became the facilitating point for Young Adult Peer Mentor model implementation within the STAY grant program had provided a platform for promoting the YAPM intervention model in Massachusetts. However, MassHealth continued to believe that there were still gaps in the knowledge base and resulting understanding of the innovative clinical practice. The educational materials served as a starting point and foundation for MassHealth's efforts to explore communication strategies for the successful implementation of the YAPM intervention model following completion of the DELTA Project.

MassHealth funding mechanisms for the YAPM intervention: Modifications.

By creating a document to present the organizational funding strategies used in the YAPM implementation, the CBHI leadership housed within MassHealth proposed to connect/network with other state agencies endeavoring to implement similar youth-voiced peer support intervention programs in their respective states. Unfortunately, there was no access to restricted, confidential financial data that was needed to present the true depth of funding strategies that had initially been the goal of the Issue Brief. The presentation of the funding mechanisms for the Issue Brief evolved to that of sharing the organizational strategy for developing mutually beneficial, trusting partnerships and promoting innovative critical thinking in healthcare delivery.

Executive Summary of DELTA Project findings.

The Executive Summary of DELTA Project findings and interpretations was proposed as an additional outcome deliverable during the course of the DELTA Project. The Executive Summary submitted to MassHealth served as an opportunity to review the DELTA Project planning and execution of planned action strategies, to succinctly summarize Project data findings, and to provide recommendations for MassHealth based on the implications of DELTA Project findings. The Executive Summary was prepared to present compiled reports of response data from staff, and the interpretations and recommendations of findings from the Peer Interest Survey, the Readiness Follow-up Survey, and the interviews with stakeholders. This reflective, critical analysis of the DELTA Project planning and outcomes can be used by MassHealth to guide the next stages of implementing the Young Adult Peer Mentor intervention model for MassHealth Providers across the state of Massachusetts.

Summary of leadership and organizational decision-making implications of DELTA Project planning and execution.

The dynamic process of change within an organizational structure is both challenging and eye-opening. After critiquing leadership challenges to the development and execution of the original DELTA Project action strategies, the Project developed into the eventual compromise between the urgent immediate needs of the host organization and the fulfillment of higher education academic requirements, which led to the modifications of planned action strategies. Previously validated instruments may have been helpful for direct comparisons between scientific findings from studies in which the same validated instruments had been administered. The tailored interest survey was helpful in understanding attitudes and perceptions of a targeted group of MassHealth Providers staff who would be directly involved in the decision to adopt and implement the YAPM intervention model. The DELTA Project outcomes illustrate the shift from the focus on an exhaustive assessment of organizational readiness for treatment change to the foci on interest in implementing an innovation in therapeutic intervention, and on organizational readiness for a change in clinical treatment. The shift in focus from one to two areas of interest was motivated by valid concerns on the part of MassHealth. It can be argued that the modification in assessment focus reflects the complexities of implementing system-wide change in health care and implementing evidence-based practices in mental health care for youth.

DELTA Project Plan and Execution

Peer Interest Survey 2017.

MassHealth managed care companies administered the online survey via the SurveyMonkey website to the MassHealth Provider organization staff. Pilot surveys had indicated that subjects took approximately less than 10 minutes to complete, with answers being

collected online. While most of the 17 questions were presented in a multiple-choice format, some were open ended. The Peer Interest Survey included background questions about the following topics: (1) knowledge of peer mentoring, (2) experience in therapeutic mentoring, (3) organization size, (4) number of clients served, and (5) organizational needs. The remaining questions of the Peer Interest Survey focused on the Young Adult Peer Mentoring therapeutic intervention model. Included in this group of questions were those concerning the following issues: (1) the knowledge of Young Adult Peer Mentoring job description, (2) experience with staff working as peers, (3) supervisory experience of staff working as peers, (4) workplace climate, (5) training needs to utilize lived experiences, (6) concerns about working with peers, and (7) interest in developing Young Adult Peer Mentor intervention model in the state. The survey closed with an optional request for the respondent to submit their name and the statement that their name would be shared with the MassHealth staff for policy development as quality assessment.

Readiness Follow-up Survey 2017.

The Readiness Follow-up Survey for the Young Adult Peer Mentor (YAPM) intervention model focused on organizational readiness as a way to observe the degree to which staff at selected MassHealth Provider sites reported a likelihood to adopt the innovation in therapeutic practice (YAPM model). MassHealth managed care companies administered the online survey to MassHealth Provider staff via the SurveyMonkey website. Pilot studies had indicated that subjects took an average of fifteen minutes to complete the 24 questions. A multiple-choice format was chosen for some questions, and other questions were open-ended.

The readiness survey included background questions which focused on the following issues: (1) the organization's knowledge of peer mentoring, (2) the organization's experience in

therapeutic mentoring, (3) the size of the organization, and (4) the youth clients served. The readiness questions examined the staff's understanding of the purpose and duties of the Young Adult Peer Mentor (YAPM) role, the supervision practices, the staff beliefs and perception of peer employees, the process of training, willingness to participate in intervention, reaction to the stigma of mental illness, responsiveness to boundaries and accommodations for peer mentors, and agency policies and practices that affect the work to be undertaken by peers who would be a part of the Young Adult Peer Mentor intervention staff.

Semi-structured Stakeholder Interviews.

The interviews consisted of approximately thirty minutes of semi-structured questions about those variables which could be facilitators or barriers to the successful implementation of Young Adult Peer Mentor treatment strategies at the MassHealth Provider sites. Interview subjects were selected by referrals from the Children's Behavioral Health Initiative (CHBI) staff and Department of Mental Health staff. Questions were selected from a pool of questions representing possible factors which could support or delay the development and implementation of the innovative Young Adult Peer Mentor intervention model. Face-to-face and phone interviews were used to gather information. No audio recordings were made. Subjects were asked a series of questions while interview notes were recorded by hand and by computer.

Results Statement

Overview

Among the state's responses to the overwhelming housing, mental health treatment, unemployment, poverty, and education challenges facing its youth (TAY) who are transitioning from child social services to adult social services was the combined effort by MassHealth (Medicaid) and the Massachusetts Department of Mental Health to implement a statewide innovation in peer support mental health treatment for this vulnerable population: the Young Adult Peer Mentor (YAPM) therapeutic intervention model. MassHealth had communicated the need to determine the depth and diversity of the peer support experiences and knowledge of the YAPM model for staff at MassHealth Provider organizations. The DELTA Project was developed to target specific issues raised as part of the solution to the TAY crisis which MassHealth was facing in the state. To meet this gap in information, The Peer Interest Survey 2017 and Readiness Follow-up Survey were administered to MassHealth Provider site staff. Additionally, stakeholder interviews provided valuable information about the staff perceptions and attitudes toward the YAPM intervention model. Findings of those assessments allowed for identification of relevant factors which could impact the effective implementation of the YAPM model.

The Peer Interest Survey 2017

The Peer Interest Survey was administered electronically by MassHealth managed care companies to a total number of 98 unique Provider organizations, with 55 staff participants responding from Provider organizations (Table 1). Most staff at MassHealth Provider organizations who participated in the Peer Interest Survey had a minimum of at least five years of experience providing therapeutic mentoring mental health services. Over half of the Provider

organizations employed supervisory staff with experiences supervising some mental health services staff who utilized lived experiences in their therapeutic duties. Being informed of how staff experiences related to the degree of interest in implementing the YAPM intervention was informative and insightful. Among respondents, many of the staff at Provider organizations reported a staff size of ten or less, while serving a client population of approximately ten to three hundred youth. Many staff reported that there was an unmet need of the population they served that could be met by a specialized expertise within therapeutic mentoring. In addition, many respondents stated that they were willing to be a part of efforts to improve mental health outcomes by participating in the statewide implementation of the Young Adult Peer Mentor therapeutic intervention model.

However, respondents also stated that there was a need for more detailed education about the YAPM intervention model and how it would be implemented by staff at MassHealth Provider sites. Respondents reported that they would be more comfortable describing the job duties of the peer support staff member whose role would be to provide specialized expertise within therapeutic mentoring if additional training was available. Many of the staff from MassHealth Provider organizations who were surveyed indicated that there was a need for formalized training to prepare staff to effectively use their lived experiences in a therapeutic setting. Staff at Provider organizations reported that the type of support needed to effectively employ staff who would be using their own lived experiences in mental health treatment included the following: (1) educating senior level administrators on the positive client outcomes resulting from the therapeutic intervention input from employees with lived experiences, (2) training focused on awareness of staff boundaries and information disclosure, (3) providing supervision support for the formal YAPM model developed by MassHealth, and (4) discussing

employee expectations. The greatest concerns that staff at these Provider organizations expressed about the challenge of employing peers with lived experiences of mental illness centered on boundaries, stigma, and support. Boundaries between the functions and responsibilities of administrators/supervisors could be blurred if the peer support staff member were concurrently dealing with mental illness recovery challenges. Again, the stigma of mental illness must be faced by administrators/supervisors, non-peer support staff, and peer support staff. Support from administrators/supervisors and non-peer support staff is imperative if the peer support staff member (such as YAPM staff) is to be successful in their duties. Despite concerns, feedback from staff at MassHealth Provider sites participating in the surveys was overwhelmingly positive regarding the possible employment of young adult peer support mentors in their respective organizations. Over ninety percent of staff (from observations) stated that their workplace climate was one that would be supportive of young adults who have recovered from prior mental illness and are professionally trained to deliver mental health services to support other youth and young adults.

Table 1.

Results for MassHealth Provider Organizations - Peer Interest Survey

Question Topic	% (N=55 Respondents)	Outcome
Background of Organization & Survey Respondent		
Organization Size (Q2)	61%	Staff of 10 or less
Participant role in organization (Q5)	56%	Primary decision-maker for whether to implement YAPM
Organization climate (Q9)	92%	Organization would be supportive of peer staff

(continued)

Table 1. (continued)

Results for MassHealth Provider Organizations - Peer Interest Survey

Question Topic	Question Topic	Question Topic
Organization climate (Q9)	92%	Organization would be supportive of peer staff
Knowledge & Experience		
Therapeutic Mentoring* Experience (Q1)	81%	Five years or more experience
Knowledge of YAPM job role (Q6)	84%	Comfortable explaining YAPM role with more training
Experience working with any type of peer staff (Q7)	55%	Experience working with peers as part of treatment team
Supervision of Peers (Q8)	55%	Experience supervising peers as part of treatment team
Support needed to train staff using lived experiences (Q10)	64%	Needed support in training to use lived experiences
Interest in Young Adult Peer Mentoring Practice & Implementation		
Observe an unmet need for peer mentoring (Q4)	54%	See an unmet need
Interest in ongoing YAPM development statewide (Q13)	77%	Willing to engage in future collaboration to support YAPM implementation

Note: Therapeutic Mentoring refers to "structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs" (MassHealth, 2012)

The Readiness Follow-up Survey

The Readiness Follow-up Survey was developed to assess the degree of Provider staff readiness to implement the YAPM intervention model by examining the likelihood of support for

this therapeutic innovation by the workplace organizational culture. The Readiness Follow-up Survey was administered electronically by MassHealth managed care companies to a total of 98 unique MassHealth Provider organizations, with 22 staff responding (Table 2). More than eighty percent of the Provider site staff reported having at least five years of experience in therapeutic mentoring as a treatment option. Approximately half of the Provider organizations had relatively small staffs of ten or fewer employees and a broad range in the number of youth and young adult clients. Among those staff completing the survey, some were decision-makers who could authorize implementation of the Young Adult Peer Mentor intervention model at their respective Provider sites.

Table 2.

Results for MassHealth Provider Organizations – Readiness Follow-up Survey

Question Topic	% (N=22 Respondents)	Outcome
Background of Organization & Survey Respondent		
Therapeutic Mentoring Experience (Q1)	81%	Five years or more experience
Organization Size (Q2)	54%	Staff of 10 or less
Participant role in organization (Q4)	54%	Primary decision-maker for whether to implement YAPM
Organizational Culture		
Staff perception of YAPM (Q9)	75%	Strongly Agree or Agree that YAPM can be valuable team members
YAPM leadership (Q20)	11%	Believe YAPM are in leadership positions

(continued)

Table 2. (continued)

Results for MassHealth Provider Organizations – Readiness Follow-up Survey

Question Topic	% (N=22 Respondents)	Outcome
YAPM support (Q23)	77%	Culture promotes YAPM seeking support
Management / Supervisory Practices		
YAPM supervision (Q6)	94%	YAPM receive appropriate supervision
Stigma & discrimination (Q12)	85%	Agency addresses stigma & discrimination against mental illness
Staff Accommodations (Q18)	83%	Staff & Supervisors address accommodation needs together
Leadership support for YAPM role (Q19)	66%	Organization leadership communicates YAPM importance
Staff Practice		
Staff attitude toward young adult clients (Q7)	100%	Staff respect preferences of young adult clients
Staff support for YAPM (Q10)	95%	Staff support YAPM in roles
Staff communication (Q16)	100%	Staff use person-centered language in written and verbal communication
Staff Provider relationships with young adult clients (Q21)	100%	Staff motivate young adults toward independence
Education & Training		
Staff Knowledge of YAPM role (Q5)	42%	Staff understand YAPM purpose and duties

(continued)

Table 2. (continued)

Results for MassHealth Provider Organizations – Readiness Follow-up Survey

Question Topic	% (N=22 Respondents)	Outcome
Staff Knowledge of young adult experience (Q8)	100%	Staff understand young adult developmental experiences and needs
Agency practices & diversity (Q11)	95%	Agency policies and trainings that respect diversity
Agency promotes peer support services (Q13)	75%	Information provided on peer support and resources to youth clients
Staff Orientation and training address YAPM needs (Q14)	52%	Staff Orientation and training addresses YAPM job duties
Staff beliefs around capacity of young adult with mental illness for work (Q15)	95%	Staff believe young adults with mental illness can work with support
Staff knowledge of accommodation request process (Q17)	72%	Staff can request reasonable accommodations
Agency addressed YAPM concern for boundaries and conflict of interests (Q22)	61%	The agency can address YAPM concerns for relational boundaries and conflict of interests

Note: Therapeutic Mentoring refers to "structured, one-to-one, strength-based support services between a therapeutic mentor and a youth for the purpose of addressing daily living, social, and communication needs" (MassHealth, 2012)

Many of those who responded reported that their staff did not fully understand the purpose or duties of employees who would be participating in the Young Adult Peer Mentor intervention program as peer support staff. However, it is important to note that all staff reported that they respected and responded to the goals and treatment preferences of young adult clients. The staff also indicated that they understood the unique developmental experiences and needs of

young adults in today's society, especially those of the TAY population in the state of Massachusetts. More than two thirds of Provider site organization staff reported that their staff believed that young adult peer mentors could be valuable members of the mental health treatment team. Furthermore, positive indications that this innovation in therapeutic practice could successfully be adopted as a treatment strategy was the finding that almost all respondents reported that staff would support young adult peer mentors in carrying out their peer support job duties and responsibilities.

Additionally, Provider site organization staff were asked about agency/organization practices that contribute positively to staff readiness for implementing the Young Adult Peer Mentor intervention model. Most staff at MassHealth Provider sites reported that their agency implements policies and trainings that respect the diversity of different cultures, (e.g., racial/ethnic, age, gender). Workplace stigma and discrimination (i.e. mental illness) were addressed specifically through policy, practices, education programming, and training by a high percentage of the organizations participating in the survey. Most of the agencies provided information about peer support groups and resources available to the youth and young adults receiving mental health services. Approximately one-half of the organizations surveyed reported that orientation and training of all staff address the specific responsibilities of young adult peer mentors. In addition, most staff reported that non-peer staff do understand that young adults with mental illnesses can do required duties as members of the mental health services treatment team if the young adults have the necessary support. Staff added that they assume that most peer support staff know how to request reasonable accommodations, and that non-peer staff are willing to work together with peer support staff to find the best accommodations.

Questions were also asked about supervision and leadership. Supervisors were reported to have given individualized and regularly scheduled supervision of young adult peer mentors in most of the Provider site organizations participating in the survey. More than two thirds of the staff reported that their agency represented a culture that encouraged young adult peer mentors to reach out to supervisors for support and guidance in the work. However, only eleven percent reported that young adult peer mentors held leadership positions at the agency or program.

Stakeholder Interviews

Stakeholder semi-structured interviews were conducted to gain insight into the YAPM implementation process from researchers, mental health advocates, policymakers, and clinical staff in the field. Table 3 shows the pool of questions from which questions were selected and used for interviews. The interviews were approximately 30 minutes in length. Open-ended questions were included in the pool of questions to allow for greater flexibility in responses from the interviewees.

Table 3.

Pool of Questions for Key Stakeholders in DELTA Project Interviews

Stage of YAPM Intervention Model	Questions
Development & Initiation	1. How did the partnership develop between you, MassHealth and the Department of Mental Health? 2. What would you have done differently if you started another intervention model like the Young Adult Peer Mentor model?

(continued)

Table 3. (continued)

Pool of Questions for Key Stakeholders in DELTA Project Interviews

Stage of YAPM Intervention Model	Questions
Implementation	1. What are your goals and priorities in implementing the Young Adult Peer Mentor intervention model? 2. What is working well in implementing the pilot? 3. What is not working well in implementing the pilot? 4. What are your greatest challenges in implementation? 5. What are the concerns of people doing the work? 6. During the Young Adult Peer Mentor workgroup, the theme of tensions between practice development vs. practice implementation have come up. This is a learning opportunity for me as someone new to implementing a new therapeutic intervention process. Can you share your thoughts on this tension between development and implementation of the Young Adult Peer Mentor intervention model?
Sustainability	1. What is the greatest challenge to achieving sustainability? 2. What do you hope to see in the future?

Note: YAPM = Young Adult Peer Mentor

Some stakeholders stated that they had some experience with YAPM and others were currently associated with potential MassHealth Provider implementation sites. Takeaways from those notes summarize the comments made by stakeholders and reflections of the interviewer on those comments. The notes were reviewed for themes, and the themes were critically evaluated for comparisons of major key common or discordant findings across interview subjects. Themes were clearly evident when reviewing the discussion with stakeholders and are summarized in Table 4. Of the five major themes identified, the major themes related to the implementation process were issues of advocacy, education, and mental health stigma. The major themes related to the sustainability of the YAPM model were issues of the peer model versus medical model and model fidelity.

Interview Theme 1: Advocacy.

Takeaway 1: Internal Advocacy. There is a need for a champion to advocate for the YAPM intervention. This advocacy needs to occur within the organization internally. Advocacy throughout the agency can show the value of the youth voice. Public advocacy shows an investment in youth input. With the grant participant who was interviewed, public advocacy within the organization was not just important, it was *critical* to the current success they enjoyed.

Takeaway 2: External Advocacy. External advocacy was reported as also being important to a successful YAPM intervention implementation. It is unclear why external outreach is important, but this interview highlighted its importance. Community outreach in the surrounding city neighborhoods was said to be helpful. The interviewee reported that promotion of the YAPM and the YAPM practice would let people see that the agency supported the YAPM initiative. I think this community outreach validated the practice and validated the YAPM staff.

Takeaway 3: Advocacy training. Most agencies need advocacy for the YAPM role. Advocacy training for supervisors was suggested by one of the interviewees. The need for training for advocacy was a unique idea. The respondent felt that it was assumed that supervisors would be able to recognize when there was a need for advocacy and would have the skills to advocate for the YAPM role and for the YAPM employee. What can make it difficult is that the need for advocacy can arise between the supervisor and someone at a higher position (organizational structure importance). The differential in power positions can be navigated, but it requires skills that an employee either has a natural aptitude for or needs to be explicitly taught. Respondents felt that it should not be assumed that supervisors already had these skills. If there are trainings being designed for the supervising of YAPM, then advocacy skills can be added to the skills training program. There is an excellent opportunity for advocacy through sharing successful stories of the YAPM peer support intervention model.

Takeaway 4: Relationship building fostered by advocacy. Relationships built from advocacy are important in supporting the goals of YAPM. A strong supervisor and staff relationship will provide the best work environment for the successful YAPM implementation. This premise is related to the broader concept of the critical role of the workplace culture in the organizational social system created in the facility where staff deliver mental health services. Work with Human Resources can play a large role in facilitating a culture that accepts and values YAPM participation in the delivery of mental health services. There is a need for all people to understand the role of the YAPM intervention model. Understanding the role of the YAPM peer support staff in the agencies can help other staff to understand the challenges of the peer support role. The best way to implement the YAPM model statewide in the future is to look at what is

working, identify what is not working, and try to implement what the position should look like when addressing the entire system.

Interview Theme 2: Education.

Takeaway 1: Role of education. Education is the key. Staff needed to be educated on what the YAPM model involved and how it was a complement to, rather than in competition with, the practices/treatment options they were currently using. It was important to understand the training that YAPM staff encounter to know that the YAPM model defines a different kind of professional with a different kind of training, but it is still a valid therapeutic intervention treatment strategy. Education is important in communicating the validity of the practice and the value of the peer mentor support staff. Education is also important in dealing with the myths and misconceptions regarding a new innovation in therapeutic practice. Education can anticipate and address conflict and misunderstandings. Education should be laid as a foundation and sincere effort put forth for people to learn about and understand an innovation and how it affects their work and their organization. Practitioners want it to be a separate practice, and they discussed the difficulty of billing for YAPM services.

Takeaway 2: Education and value of peer mentor. Education of the peer mentor arose as an important explanatory and action-oriented variable throughout the interviews. One primary concern for the Provider site was the importance that Human Resources (HR) understand the need for lived experience in the therapeutic setting. It is one thing to say that the role of the peer mentor is important. It is another thing to show that the role is needed and that it is a necessary enhancement of mental health services. There does not appear to be a clear argument for the benefits of the YAPM model that was communicated during interviews, other than it is felt that the YAPM employees can relate well to youth clients. These proposed benefits

of the peer support staff in YAPM are very important, but are not well communicated. Clearer communication is a critical variable to YAPM success in order to appropriately promote the ways in which this peer support intervention is a necessary part of the delivery of mental health services. What should also be better communicated is how the YAPM employees add value to clinical components of this delivery of mental health services at Provider sites.

Takeaway 3: Stigma of disability. Another aspect of education is for the administration to understand what disability looks like for people. There does appear to be a stigma affecting the supervisors' and clinicians' understanding that someone with a disability can be a fully functioning employee and can properly execute their job function. Interviewees had concerns that employees in Human Resources and the Provider site administration were hesitant to hire or consider roles of YAPM employees due to the disability that the YAPM employees have. This is a form of stigma regarding mental health and regarding disability. The education of administration can be an important part of addressing stigma of mental illness so that they understand what disability looks like for people and that disability does not have to be an inhibiting factor in carrying out job duties.

Takeaway 4: Importance of training in education programming. A final part of education for supervisors and administration is for them to understand all facets of the specialized training that YAPM employees undergo for the role they are to play as members of the mental health services delivery team. The overall benefits for the peer support role are important to understand, as is the capability of the YAPM employees to carry out the role. But the understanding of the rationale, utility, and implications of YAPM employee training can help bridge the gap between the YAPM role and the YAPM employee capability to fulfill the role, given the YAPM staff disclosure of mental health status and disability. YAPM training addresses

issues of boundaries, professionalism, accommodation, and treatment competencies. Education about the training process for YAPM employees can answer reservations and concerns expressed by supervisors, administrators, and non-peer support staff about the duties, dependability, and competency of the YAPM staff member. There needs to be an investment in the YAPM model. Training is a *core component* of the education programming. There should be training for the supervisors and training for the supervised staff. The investment in training and the investment in employees is thought to pay off in improved health outcomes for clients, as well as improved financial outcomes for the payer (MassHealth).

Interview Theme 3: Mental Health Stigma.

Takeaway 1 : Education, advocacy, and training related to stigma. Education and advocacy can overcome the barriers to acceptance of peer support staff by administrators, supervisors, and non-peer support staff by providing evidence of the direct benefits of employing, training, and supervising YAPM peer support staff. Non-peer support staff can learn from the experience of people who are already working in the field with peer support staff. The motivation for employing YAPM staff is that the YAPM employees can truly engage with youth on their level. YAPM have the ability to validate the experiences of youth and young adults who are undergoing treatment. The youth and young adult clients can know that they are not alone and that hope can be inspired in the youth clients and their parents. The lived experiences and successful examples can be powerful motivations for recovery for those seeking care. Successful YAPM peer support staff will be professionals with a good work ethic and should perform job duties to support youth and young adult clients. The age of the work force can be a challenge, but that is where training can address any lack of work experience and competence.

Takeaway 2: Training for success. YAPM employees can be trained on how to be successful with clients, co-creating individualized goals for clients with the clients and their caregivers. The treatment can be tailored to meet client needs. The peer mentors can also be trained on how to strategically share their lived experiences. With training and further experiences, YAPM staff can learn to make mature decisions about what to share, when to share, and how to behave in difficult client situations.

Interview Theme 4: Medical Model vs. Peer Model.

Takeaway 1: Lived experiences vs. Living experiences and training for boundaries. One interviewee said that "there is no fine line between living experiences and lived experiences." There are needs centered around personal life and mental health needs. Supervisors have constraints on their time, even with regular meetings and individual supervision. There are no definite boundary lines when it comes to personal life or personal struggle for the YAPM staff. So, the YAPM staff member may have to deal with their current "living experience" of mental health recovery at the same time that they are delivering mental health services to clients. While the supervisors are not therapists for the YAPM staff, they can connect YAPM staff with employee assistance programs and provide accommodations according to the YAPM staff member's needs. There is just as much of a need for supervisors to exercise professionalism in their role and adherence to boundaries while providing supervision with accommodation, as opposed to clinical support, as there is a need for YAPM staff to provide professional support to clients without crossing boundaries to a casual friendship. Training is needed for recognizing and maintaining some boundaries on both ends (supervisors and peer support staff). Supervisors can give staff time to deal with whatever personal issues arise that require attention. However, there is a learning curve for the supervisors to discern what

constitutes sufficient support and the nature of the needed support for YAPM staff members. There are adequate concerns for the YAPM supervisors that need to be addressed in initial YAPM staff training and ongoing supervisor training because there are still life issues that a YAPM staff member must address. One task of the agency/organization is to understand what additional support looks like for a YAPM employee, so that there are guidelines for the policies that are developed. There should be acknowledged boundaries for the YAPM employee and their clients, as well as boundaries for the YAPM employee and their supervisor. This is a critical part of readiness for the agency/organization, and it must be in place for the success of the YAPM employee in serving clients and integrating positively within the mental health treatment team. The possibility of requiring additional support and accommodation is a situation of need that may change for each individual YAPM employee. Changing individual needs can also result in adjustment for the agency/organization. However, some informal or formal policy should be in place. Supervisors should understand that policies may need to be adjusted for particular situations with specific YAPM employees.

Takeaway 2: Strain on supervisors. A lot of agencies do not have systems or policies in place for additional support which may be required for supervising and supporting young adults as peer support staff when their additional needs "come out." There are a number of systematic issues that affect the job responsibilities of the YAPM staff member. There appears to be a perception that supervisors bear the brunt of the additional work beyond the normal work burden of a supervisor. It is important to know if there is a perceived burden and no direct perceived benefits. There was feedback from interviewees stating that higher administration and co-workers needed more education about the YAPM role, and that YAPM staff would benefit from having advocates in the agency. A champion is ideal. If that champion for the YAPM role

does not exist, then the burden of advocacy falls on the supervisor alone. If they are the only champion, the supervisors must then manage multiple relationships on multiple fronts and be the additional support for their employees. These are not impossible expectations, but these expectations should be clear and addressed upfront. There should be as much training as possible for the roles that the supervisors must assume. While there appears to be unanimous support for adopting the YAPM model, there is still a lot of uncertainty about the investment demands and the anticipated benefits which are tangible and worthwhile in exchange for the burden of undertaking the innovative therapeutic intervention model.

Interview Theme 5: Model Fidelity.

Takeaway 1: Evaluation. Fidelity, as it relates to implementation, can be generally thought of as "an intervention being delivered as intended by the program developers and in line with the program model" (Breitenstein, et al., 2010). The fidelity of a model is thought to be an important part of translating evidence into actual practice. Lack of fidelity can explain why some models are not successful when implemented outside of controlled settings (Breitenstein, et al., 2010). Evaluating the fidelity of an intervention provides information and helps to explain interpretations of intervention outcomes that occur and the factors that influence those outcomes.

Takeaway 2: Exploring. Fidelity can then be explored through examination of contributing and defining variables, such as the adherence to the model, exposure to challenges, quality of delivery, participant responsiveness, and program differentiation for a model being implemented (JBA, 2009).

Table 4.

Themes from Stakeholder Interviews

Theme	Subtheme
YAPM model Implementation	
Advocacy	➢ Advocacy for YAPM in community
	➢ Advocacy training for supervisors
	➢ Advocacy for YAPM with coworkers & administrators
Education	➢ Education for YAPM in community
	➢ Education & training for supervisors
	➢ Education for YAPM with coworkers & administrators
Mental Health	➢ Stigma among healthcare professionals
Stigma	➢ Stigma among administrators
	➢ Role of Advocacy and Education in addressing stigma
YAPM model Sustainability	
Medical model vs.	➢ Nontraditional employee (not academically trained)
peer model	➢ Biggest asset is lived experiences that engage youth, but also provide opportunity for stigma
	➢ Education and advocacy key to bridging the gap
Model fidelity	➢ Theory to policy and issues in model fidelity
	➢ Policy to pilot and issues in model fidelity
	➢ Pilot to practice and issues in model fidelity

Note: YAPM = Young Adult Peer Mentor

Results Summary

Most of the respondents indicated that they have had five years or more of experience with some aspects of the therapeutic mentoring intervention model. Therefore, this implies some prior knowledge of organizational competency level in the intervention category defined by the therapeutic mentoring treatment option. The survey results showed that there was a definite interest in implementing the Young Adult Peer Mentor intervention model among organizational staff who responded. This interest is coupled with a belief that the YAPM intervention model could add value to responding staff at Provider site organizations and that the workplace culture would be amenable to peer staff with lived experiences. Both surveys revealed that the staff at the responding Provider site organizations were aware of the roles and duties of the YAPM intervention to some extent. Some respondents reported that their organizations were currently training staff on the job role of YAPM and that supervisors would support young adult peer support staff. However, the stigma about mental illness still persists as employers are concerned about boundaries and professionalism issues centering around the age of peer mentor employees and their disclosed mental health status. The support for the YAPM model implementation was encouraging. Survey participants reported that staff were aware of the accommodations, support, and guidance that supervisors were willing to make in order to promote the positive value of YAPM peer support staff being a part of the mental health services team. Discussion of the sequence of DELTA Project planning and results is presented in Appendix E.

Recommendations

The recommendations reflect the critical elements which were the focus of the staff surveys and interviews at MassHealth Provider site organizations: education, advocacy, and training. Specifically, these recommended actions include a consideration of the following:

- Recommendation #1: Focus on education programming; this will be the key to implementation of the innovative therapeutic practice as MassHealth Provider organizations consider adding young adult peers to the mental health services staff.
    - This education programming is important not just for the Young Adult Peer Mentor model employee who is performing the job, but also for the supervisor who is managing the employee and the co-workers in the organization who will interact with those youth and young adults who will be part of the YAPM program.
    - Education can help deal with stigma against mental illness that can exist in organizations. Education programs can also train staff on the best practices to facilitate positive working relationships with peer mentors.
- Recommendation #2: Maintain an attitude of advocacy for the YAPM role, promoting its value and effectiveness.
    - Advocacy is needed within the organization's administration to show the added value of the Young Adult Peer Mentor intervention model within clinical organizations
    - Advocacy skills may have to be part of training for all mental health services staff and administrators.
    - Advocacy should be extended to engagement of the neighboring areas in the community surrounding the Provider site.
- Recommendation #3: Training should be a focus for all staff that work with the YAPM model, not just supervisors of YAPM.
    - The Young Adult Peer Mentor intervention treatment strategy can be a valuable part of the clinical team's repertoire of tools for recovery for their clients. These positive recovery outcomes can occur only if the organizational workplace culture values the

lived experience of the peer mentors and understands their critical role in the recovery of clients. This commitment is translated into training aspects for all organization staff to create an affirming and supporting culture.

Special training for peer support staff in decisions about sharing lived experiences must be part of implementation of YAPM intervention model.

Conclusion

DELTA Project Overview

For the state of Massachusetts, over 500,000 youth and young adults between 18 and 24 years of age are transitioning from child to adult social and health services. These Transition Age Youth (TAY) often face challenges in diverse social systems, including poverty, education accessibility and retention, juvenile justice engagement, unemployment, and mental health services. Mental health issues are of particular concern because disruption in their mental health care can exacerbate these and other challenges for Transition Age Youth (TAY). However, in their joint effort to address this urgent problem and to improve the mental health outcomes of this vulnerable population, MassHealth (state Medicaid agency) and the Massachusetts Department of Mental Health (DMH) found that they lacked sufficient, relevant information on the current interests and organizational readiness of staff at MassHealth Provider organizational sites who would be directly implementing a newly-developed innovation in peer support treatment: the Young Adult Peer Mentor (YAPM) therapeutic intervention model. The DELTA Project provided the information needed by MassHealth by identifying the barriers and facilitators to the successful statewide implementation of the YAPM model through administering interest and organizational readiness surveys to MassHealth Provider site staff, conducting stakeholder interviews regarding peer support, preparing educational materials to promote benefits of the Young Adult Peer Mentor model, writing an Issue Brief to discuss program funding mechanisms, and preparing the Executive Summary to present the DELTA Project outcomes and recommendations to MassHealth for review and application.

DELTA Project Key Findings and Analytical Takeaways

The key findings of the DELTA Project emphasize organizational readiness to change and probability of adopting innovative policies/practices dependent upon the organizational workplace culture. The DELTA Project data revealed these key themes as critical during the Project implementation with MassHealth:

1. Education programming was critical to provide comprehensive description of the new intervention, with the investment in workforce development being imperative as well. The findings that training programs were a major contribution to the successful integration of peer mentors into the organization for peer support staff and for their supervisors in the implementation of the YAPM model;
2. Both internal (supervisors and colleagues) and external (community engagement) advocacy were essential components to success, providing support for new practices/intervention in facilitating the adoption of the YAPM intervention model in mental health services organizations;
3. Addressing the stigma surrounding mental health among mental health professionals was a necessary acknowledgement by mental health treatment sites. This recognition is particularly required because in the YAPM intervention model, peer participants would have disclosed, through the employment process, their mental health status and possibly received negative responses to their health status from administrators/supervisors, and/or fellow members of the mental health services team;
4. Fidelity of the model practice was believed to be essential to sustainability of the YAPM intervention in Provider organizations.

DELTA Project Lessons Learned and Future Directions

Lessons Learned - Student.

As a former employee for state and federal government organizations, I was interested in learning about MassHealth's approach to collaboration, and I had certain expectations for the DELTA Project. "Culture eats strategy for breakfast" is a quote by Peter Drucker that was often used by a president of Ford Motor Company, Mark Fields (Durbin, 2006). This idea speaks to the power of organizational culture and how it can enable or undermine organizational goals. What I found to be true at MassHealth and the Department of Mental Health was that the organizational culture did strongly influence how staff approached project management and the broader issues of TAY. The broader implications for public health and the personal lesson for me were the insights gained on how strategy needs to be informed by the culture of an organization. This was evident for MassHealth Provider organization sites that were to implement the Young Adult Peer Mentor therapeutic model intervention as well as for MassHealth, which was leading the implementation process.

The DELTA Project provided an opportunity to consider a traditional, academic approach to scientific investigation and to understand the restrictions of working in the field with limited resources, time, and access to information. The applied Office of the Assistant Secretary for Planning and Evaluation of the DELTA Project provided an opportunity to collect data that was relevant to the host organization and to collect data in a way that was flexible enough to meet the organization's needs. There are questions of how to make the best use of available resources and how to reach conclusions in a balanced way without having all of the desired and, in some cases, required information. With ongoing evaluation, organizations can make better-informed decisions and, hopefully, produce better outcomes.

For MassHealth's initiative, there appeared to be a lack of robust information showing long-term improved health outcomes and financial savings. This lack of information may pose the question, "How do you address mental health issues in a vulnerable population without full information on the effectiveness of the existing mental health services program or financial return on investment?" This lack of data makes the task of advocacy in promoting the Young Adult Peer Mentor therapeutic intervention model an extremely challenging one.

The DELTA Project provided valuable learning opportunities for the student host organization, adding to the pool of knowledge for the field of public health. My leadership journey was permanently impacted by completing the DrPH program and navigating the DELTA Project experience. I believe that I can be a more strategic and practical leader to enable lasting public health change drawing from my experiences in the DELTA Project.

Lessons Learned - Host Organization.

The Peer Interest Survey captured information that can be utilized to understand the type of organizations that are aware of the Young Adult Peer Mentor intervention and the type of organizations that would be engaged in the implementation process. Using the data provided by the Readiness Follow-up Survey, MassHealth can develop a strategy for targeting growth in Provider utilization of the Young Adult Peer Mentor intervention model. MassHealth also had the opportunity to learn about multiple perspectives of model progress from the Provider surveys and stakeholder interviews. Diverse viewpoints allowed for reflections on current strategies and evaluation of future goals for the host organization.

Lessons Learned - Public Health Knowledge.

There are opportunities for the DELTA Project to provide information that contributes to the pool of knowledge in the field of public health, focusing on the diversity of mental health

interventions. The DELTA Project's focus on the attitudes and experiences of Provider staff related to the challenges of employing new clinical practices is helpful for critically thinking about how change occurs and how healthcare organizations facilitate or delay such change. The DELTA Project focus on interest in the YAPM intervention model and the organizational readiness to adopt the intervention innovation present an approach to critically analyzing health care innovation and systems change.

The Diffusion of Innovation Theory identified components of change that occur or that can occur in any organizational setting. The DrPH DELTA Project showed that interest in change and motivation to change are just as important as the capacity to change. Motivation to change was explored in the Peer Interest Survey and could be examined further to discover factors related to Provider interest and motivation to implement new clinical practices. Elements such as the financial costs, human resource needs, and perceived benefits of new clinical practices could provide entry points to influence change by increasing or decreasing the motivation to change. During stakeholder interviews for the DELTA Project, the support of organization leaders was cited more than once as a vital part of creating a successful implementation of a new practice with peer support through the YAPM model. It could be said that invested, supportive leadership may be the best enabler of change. Efforts to cultivate that leadership will have positive outcomes in personal and professional undertakings.

DELTA Project Impact

Student learning impact from DELTA Project.

There were several areas of impact that facilitated professional growth during the DELTA Project period. I came to the DELTA Project experience at MassHealth as the host organization out of a desire to expand my public health experience in state government. My

employment as an Epidemiologist at the Mississippi State Department of Health (MSDH) focused on maternal and child health, with research centering on women's health, birth outcomes, and infant mortality. The duties and responsibilities at MSDH involved mostly public health research surveillance reporting for a population-based national survey administered by the Centers for Disease Control and Prevention (CDC). I also managed federal and private grants for research and programming in maternal and child health. With these job responsibilities, I engaged in a considerable amount of networking with colleagues across departments within my organization. I also worked with stakeholders in other state agencies. There were numerous opportunities to partner with researchers, advocacy groups, and policymakers to create state survey questions that addressed the state's specific needs in parts of the CDC survey. The federal grant reporting pulled child health data from several state agencies. Thus, forming and maintaining relationships were the keys to obtaining and maintaining external data source access. I was hoping to utilize and build networking and bridge-building skills with the DELTA Project that supported career and work-related professional relationships among Massachusetts state agencies. The DELTA Project afforded life and career lessons that have impacted my learning, including working in an advisory role for a large organization, adjusting to changes in organizational focus, and navigating public partnerships with similar goals, but different priorities. The DELTA Project experience enhanced leadership skills which I learned in the classroom and expanded on content knowledge from traditional learning. I was able to refine leadership, communication, and management skills by observing and collaborating with leaders at MassHealth and its collaborative agencies.

DELTA Project related learnings for translating knowledge to practice and policy.

The DELTA Project development was founded on the premise that the Young Adult Peer Mentor therapeutic intervention model was an innovative, useful clinical treatment option that would improve mental health outcomes for the targeted TAY population. MassHealth needed assistance in the statewide implementation process to successfully integrate the treatment into existing child behavioral health treatment options among MassHealth Providers. The DELTA Project sought to identify the impact of Provider attitudes and behaviors in creating a workplace culture that was either supportive or detrimental to a successful implementation of the YAPM model. Provider surveys and stakeholder interviews gave the additional required information for MassHealth to create a more effective plan for YAPM implementation. The DELTA Project findings translated that knowledge by producing deliverables that utilized the information to more effectively address YAPM implementation and sustainability. The Issue Brief and educational materials included input from the interpretation of Project surveys, interviews, and communications with MassHealth, the Department of Mental Health, and their affiliated committees. I anticipate that the policies and practices of CBHI will be modified and developed by incorporating much of the information presented in the Project findings and deliverables. The experiential learning with MassHealth and the Department of Mental Health provided the opportunity to improve my skills in problem-solving and communication, in translating knowledge into action through independent work, in collaborative work, and in resolving critical thinking challenges.

DELTA Project Implications for Public Health

The DELTA Project offers to the field of Public Health information that adds to the knowledge of the variables affecting the adoption of innovations in mental health settings.

Findings from the DELTA Project will also offer contributions to programs that need to define the most effective models for expanding treatment options for mental health delivery to patient populations. The Project's investigative strategies gave particular attention to the Young Adult Peer Mentor model, which is part of a broader classification of the non-traditional, peer support workforce comprised of employees without exhaustive clinical training or academic degrees relevant to their peer support role as members of the mental health services delivery team. MassHealth has found the YAPM model peer support staff to be helpful in advancing positive behavioral outcomes for the young adult population receiving mental health services. The focus of the DELTA Project on these unique, nontraditional staff roles can contribute to the increased use of a peer support intervention model by mental health service organizations. Employing more peer support staff could also address the more significant issues of workforce shortages in mental health services.

Concluding, lessons learned in conducting the DELTA Project can be applied to other settings for health interventions, particularly in response to the opioid crisis facing the state and the nation.

DELTA Project Impact on Host Organization

The DELTA Project supported MassHealth efforts in their initiative for expanding the Provider use of therapeutic intervention programs focusing on young adult peer mentors. The MassHealth current funding and programming plans focus primarily on the innovation in a peer support treatment options in which young adult peer mentors participate as members of the mental health services team, the Young Adult Peer Mentor (YAPM) therapeutic intervention model. The DELTA Project assisted in those efforts to implement what is perceived to be an effective treatment practice for MassHealth Providers. Project deliverables included

organizational interest and organizational readiness surveys, educational support materials, an Issue Brief on the funding mechanisms for initiating and sustaining the YAPM model, and the Executive Summary of the DELTA Project outcomes and recommendations that will continue to enhance the MassHealth commitment to recovery-focused, community-based mental health services after the DELTA Project has ended. The findings from the DELTA Project can be applied on a larger scale by similar social services organization to address other societal problems experienced by vulnerable parts of our population, such as opioid/drug abuse, and can be applied to other therapeutic innovations in clinical practice.

Reflections and the Future

The DELTA Project afforded life and career lessons from working in an advisory role for organizations, adjusting to organizational priorities, and navigating public partnerships. The work that I do and the people I serve inspire me. I will continually develop skills from the DrPH experience to enable change and advance health for all.

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Appendix A

Harvard T.H. Chan School of Public Health, Office of Human Research Administration

Determination of Project - Not Research as per Federal Guidelines

HARVARD
Human Research Protection Program

Harvard T.H. Chan School of Public Health
Office of Human Research Administration
90 Smith Street, 3rd Floor
Boston, MA 02120
Federalwide Assurance FWA00002642

Notification of Determination - Not Research

November 2, 2017

Mary Wesley
mmw086@mail.harvard.edu

Protocol Title: MassHealth Expansion of Enhanced Peer Support
Principal Investigator: Mary Wesley
Protocol #: IRB17-1722
Funding Source: None
IRB Review Date: 11/2/2017
IRB Review Action: Not Research [45 CFR 46.102(d)]

The Institutional Review Board (IRB) of the Harvard T.H. Chan School of Public Health determined that this submission is not research as defined by DHHS regulations.

The IRB made the following determinations:

- Research Information Security Level: The research is classified, using Harvard's Data Security Policy, as Level 0 Data.

Additional review is not required. This determination applies only to the activities described in the IRB submission. Any changes that may alter this determination must be submitted via a modification (use the Modify Study button in the ESTR system) for review.

Please contact me at (617) 432-3071 or gbullock@hsph.harvard.edu with any questions.

Sincerely,

Grace Bullock
IRB Review Specialist

Appendix B

Initial Peer Support Survey

Peer Support Interest Survey

Instructions and Consent Form

The Child Behavioral Health Initiative at MassHealth is interested in finding out your organization's interest in implementing peer support services in your intervention strategies for youth and young adults, specifically in the Young Adult Peer Mentor (YAPM) model:

> Young Adult Peer Mentor (YAPM) - young adult provider who brings to the mental health services care team a story of the lived experiences of having met mental health problems and a recovery journey that is motivational and authentic. This specialty expertise is within the Therapeutic Mentoring services provided by the Children's Behavioral Health Initiative (MassHealth, CBHI & DMH, 2017). Peer Support staff can provide inspiration, acceptance, mutual shared experiences, empowerment, advocacy, and a model of successful recovery (Delman, & Klodnick, n.d., p. 80).

Participation in this brief, 10- minute questionnaire will involve questions about your opinions and feelings about using the Young Adult Peer Mentor model in your practice. Your participation is completely voluntary and you will not be penalized in any way if you decide not to take part in the study. You may stop the survey at any time. Your responses are completely confidential and Dr. Jack Simons (MassHealth), Jennifer Hallissey (MassHealth), and Mary Wesley (Harvard University Doctoral Student) will be the only ones who will have access to your individual answers. All participant responses will be analyzed in aggregate and the results presented to MassHealth to help them explore expansion of the Young Adult Peer Mentor model for providers of mental health services to youth and young adults. Please darken the appropriate consent to participate in the study : ○ Yes ○ No

If you have any questions about this research, please contact me at mary.wesley@mail.harvard.edu.

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Peer Support Interest Survey

Demographic Information (*Darken the appropriate circle)*

Gender : ○ Male ○ Female

Position : ○ Administrator ○ Physician/ Clinical Therapist
○ Counselor ○ Staff (not mental health provider)

Education: ○ Doctorate ○ Master's ○ B.A. / B.S.
○ Some college work ○ High School ○ Other

Work Experience (time employed in present position) : ○ 0 - 1 yr. ○ 1 – 3 yrs.
○ 3 – 5 yrs. ○ 5- 10 yrs. ○ over 10 yrs.

Work Setting (*Darken the appropriate circle)*

1. How would you classify your workplace? : ○ Clinic ○ Hospital
○ Non-profit facility ○ Private practice office ○ None of the above

2. Are you the primary decision maker for the review and implementation of new clinical interventions in your work unit?
○ Yes ○ No ○ Decline to Answer

3. Would you or someone on your staff be able to participate in a monthly meeting or conference call to facilitate implementation of the Young Adult Peer Mentor (YAPM) intervention model in your organization?
○ Yes ○ No ○ Decline to Answer

4. With further training, would you feel comfortable describing the Young Adult Peer Mentor (YAPM) intervention model to a colleague?
○ Yes ○ No ○ Decline to Answer

5. In your opinion, from your observation, is your workplace climate one that would be supportive of young adults who have recovered from prior mental illness and are professionally trained to deliver mental health services support to younger youth?
○ Yes ○ No ○ Decline to Answer

Instructions: The following questions ask about your feelings about peer support in your workplace. Please rate each statement on scale of 1 to 5, with 1 being "Strongly Disagree", 2 being "Disagree", 3 being "Not Sure/Neutral", 4 being "Agree", 5 being "Strongly Agree".
Questions are modified from Aaron's Evidenced Based Practice Attitude Scale (Aarons, 2004).

6. In my opinion, from my observation, if people in my workplace were trained in a therapy or intervention that was new, they would be likely to respond **if the new practice was intuitively appealing**?
   - ○ Strongly Disagree
   - ○ Disagree
   - ○ Not Sure/ Neutral
   - ○ Agree
   - ○ Strongly Agree

7. In my opinion, from my observation, if people in my workplace were trained in a therapy or intervention that was new, they would be likely to respond **if the new practice "made sense" to people**?
   - ○ Strongly Disagree
   - ○ Disagree
   - ○ Not Sure/ Neutral
   - ○ Agree
   - ○ Strongly Agree

8. In my opinion, from my observation, if people in my workplace were trained in a therapy or intervention that was new, they would be likely to respond **if the new practice was required for people (by supervisor, agency, state**)?
   - ○ Strongly Disagree
   - ○ Disagree
   - ○ Not Sure/ Neutral
   - ○ Agree
   - ○ Strongly Agree

9. In my opinion, from my observation, if people in my workplace were trained in a therapy or intervention that was new, they would be likely to respond **if the new practice was being used by colleagues who were happy with it**?
   - ○ Strongly Disagree
   - ○ Disagree
   - ○ Not Sure/ Neutral
   - ○ Agree
   - ○ Strongly Agree

10. In my opinion, from my observation, if people in my workplace were trained in a therapy or intervention that was new, they would be likely to respond **if they felt they had enough training to use it correctly**?
    - ○ Strongly Disagree
    - ○ Disagree
    - ○ Not Sure/ Neutral
    - ○ Agree
    - ○ Strongly Agree

Reference: Aarons, G. A. (2004). Mental Health Provider Attitudes Toward Adoption of Evidence-Based Practice: The Evidence-Based Practice Attitude Scale (EBPAS). Mental Health Services Research, 6(2), 61-74

Appendix C

Peer Interest Survey 2017

This survey is being conducted by the MassHealth Children's Behavioral Health Initiative (CBHI). "Young Adult Peer Mentors" (YAPM) and peer support staff referred to in the survey are part of peer mentoring that is a specialty expertise within Therapeutic Mentoring. It involves young adults who utilize their lived experience of mental health recovery within Therapeutic Mentoring services for optimal client care (MassHealth, CBHI & DMH, 2017).

If there are any questions, please contact CBHI Program Manager Jennifer Hallisey (jennifer.hallisey@state.ma.us) or CBHI Director Dr. Jack Simons (jack.simons@state.ma.us).

If possible, please print this page to keep for your records.

Click "NEXT" to confirm your consent to participate and enter the survey.

Background

1. How long has your organization been providing therapeutic mentoring?

○ 1-2 yrs

○ 3-4 yrs

○ 5 yrs +

○ None of the above

2. How many staff provide services?

- ○ 0-10
- ○ 11-20
- ○ 21-30
- ○ 31-40
- ○ 41-50
- ○ 51-60
- ○ 61-70
- ○ 71-80
- ○ 81-90
- ○ 91-100

3. Approximately how many youth or young adults receive Therapeutic Mentoring from your agency per month?

4. At your organization, do you see an unmet need which could be addressed by developing peer mentoring as a specialty expertise within Therapeutic Mentoring?

- ○ Yes
- ○ No

5. Are you the primary decision-maker for whether to implement YAPM within your program?

- ○ Yes

○ No

6. With further training, would you feel comfortable describing to a colleague the job description for a Young Adult Peer Mentor (YAPM) as a specialty expertise within Therapeutic Mentoring?

○ Yes

○ No

○ Not Sure

7. Do you have experience with peers working at your agency as members of the treatment team?

○ Yes

○ No

8. Do any supervisory staff have experiences supervising people who utilize their lived experience in their work?

○ Yes

○ No

9. In your opinion, from your observation, is your workplace climate one that would be supportive of young adults who have recovered from prior mental illness and are professionally trained to deliver mental health services support to younger youth?

○ Yes

○ No

○ Decline to Answer

10. Do you need formalized training to allow you to train staff in using lived experiences?

○ Yes

○ No

11. What support is needed?

12. What is your biggest concern including peers in your staff ? (e.g. boundaries, professionals, stigma, support, etc.)

13. Would you or someone on your staff be able to participate in a regularly scheduled meeting or conference call to facilitate implementation of Young Adult Peer Mentors in your organization?

○ Yes

○ No

○ Decline to Answer

14. If there is a regularly scheduled meeting, what frequency would be best?

○ Weekly

○ Monthly

○ Bimonthly

○ Quarterly

15. If there is a regularly scheduled meeting, what type would be best?

○ Web

○ Phone

○ In-person

○ Computer/video

16. If there is a regularly scheduled meeting, what geographical coverage would be best?

○ Statewide

○ Regional

17. Your name will be shared with MassHealth staff for policy development as quality assessment.

Name (optional) _____

Agency name (optional) _____

Appendix D

Readiness Follow-up Survey - Peer Support – 2017

Information

This survey is being conducted by the MassHealth Children's Behavioral Health Initiative (CBHI).

"Young Adult Peer Mentors" (YAPM) and peer support staff referred to in the survey are part of peer mentoring that is a specialty expertise within Therapeutic Mentoring. It involves young adults who utilize their lived experience of mental health recovery within Therapeutic Mentoring services for optimal client care (MassHealth, CBHI & DMH, 2017). If you are asked about current practices that are not yet in place, please answer according to what you think would happen based on your organizational practices.

If there are any questions, please contact CBHI Program Manager Jennifer Hallisey (jennifer.hallisey@state.ma.us) or CBHI Director Dr. Jack Simons (jack.simons@state.ma.us).

If possible, please print this page to keep for your records.

Click "NEXT" to confirm your consent to participate and enter the survey.

Background

1. How long has your organization been providing therapeutic mentoring?

- ○ 1-2 yrs
- ○ 3-4 yrs
- ○ 5 yrs +
- ○ None of the above

2. How many staff provide services?

- ○ 0-10
- ○ 11-20
- ○ 21-30
- ○ 31-40
- ○ 41-50

3. Approximately how many youth or young adults receive Therapeutic Mentoring from your agency per month?

4. Are you the primary decision-maker for whether to implement YAPM within your program?

- ○ Yes
- ○ No

Readiness for Peer Support Strategy

5. Staff understand the purpose and duties of the Young Adult Peer Mentor (YAPM) role.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

6. Young Adult Peer Mentors in the agency receive individualized and regular supervision.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

7. Staff respect and work with the goals and treatment preferences of young adult clients.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

8. Staff understand the unique developmental experiences and needs of young adults in today's society.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

9. Staff believe that Young Adult Peer Mentors can be valuable members of the treatment team.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

10. Staff will support Young Adult Peer Mentors to conduct their job duties.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

11. The agency implements policies and trainings that respect the diversity of different cultures, (e.g., racial/ethnic, age, gender).

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

12. The agency takes specific steps to address workplace stigma and discrimination [i.e., mental illness].

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

13. The agency provides information about peer support groups and resources to the youth and young adults receiving services.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly

○ Agree

14. Orientation and training of all staff addresses the specific responsibilities of Young Adult Peer Mentors.

○ Strongly Disagree

○ Disagree

○ Not sure / Undecided

○ Agree Strongly

○ Agree

15. Staff understand that young adults with mental illnesses can do required work if the young adults have the necessary support.

○ Strongly Disagree

○ Disagree

○ Not sure / Undecided

○ Agree Strongly

○ Agree

16. Staff use person-centered language in all written and verbal communication.

○ Strongly Disagree

○ Disagree

○ Not sure / Undecided

- ○ Agree Strongly
- ○ Agree

17. Staff know how to request reasonable accommodations.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

18. When a staff member requests a reasonable accommodation, the supervisor and staff member work together to find the best accommodation.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

19. Organizational/program leaders communicate the importance of the Young Adult Peer Mentor role to staff and program participants.

- ○ Strongly Disagree
- ○ Disagree

- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

20. Young Adult Peer Mentors are in leadership positions at the agency or program.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

21. Staff working with young adults motivate them to take greater control over their health and life.

- ○ Strongly Disagree
- ○ Disagree
- ○ Not sure / Undecided
- ○ Agree Strongly
- ○ Agree

22. The agency has carefully considered how to address relational boundaries and conflict of interests concerns with Young Adult Peer Mentors.

- ○ Strongly Disagree

○ Disagree

○ Not sure / Undecided

○ Agree Strongly

○ Agree

23. The agency has a culture that promotes Young Adult Peer Mentors to outreach supervisors for support and guidance in the work.

○ Strongly Disagree

○ Disagree

○ Not sure / Undecided

○ Agree Strongly

○ Agree

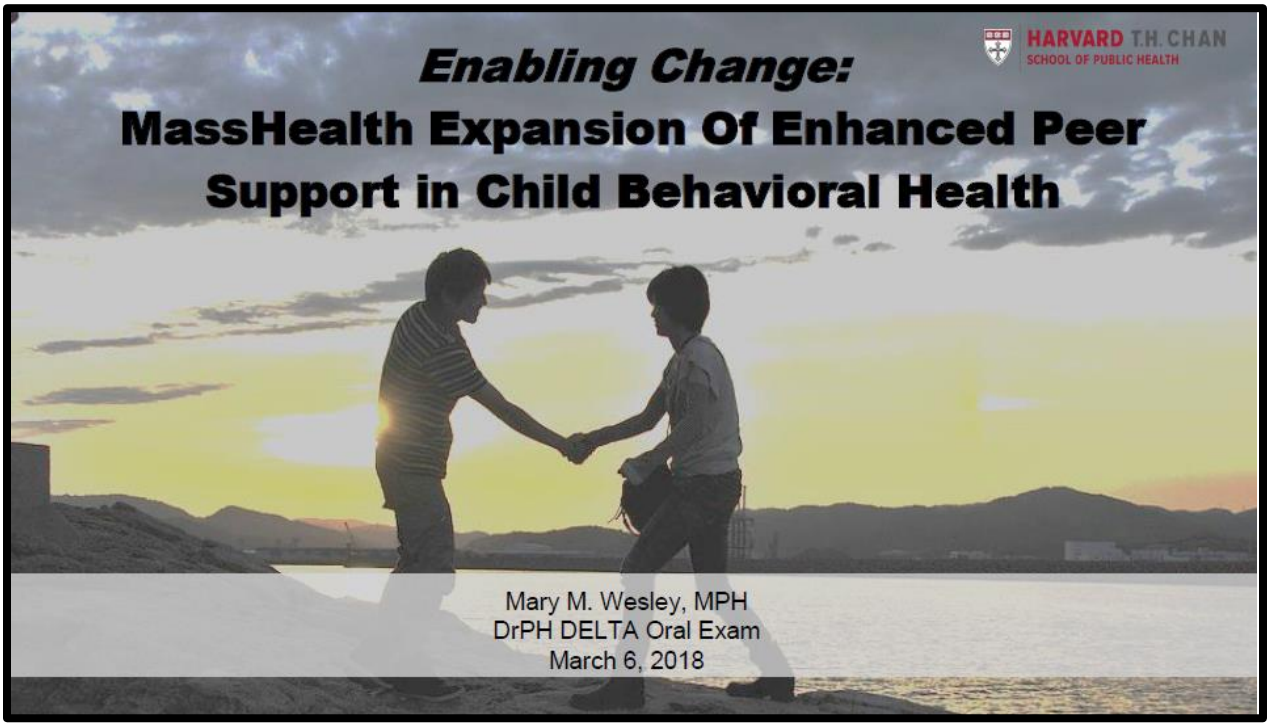
24. Your name will be shared with MassHealth staff for policy development as quality assessment.

Name (optional) _____

Agency name (optional) _____

Appendix E

DrPH DELTA Final Oral Exam Meeting Presentation



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AGENDA

(1) Problem Statement, Intervention & Host Organization
(2) Project Description
(3) Theory of Change
(4) Methods & Deliverables
(5) Results
(6) Recommendations
(7) Impact

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PROBLEM STATEMENT

Transition Age Youth (TAY), ages 16-25 yrs, are a part of social welfare systems and transitioning from child to adult services or independence. There is a risk for mental health crises. The response is a focus on the continuum of care.

- Healthcare, housing, employment, education & developmental challenges exist
- TAY have a decreased use of long term mental health services
- Increased risks of school failure, correctional system involvement, and dependence on social assistance services

- MA has over 800,000 TAY; 16% are in poverty
- Effective care is needed to engage TAY and empower recovery
- Department of Mental Health Programs address TAY mental health and other needs

- 2 million members, $13 billion in expenditures, 40% state budget, reduced funding
- Child Behavioral Health Initiative (CBHI) (in response to Rosie D. v Patrick Lawsuit)
- CBHI partnership with DMH to pilot Young Adult Peer Mentor (YAPM) model

(Bump, 2017; Department of Mental Health, 2010; Marchand, Pirk, Putnam, & Savir, 2016)

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INTERVENTION

Peer support (in various forms) has shown to be an effective treatment option for youth and young adults in behavioral health care and is being promoted by MassHealth among its provider network.

- Young Adult Peer Mentors - "individuals in recovery from mental health and/or substance use issues who strategically share their lived experience with clients to inspire hope, provide emotional support, and aid in developing a recovery plan"

- Adolescents report greater satisfaction with peer support services
- Better outcomes are reported: reduced care costs, improved school attendance, fewer law enforcement contact, increased behavioral & emotional strength

- MassHealth's Young Adult Peer Mentor (YAPM) Model combines peer coaching and therapeutic mentoring as a specialty expertise within CBHI services
- YAPM model piloted with 10 MassHealth provider sites under grant funds

(The Practice Profile Workgroup, 2017; Department of Mental Health, 2010)

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YOUNG ADULT PEER MENTOR MODEL – Summary

Peer support (in various forms) has shown to be an effective treatment option for youth and young adults in behavioral health care and is being promoted by MassHealth among its provider network.

Slide figures omitted

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YOUNG ADULT PEER MENTOR MODEL – Practice Profile Core Elements

Peer support (in various forms) has shown to be an effective treatment option for youth and young adults in behavioral health care and is being promoted by MassHealth among its provider network (2017).

- **Building Relationships & Collaboration** – This practice requires making connections and maintaining trust with young adults and their family members, providers, other adult allies, and young adult peer group through respectful curiosity.

- **Demonstrating Safe, Ethical & Professional Behavior** – This practice requires that Young Adult Peer Mentors adhere to practices that promote integrity and dignity while working with young adults.

- **Role Modeling** – This practice requires demonstrating, through actions, words, and manner, the types of behaviors that will contribute to young adults' success and personal growth.

(Practice Profile Workgroup, 2017)

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YOUNG ADULT PEER MENTOR MODEL – Practice Profile Core Elements *(cont'd)*

Peer support (in various forms) has shown to be an effective treatment option for youth and young adults in behavioral health care and is being promoted by MassHealth among its provider network.

- **Promoting Self-Care** – This practice requires demonstrating resiliency and self-advocacy and providing empathic encouragement to safeguard the overall emotional and physical health of both the YAPM and young adults.

- **Practicing Cultural Responsiveness** – This practice requires learning how values, beliefs, attitudes, traditions grow from identities and learning about person experiences and their influences on behavior in order to counsel youth.

- **Supporting Young Adult Visions & Goals** – This practice requires collaborating with young adults and their care teams to encourage a vision for the future.

(Practice Profile Workgroup, 2017)

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YOUNG ADULT PEER MENTOR MODEL - Example

Peer support (in various forms) has shown to be an effective treatment option for youth and young adults in behavioral health care and is being promoted by MassHealth among its provider network.

Slide figures omitted

(The Home for Little Wanderers. n.d.)

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DELTA PROJECT

The DELTA Project supports MassHealth's expansion of the Young Adult Peer Mentor (YAPM) model by examining organizational readiness and understanding the social context for the peer workforce.

- The **social context** of the organization's workplace, its the organizational culture and climate, and the individual preferences toward innovation will provide critical information regarding an organization's readiness for adopting the innovation
- The peer workforce is supported when the organizational culture **values** lived experiences

Social Organizational Context in Child Mental Health Services that Influence Organizational Readiness (Glisson,2002)

Organizational Social Context:	Response to Innovation:	Impact of Organizational Context:
✓ Organizational Culture ✓ Organizational Climate ✓ Organizational Structure ✓ Organizational Domain	✓ Invite or reject innovation ✓ Complement or inhibit activities required for success ✓ Sustain or alter organization's core protocols	✓ Adopting, implementing, and sustaining innovation ✓ Quality and outcomes of mental health services ✓ Therapeutic alliance for provider and client

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THEORY OF CHANGE

The Diffusion of Innovation Theory (Rogers, 2003) characterizes how change occurs in a social system and examines the innovation, adopters, influence of communication, time, and the social system.

- **The Innovation -** The nature of the innovation affects the likelihood it will be adopted, and includes considerations of relative advantage, compatibility, simplicity, trialability, observability **(Project application: Young Adult Peer Mentor Model)**

- **Adopters -** People can be grouped by their preferences and attitudes toward change and likelihood of adopting an innovation: innovators, early adopters, early majority, late majority, laggards **(Project application: MassHealth Provider Staff)**

- **Communication, time, and social systems -** Communication has varied influence for groups, time can inhibit or facilitate, and social system structure and culture can influence population behavior **(Project application: MassHealth Provider policies, practices, training, & workplace context for peer workforce)**

(Robinson,2009 ;Rogers, 2003)

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METHODS & DELIVERABLES

The DELTA Project includes (1) Peer Support Interest Survey, (2) Peer Support Readiness Survey, (3) Stakeholder interviews, (4) Executive summary, (5) Educational materials, and (6) An issue brief of funding mechanisms for the Young Adult Peer Mentor model.

- **Peer Support Provider Surveys –** Online surveys of 98 unique therapeutic mentoring providers administered through managed care companies, used to examine adopters of Young Adult Peer Mentor (YAPM) model innovation

- **Stakeholder Interviews –** Open ended, semi structured interviews using grounded theory to see emergent themes; key informants referred by MassHealth; 10 Questions: youth mental health experience, YAPM challenges, successes & sustainability.

- **Deliverables -** Executive Summary reviews project activities and gives key findings; Educational materials target providers and staff; Issue Brief highlights funding mechanisms for the start-up and sustainability of peer support programs

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RESULTS: Provider Surveys - Interest

- **Background of Organization & Survey Respondent**
  - 61% - Staff of 10 or less
  - 56% - Primary decision maker for whether to implement YAPM
  - 92% - Organization would be supportive of peer staff
- **Knowledge & Experience**
  - 84% - Comfortable explaining YAPM role with more training
  - 55% - Experience supervising or working with peers as part of treatment team
- **Interest in Young Adult Peer Mentoring Practice & Implementation**
  - 54% - See an unmet need for YAPM
  - 77% - Willing to engage in future collaboration to support YAPM implementation

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SUMMARY RESULTS: Provider Surveys – Organizational Readiness

- **Background of Organization & Survey Respondent**
  - 81% - 5 years or more in Therapeutic Mentoring
  - 54% - Staff of 10 or less
  - 54% - Primary decision maker for whether to implement YAPM
- **Organizational Culture**
  - 75% - Agree that YAPM can be valuable team members
  - 11% - Believe YAPM are in leadership positions
- **Education & Training**
  - 42% - Staff understand YAPM purpose and duties
  - 52% - Staff Orientation and training addresses YAPM job duties

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METHODS: YAPM Model Implementation

- **Advocacy** (internal and external)
  - Advocacy training for supervisors / administrators (internal)
  - Advocacy for YAPM with coworkers (internal)
  - Advocacy for YAPM in community (external)
- **Education**
  - Education & training for supervisors / administrators
  - Education & training for YAPM with coworkers
  - Education & training for YAPM with peer support staff
- **Mental Health Stigma**
  - Stigma among healthcare professionals
  - Stigma among supervisors / administrators
  - Role of advocacy and education in addressing stigma

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SUMMARY RESULTS: YAPM Model Sustainability

- **Medical model vs. Peer model**
  - Nontraditional employee (not academically trained for the peer support role)
  - Greatest asset is lived experiences that engage youth, but also provide opportunity for stigma
  - Education and advocacy key to bridging the gap
- **Model fidelity**
  - Theory to policy and issues in model fidelity
  - Policy to pilot and issues in model fidelity
  - Pilot to practice and issues in model fidelity

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DELTA Project Key Recommendations

- **Education Programming**
  - Education is vital for internal (supervisors and colleagues) and external (community engagement) advocacy for new practices
- **Mental Health Stigma**
  - Stigma among mental health professionals must be addressed
- **Workforce Investment**
  - The investment in workforce development is imperative

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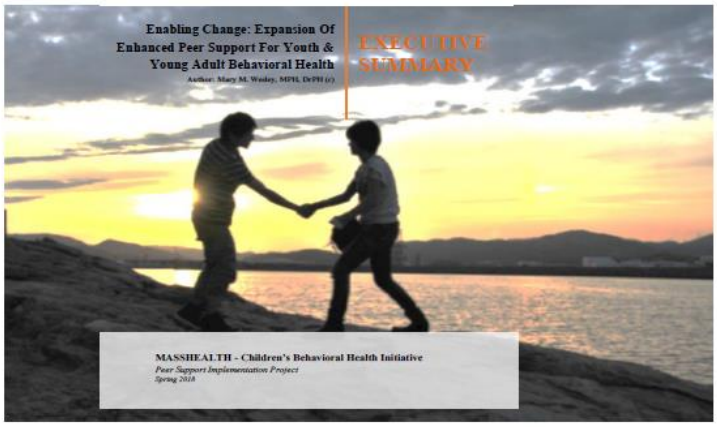
DELTA Project Key Recommendations



MEDICAID FUNDING STRATEGIES FOR ADOLESCENT PEER SUPPORT SERVICES IN MASSACHUSETTS

Author: Mary M. Wesley, MPH, DrPH (c), Harvard T. H. Chan School of Public Health

This issue brief provides insight into the funding of pilot and implementation initiatives of Medicaid supported peer support services for adolescents in Massachusetts. Note that the intervention program, the Young Adult Peer Mentor intervention model, and the peer staff who are employed in the program will be referred to as YAPM.

Background

Behavioral Health for Youth. There is an unmet need in mental health services for youth and young adults in the United States. The National Institute of Mental Health reports that one out of every five adolescents ages 18-25 years has some form of mental illness; however, only thirty-five percent receive treatment for their mental health needs. Almost half of the youth ages 14-18 years report mental illness and yet only one fifth receive treatment (NIMH, 2017). The disparity between the prevalence of mental illness and the treatment of mental illness highlights a need for appropriate, competent care that ensures mental wellness for youth.

Transition Age Youth. Transition Age Youth (TAY), approximately ages 16 to 25 years, are a vulnerable population that requires attention from state and federal entities to ensure that they receive sufficient mental health care. The transition from child social services to adult social services or to complete independence can bring instability for Transition Age Youth that already face challenges in education, employment, healthcare, juvenile justice system, and housing (Marchand, 2016). Mental health needs that are not adequately addressed or subjected to a disruption in care may result in mental health crises. MassHealth and the Massachusetts Department of Mental Health sought to address mental health needs for transition age through the use of the Young Adult Peer Mentor (YAPM) intervention model.

Young Adult Peer Mentors. Young Adult Peer Mentors (YAPM) are adolescents that have recovered from mental illness conditions who are trained to strategically use their "lived experiences" in a coaching and counseling role with youth as a subspecialty of therapeutic mentoring (YAPM Practice Profile Workgroup, 2017). Lived-experiences are defined as "the personal experience of living with and overcoming a mental health/substance abuse / traumatic life concern which has caused problems in one or more areas of life. A person with lived experience will also have had valuable experience in navigating or using community resources, therapeutic services, or other supports to overcome the challenges" (YAPM Practice Profile Workgroup, 2017). Young Adult Peer Mentors share similar life experiences "with purpose and intent" in order to "inspire hope and motivation" with youth who face mental health challenges and can relate to a peer who has successfully recovered; the goal for YAPM intervention model is to make mental health services accessible and more appealing (YAPM Practice Profile Workgroup, 2017). The core elements of Young Adult Peer Mentoring are:

- ✓ Practicing cultural responsiveness
- ✓ Building relationships and collaboration
- ✓ Supporting young adult vision and goals
- ✓ Role modeling
- ✓ Promoting self-care
- ✓ Demonstrating safe, professional, and ethical behavior

(YAPM Practice Profile Workgroup, 2017).

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DELTA Project Impact

- **Student learning impact**
  - Connections to previous state & federal government experience: Mississippi to Massachusetts, resource poor to resource rich environment
  - Lessons in collaborating partnerships, communication and management styles
- **Host Organization impact**
  - Modification of policies and practices of CBHI to incorporate project findings
  - Enhancement of the MassHealth commitment to recovery-focused, community-based mental health services
  - Project findings can be applied on a larger scale for network of MassHealth providers, similar organizations and similar therapeutic innovations

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DELTA Project Impact for the Future *(continuation)*

- **DELTA Project Impact for Public Health**
  - Added knowledge in the adoption of innovations in mental health settings
  - Project findings offer contributions to programs that utilize non-traditional, peer support workforce that can address larger issues of workforce shortages in mental health services
  - Lessons learned can be applied to other health interventions, i.e. opioid crisis in the region and nation

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