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A Program Evaluation of Virtual Office Hour Sessions for Certified Peer Specialists in the United States During the COVID-19 Pandemic

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2015

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An abstract of
A thesis submitted to the Faculty of the
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Master of Public Health
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2021

ABSTRACT

Background. In March 2020 Coronavirus (COVID-19) pandemic swarmed many countries unexpectedly, exacerbating disparities in health, social, and economic infrastructures. It was declared a national public health emergency causing state-mandated stay-at-home orders. During this time, mental healthcare services transitioned from in-person to telemental health. During this time, anxiety and depressive symptoms increased to 41%. Those with unmet mental healthcare needs also increased to 11%. With the urgency to support the demands of healthcare needs and mental health professionals providing services, the Southeast Mental Health Technology Transfer Center launched virtual Office Hours Sessions (OHS) to provide consultation services for Certified Peer Specialists (CPS). CPS are mental health professionals with a history of a mental health condition and/or substance use disorder, trained to provide services to others on their path to recovery. The purpose of this program evaluation was to assess the delivery of the virtual OHS for CPS during COVID-19. **Methods.** A mixed-methods analysis was conducted to examine the demographics of participants, knowledge, and skills gained from OHS, the engagement of participants, and barriers when delivering OHS. **Results.** Half of the participants attended the sessions from a southeastern state. The majority of attendees were women, white, received some college but no degree, and are Peer Professionals or Outreach Facilitators. Most attendees reported working in Community Recovery Support Centers or Community Health Centers. Reports showed that participants found OHS topics relevant and planned to implement newly gained knowledge and skills in their current practice. The main barriers to delivering sessions included low participant interaction and external factors. **Conclusion.** The findings highlight proficient presenters, relevant topics, stakeholders' feedback, a versatile conferencing system, and external sources as important factors to consider when delivering virtual OHS for CPS during a pandemic.

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With much love and gratitude,

HANNAH AMDE ARAYA

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CHAPTER I: INTRODUCTION AND REVIEW OF LITERATURE

Certified Peer Specialists (CPS) or Peers play an integral role within the mental healthcare system. For decades, CPS have gained recognition and respect for their unique theoretical framework. Peers are certified mental health professionals who provide support to people with a mental health condition and/or substance use disorder, informed by their training and history of personal recovery from similar mental health conditions. (GMHCN, 2021b; Salzar, 2010; Walker & Bryant, 2013). The role of CPS is to empower, instill self-determination and personal responsibility to their clients who are in the process of recovery. Recovery is defined as the process of improving one's health and wellbeing (NASEM, 2016). Recovery from mental health conditions or substance use disorder is not a linear process and can be a life-long journey. Mutual support groups play an integral role in strengthening a person's recovery process. Examples of mutual support groups include Alcoholics Anonymous or Narcotics Anonymous. One of the main guiding principles of such support groups is sharing one's personal recovery journey with others who are also in the process of recovery. Sharing one's experience overcoming addiction, for example, fosters a sense of community and instills hope in others. Similar to such anonymous support groups, CPS hold a code of ethics that openly encourage sharing about personal recovery to enhance optimism and self-determination (Repper & Carter, 2011; Salzar, 2010; SAMHSA, 2017).

Operating as a CPS in client's recovery entails deliberate planning with and the client. More specifically, the CPS guides the client to set wellness goals, develop self-monitoring progress, link the client with appropriate resources and interventions, identify personal strengths and limitations, and create relapse prevention plans (GMHCN, 2021b; Repper & Carter, 2011).

To become a CPS, a person must undergo intensive training to become certified in providing support. Trainings are regulated by state department of behavioral health and services. As of 2016, 46 states provide certification training programs (Jones et al., 2019). Among the 46, 39 states allow

Medicaid billing for any type of peer support services. Georgia's peer organization – Georgia Mental Health Consumer Network (GMHCN) – was the first to certify CPS trainings and first to receive Medicaid reimbursement for CPS (GMHCN, 2021a).

While the work of CPS greatly impacts those in recovery, services offered to clients are not to be replaced by case managers or mental health clinicians. Rather, the role of CPS is to further promote a client-focused system of care. CPS provide services in varying environments. They can be found working with case managers, at community health centers, substance use treatment centers, emergency departments, and even primary care settings (SAMHSA, 2017). In addition to providing mental health support, CPS also conduct an array of outreach and advocacy support. Some CPS can be found working at drug courts or other criminal justice settings (SAMHSA, 2017).

Substantiated in mutual support and social connection, most support groups, events, and trainings for CPS were hosted primarily in person. Connecting with other peers offers a sense of community, which remains an instrumental aspect of recovery and peer support (Jones et al., 2019; Repper & Carter, 2011; Salzar, 2010). However, since the onset of the Coronavirus (COVID-19) pandemic, in-person meetings and trainings temporarily ceased.

Mental Health Impact of COVID-19

In early March 2020, Coronavirus (COVID-19) swarmed many countries unexpectedly. Declared a pandemic by WHO, COVID-19 exacerbated the disparities in health, social, and economic infrastructure in the United States (Cucinotta & Vanelli, 2020; Moreno et al., 2020). In an effort to contain the spread of this communicable disease, individual states mandated stay-at-home orders as the federal government declared a public health emergency. Millions of people worked from home, while others became unemployed as non-essential businesses closed due to the mandated quarantine measures (Şahin, Tasci, & Yan, 2020).

The primary symptoms of COVID-19 were respiratory symptoms, although the effects resulting from COVID-19 impacted the mental and emotional wellness of people. Unexpected shifts in people's lives led to an increase in mental health conditions. Adults with anxiety and depressive disorder increased from 36% to 41% during the pandemic (Vahratian, 2021). Studies also showed an increase in substance use, food consumption, gambling, and gaming (Ghebreyesus, 2020; Moreno, 2020). While people were impacted by quarantine orders, healthcare systems bared the burden of the virus as well.

Outpatient mental health services temporarily ceased in-person sessions. This occurred at the start of the pandemic, all while the need for mental health support increased. The proportion of adults who reported anxiety and depressive symptoms, and reported having unmet healthcare needs, increased during the pandemic from 9% to 11% (Vahratian, 2021). Upon the transition of halting in-person mental health services, many mental health care facilities explored alternative avenues of providing treatment and support to clients. Mental health professionals shifted to hosting services through virtual platforms. Some mental health professionals and patients found virtual meetings advantageous and more convenient. Simultaneously, others faced barriers to receiving and delivering care.

Most virtual mental health services required laptops, computers, or smartphones with internet access or data. This caused challenges to some mental health professionals and patients. With the implementation of the stay-at-home orders, some people did not have access to appropriate technology to communicate with their mental health provider or patient (Tan, Tee, Seetharaman, 2020; Uscher-Pines, 2020). Some people quarantined in areas with no internet, ultimately making it difficult to access necessary services. Others were also required to share internet bandwidth with roommates and family. With the demand of internet use of everyone staying at home, some people may have not had strong internet to virtually stream with their provider or patient. Troubleshooting technology and internet

issues was another common concern. (Tan, Tee, Seetharaman, 2020; Uscher-Pines, 2020). This took away from the time patient usually has with their provider.

Another disadvantage that affected both patients and mental health professionals was the loss of privacy. Rather than meeting in a private office space, both patients and mental health professionals had to identify a location where they were alone and comfortable to virtually meet. In some cases, people did not have private spaces to meet with their provider. Healthcare providers also had to ensure their telemental health delivery platform is Health Insurance Portability and Accountability Act (HIPAA) compliant. Service providers had to ensure their servicing tool was HIPAA-compliant to maintain patient privacy (McGinty, Saeed, Simmons, & Yildirim, 2006).

Mental health professionals faced additional barriers when delivering services as well. To meet the present mental health needs, some mental health professionals increased their workhours. (Ghebrehyesus, 2020; Uscher-Pines, 2020). In addition to the pressures resulting from providing more services to patients, mental health professionals also faced stressors that non-healthcare workers also faced – including taking care of loved ones and managing their children's education from home to name a few. Such added stressors brought up common feelings of sadness, anger frustration, fear of illness and death, social isolation, grief, and nightmares, insomnia, and worsening physical and mental health conditions – both in mental health and non-mental health professionals (CDC, 2020; Vahratian, 2021). In an effort to manage the significance of adverse mental health outcomes during and after the pandemic, national organizations began focusing on investing in mental health services and health care workers (Ghebreyesus, 2020; Moreno, 2020).

Southeast MHTTC and GMHCN

Among other mental health professional support organizations, the Southeast Mental Health Technology Transfer Center (Southeast MHTTC) transitioned its services to digital avenues amidst COVID-19. The Southeast MHTTC is a Substance Abuse and Mental Health Services Administration

(SAMHSA) funded organization aiming to further disseminate and implement evidence-based practices for mental disorders. Located at Emory University's Rollins School of Public Health, the Center serves HHS Region IV, spanning the southeastern region of the United States. Southeastern states comprised of Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee; making up 26% of the U.S. population (Southeast MHTTC, 2021a).

The Southeast MHTTC's programs and services are geared to regional needs of mental health professionals. The Center's current areas of focus include suicide prevention, provider well-being, Peer support services, and overall public mental health. When providing services, the Southeast MHTTC partners or contracts with consultants and community organizations. With Peer support services as one of its priorities, the Southeast MHTTC collaborated with Georgia's Peer organization.

Georgia Mental Health Consumer Network (GMHCN) is a nonprofit organization whose aim is to promote peer support, education, and self-help for those experiencing mental health, developmental disabilities, and addictive diseases (GMHCN, 2021a). Launched in 1990, the organization evolved to one of the leading CPS state organizations in the United States that provides extensive recovery-based trainings, including CPS state certification trainings (GMHCN, 2021a).

Prior to COVID-19, the Southeast MHTTC and GMHCN hosted trainings, listening sessions, continuing education courses, and programs primarily in person. Upon the onset of COVID, the Center shifted its delivery of services beginning in early April 2020. One of the Southeast MHTTC's first virtual events were offered to support CPS amidst COVID-19. The webinars were hosted in April and May 2020. At the end of each webinar, participants were asked to complete a brief survey. The survey aimed to gather current training and resource needs.

After the Center's Program Evaluator analyzed the needs of survey respondents, the common themes were compiled. Those themes and topics were then presented to participants at the following webinar. Participants were asked to rank the topics from most relevant and of importance from one to

six. The Southeast MHTTC and GMHCN used these data to inform the development of Office Hour Sessions (OHS) for CPS during the pandemic.

Virtual Office Hours for CPS

The purpose of OHS was to provide intensive consultation services and increase social connection for CPS. The first OHS was hosted in early June 2020. There were four sessions, each occurring every two weeks for one to two hours. Participants had the option of attending as many sessions as they wished. A total of 39 attended, however, 32 unduplicated participants attended the sessions.

Each session covered a different topic related to CPS and the effects resulting from COVID-19. The four OHS topics included: Facilitating Online Mutual Support Groups and Wellness Activities; Cultural Competence, Cultural Awareness, and Cultural Integrity; Creating, Enhancing, and Sustaining a Resilient Peer Workforce; and Building a Recovery-Oriented System of Care (Southeast MHTTC, 2021b). Within each OHS, there were various discussion segments related to the overarching topic. Multiple discussion segments occurred per OHS and were informed by questions asked by participants. Participants had two ways of submitting questions. One was when they registered for an OHS. The registration page allowed for registrants to pre-submit up to three questions per OHS. The second way participants submitted questions was during the live OHS. During the sessions, a presenter read questions to the group which allowed for discussion on the segment topic. Participants were invited to share comments or additional questions related to the discussion segment.

At least one member from the Southeast MHTTC joined the OHS to observe and take notes on the structure, interaction, and discussion segments. At the end of session, attendees received an email from the Southeast MHTTC asking for their feedback by completing two evaluations. Presenters also provided feedback. A virtual debrief meeting with the Southeast MHTTC and OHS presenters occurred at the end of the series.

Defining Relevant Terms

This section defines key terms covered in this evaluation. Those terms include: CPS, discussion segments, engagement, GMHCN, OHS, presenters, and Southeast MHTTC.

Certified Peer Specialists (CPS) or Peers are trained mental health professionals who have a history of mental health and/or substance use disorder.

Discussion segment is a topic-specific section of an OHS that facilitates conversation among presenters and/or participants. One OHS has multiple discussion segments and is informed by questions. These questions are either pre-submitted by participants or submitted in the chat box during a live OHS.

Engagement is the process of connecting with another OHS attendee. Engagement includes a verbal exchange of words, typing in chat box, or sharing of resources during OHS. Interaction and engagement will be used interchangeably throughout this evaluation.

Georgia Mental Health Consumer Network (GMHCN) is the Peer non-profit organization of Georgia focused on providing trainings and services for mental health, developmental disabilities, and addictive diseases.

Office Hour Session(s) (OHS) are a series of intensive consultation sessions. This paper evaluated a series of OHS conducted by CPS from GMHCN.

Presenters are CPS who led OHS events. For the purpose of this evaluation and to reduce confusion, the OHS discussion leaders will be referred to as “presenters” although the role of the presenters was to facilitate and lead discussion.

Southeast Mental Health Technology Transfer Center (Southeast MHTTC) is a SAMHSA-funded organization aimed to disseminate and implement evidence-based practices for mental health professionals. To further the dissemination of trainings during COVID-19, Southeast MHTTC hosted OHS for CPS during the COVID-19 pandemic.

Purpose of Evaluation

The purpose of this program evaluation was to assess the delivery of virtual Office Hours Sessions for Certified Peer Specialists in the United States during the COVID-19 Pandemic. The evaluation explored the following questions:

1. What are the characteristics of participants in OHS?
2. Did OHS influence the professional knowledge and skills of participants?
3. What aspects of OHS increased engagement among participants?
4. What were barriers to delivering OHS?

CHAPTER II: METHODOLOGY

The program evaluation used a mixed-methods approach to assess the delivery of Office Hour Sessions (OHS) for Certified Peer Specialists (CPS). In partnership with Southeast MHTTC, Georgia Mental Health Consumer Network (GMHCN) facilitated four OHS using the Zoom conferencing platform. The sessions were hosted every two weeks. The first one was held in early June 2020 and the final session late July 2020.

Evaluation Sample

The target audience for OHS were CPS in the southeast region of the U.S. OHS attendees were invited through the GMHCN and Southeast MHTTC listservs to register for each session. The GMHCN and Southeast MHTTC listservs are mostly comprised of persons living in Alabama, Georgia, Florida, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. OHS attendees could attend as many sessions as possible. There was a total of 39 attendees. The sample size for this evaluation was 32, however, once the participants list was unduplicated.

Data Collection

This section of the methodology will explain the data sources used to inform this evaluation. There were four groupings of data sources: the registration report (RR), observation notes (ON), two participant feedback sources – GPRA Report (GR) and Qualtrics Report (QR) – and finally, feedback from presenters in debrief notes (DN).

I. Registration Report (RR)

The first data source was the RR. Each OHS registration page gathered demographic information including the name of registrants, email address, job title, organization, and zip code. Registrants had the opportunity to pre-submit up to three questions on topics they wish to discuss for each OHS as well. The RR compiled identifying information of all OHS participants. A secondary database was developed with de-identified data to maintain the confidentiality of participants.

II. Observation Notes (ON)

The second data source was observation notes. A member from the Southeast MHTTC team typed ON during each OHS session. ON were typed on a pre-developed template that gathered information on the structure of sessions, duration of each session, questions and topics discussed, and the interactions between presenters and attendees. No identifying information was recorded on this form. This form was stored in a secure, password-protected server.

III. Feedback from Participants: GPRA Report (GR) and Qualtrics Report (QR)

The third data source consisted of two post-event evaluations completed by attendees: Government Performance and Results Modernization Act (GPRA) and Qualtrics Report (QR). GPRA is required by Southeast MHTTC funders. This evaluation gathered only quantitative data. On page one of the GPRA form, participants were asked to provide four characters to develop their personal identification code: 1) the first letter in mother's first name, 2) the first letter in mother's maiden name, 3) the first digit of social security number, and 4) the last digit of participant's social security number. This personal code maintains the confidentiality of participants, however, allows for data to be linked to data collected at a later point. The GPRA form asked for demographic information, such as gender, race, education level, occupation, and zip code. The first question related to the OHS read, "How satisfied were you with the overall quality of this event?" The answer options were on a 5-point satisfaction Likert scale where 1=very dissatisfied and 5=very satisfied. The following two questions were on a 5-point agreement Likert scale, as well, ranging from 1=strongly disagree and 5=strongly agree. These two questions inquired about the OHS benefiting the participant's professional development, and if the participants would use the information to inform their current practice. The final question asked if participants would recommend to a colleague. The answer options included 1=yes and 2=no.

Upon the completion of GPRA, respondents were redirected to the second survey located on Qualtrics. The Qualtrics evaluation form was developed by the Southeast MHTTC to gather additional

information not included in the GPRA evaluation. The Qualtrics survey gathered both quantitative and qualitative data. The quantitative answer options were rated on a 5-point Likert agreement scale, answer options ranged from 1=strongly disagree through 5=strongly agree. The Qualtrics evaluation asked participant's agreement level on the following: if OHS enhanced knowledge, enhanced skills, OHS relevance to career, questions addressed by presenters, well-organized sessions, knowledgeable presenters, well-prepared presenters, and presenters receptive to comments and questions. Three open-ended questions were also asked of participants. The questions read as followed: what about the training was most useful in supporting their work responsibilities, how can the Southeast MHTTC improve its training, and what two ways can participants use the information from the training at their job.

IV. Feedback from Presenters: Debrief Notes (DN)

The fourth data source were the DN. Upon the completion of the OHS series, the Southeast MHTTC hosted a debrief meeting with the OHS presenters through Zoom. Two members from the Southeast MHTTC took notes during the meeting. DN were typed and saved in a password-protected drive. Presenters expressed their observations about the design, participant turn-out, participant engagement during sessions, and external factors such as attendance and a saturated webinar market. Next steps and recommendations for future OHS were also discussed.

Data Analysis

A mixed-methods analysis examined the data sources. The RR was downloaded from Zoom, the OHS conferencing platform. The GPRA data were downloaded from SPARS, which is a data entry and reporting system. Similarly, the Qualtrics data was downloaded as a report. The Southeast MHTTC Data Analyst then compiled the participant feedback reports from both GPRA and Qualtrics in SAS. A frequency and percentages table were developed upon completion. Finally, the debrief meeting notes with presenters and OHS observation notes were saved in Word documents.

Data sources with quantitative and qualitative data were thoroughly read and organized. To analyze the qualitative data, manual color-coding was conducted, in which each evaluation question was labeled a unique color. Thorough coding occurred to identify themes per evaluation questions. This was an iterative process. The first round of coding yielded over twenty codes related to the demographics of participants, aspects that influenced the knowledge and skills participants gained during OHS, aspects that enhanced engagement, and barriers when delivering OHS. Upon revision, the subcodes were organized under larger, topical themes. For example: when coding the first round, barriers were coded as individual themes rather than the following subcodes: duration of OHS, frequency of OHS, low attendance, and distinguishing OHS within a webinar saturated market. Ultimately, the themes were grouped under one topical theme, named "external factors." A similar iterative coding process was conducted for each evaluation question. The final overall themes include the following: participant demographics; enhanced knowledge and skills; relevant to career; Zoom features; relevant topics; proficient presenters; low interaction; and external factors.

IRB Determination

This evaluation was determined by Emory University's Institutional Review Board (IRB) to be a quality improvement and evaluation project, not human subjects research. The collection of data was geared to make judgments about the program, processes, systems, and to inform decisions about future program development; therefore, an IRB review was not necessary.

Reflexivity

I have been working as a Program Coordinator at the Southeast MHTTC for over two years. During the OHS, I operated as one of the notetakers in the sessions and the debrief meeting with presenters. I've interacted with the OHS presenters in prior to this series. I have also managed previous trainings and listening sessions hosted by GMHCN. While I believed the presenters have are

knowledgeable and highly skilled in facilitating Peer discussions and leading trainings, I ensured to use participant data to inform this evaluation rather than personal beliefs.

Additionally, I have loved ones living with mental health conditions and substance use disorders. When starting this program evaluation, I was aware of my perception of mutual support groups and peer connection. I have witnessed how useful mutual support groups are to people living with mental health conditions. However, when completing this evaluation though I only included data reflected by participant and presenter feedback.

CHAPTER III: RESULTS

This chapter will explain the main results and a results summary of the main findings that address the four evaluation questions:

1. What are the characteristics of participants in OHS?
2. Did OHS influence the professional knowledge and skills of participants?
3. What aspects of OHS increased engagement among participants?
4. What were barriers to delivering OHS?

Evaluation Question #1: What are the characteristics of the participates in OHS?

The characteristics of participants were collected from two data sources: Registration Report (RR) and GPRA Report (GR). The RR gathered participant location, professional title, and employment setting. The GR gathered gender, race, and highest degree received. While there were 32 participants who attended OHS, only 11 completed the GR. **Table 1** displays the following demographic information of participants.

Participants indicated the geographic state from which they were joining OHS. The RR showed that 50% (n=16) participants were from the southeast region: North Carolina, Mississippi, Florida, Kentucky, Georgia, or Tennessee. The other half indicated they were from the following states: California, Colorado, Maryland, Nevada, New York, Pennsylvania, or Texas. Gender and racial demographics were also demographic information indicated by participants. Seventy-two percent (n=8) of attendees were female and 27% (n=3) male. Regarding race, 46% (n=5) were White, 36% (n=4) Black, 9% (n=1) Hispanic/Latino and 9% (n=1) chose not to answer.

GR revealed that all participants have received at least some college education. More than half of the participants at 55% (n=6) completed a bachelor's or master's degree; 45% (n=5) received some college or associate's degree. The occupation of attendees varied, with most of the participants working within the health industry. The primary professions of the participants were peer professionals 31%

(n=10). The second most common occupation of the OHS participants was outreach coordinator 22% (n=7). Other occupations indicated by participants include program coordinators and leadership staff making up 13% (n=4) of attendees. Social workers, case managers, and other occupations represented 9% (n=3) of participants. The "other occupations" listed by participants include support partner, engineer, and master's student. Participants who work as a community health worker, counselor, prevention specialist, supported employment specialists, or as a trainer collectively made up 16% (n=5) of attendees.

The most predominant places of employment among participants, firstly, were community health centers reporting at 31% (n=10), and secondly, community recovery support centers 22% (n=7). Participants who work at a mental health or treatment clinic made up 16% (n=5) of attendees. Attendees who work in community organizations or state agencies, such as the state Department of Behavioral Health collectively reported at 13% (n=4). Ten percent (n=3) percent work in education, while 3% (n=3) collectively indicated criminal justice, state hospital, or "other."

Table 1: Themes Associated with Evaluation Question #1: What are the characteristics of participants in OHS?

	Frequency	Percentage
State*		
Florida	1	3%
Georgia	5	16%
Kentucky	4	13%
Mississippi	3	9%
North Carolina	1	3%
Tennessee	2	6%
Non-southeastern states	16	50%
Gender**		
Male	3	27%
Female	8	73%
Transgender	0	0

Race**		
American Indian or Alaska Native	0	0
Asian	0	0
Black or African American	4	36%
Hispanic or Latino	1	9%
Native Hawaiian or Other Pacific Islander	0	0
White	5	46%
Not answered	1	9%
Highest Degree Received**		
High school diploma or less	0	0
Some college, but no degree	4	36%
Associate's degree	1	9%
Bachelor's degree	3	27%
Master's degree	3	27%
Doctoral degree	0	0
Occupation*		
Community Health Worker	1	3%
Counselor	1	3%
Outreach Coordinator	7	22%
Peer Professional (CPS and Coach)	10	32%
Prevention Specialists	1	3%
Program Coordinator or Leadership Staff	4	13%
Social Worker or Case Manager	3	9%
Supported Employment Specialists	1	3%
Trainer	1	3%
Other (Engineer, MA, Support Partner)	3	9%
Employment Setting*		
Community-based Organization	2	6%
Community Health Center	10	31%
Community Recovery Support Center	7	22%
Criminal Justice	1	3%
Education Setting	3	9%
Mental Health or Treatment Clinic	5	16%
State Hospital	1	3%
State Agency (e.g., Department of Behavioral Health)	2	6%
Other (NA)	1	3%

*These data are gathered from the RR, where n=32.
**These data are gathered from the GR, where n=11.
Abbreviation: MA=Master of Art

Evaluation Question #2: Did OHS influence the professional knowledge and skills of participants?

The GPRA Report (GR) and Qualtrics Report (QR) were analyzed to understand aspects that influenced the professional knowledge and skills of participants. Within this evaluation question, two themes arose: enhanced knowledge and skills; and relevance to career. See **Table 2** for the description and examples of themes. The first theme is "enhanced skills and knowledge" of participants. This theme is defined as increased skills or knowledge as indicated by participants. Seventy-five percent (n=6) of respondents agreed that OHS increased their knowledge in the respective OHS topic area. The same percentage agreed that OHS enhanced their skills. Ninety-one percent (n=10) of participants answered that they expected the event to benefit their professional development and/or practice.

The second theme is relevance to career, defined as when participants indicated the relevance of OHS to their career or how they would implement new information from OHS at their job. Ninety-one percent (n=10) of participants expressed that OHS will benefit their professional development and/or practice. Similarly, 90% (n=10) agreed that they would use the information gained from that event to change their current practice. While 75% (n=6) agreed the respective OHS was relevant to their career.

Participants were asked to share the parts of OHS that were most useful to their job, and in what ways could they apply information to their job. Participants shared that they were more informed on cultural differences, as well as the perspective of administrators. Another mentioned topic was that they intended to use the information from OHS to educate their colleagues. More specifically a participant commented that they will present new ideas of cultural inclusivity and share with their employer. Attendees also shared that information from the OHS could be used for advocacy and the ability to lead trainings and initiate meetings. For example, a participant stated:

> *"I can start a support group that can bring healing and understanding about different cultures and beliefs."* (Source: QR)

Table 2: Themes Associated with Evaluation Question #2: Did OHS influence the professional knowledge and skills of participants?

Theme	Description	Data Source	Example
Enhanced knowledge and skills	When participant indicated having received information or improved their abilities.	GR, QR	Seventy-five percent (n=6) agreed with the statement, "The Office Hour enhanced my knowledge in this topic area." Source: QR
Relevant to career	When participant indicated OHS was applicable to their occupation.	GR, QR	Ninety-one percent (n=10) agreed with the following statement, "I will use the information gained from this event to change my current practice." Source: GR

Evaluation Question #3: What aspects of OHS increased engagement?

The analysis of the GPRA Report (GR), Qualtrics Report (QR), Observation Notes (ON), and Debrief Notes (DN) helped understand aspects of OHS that increased engagement. Three aspects of OHS that increased participant engagement, were the Zoom features, discussion topics, and proficient presenters. **Table 3** displays the listed themes and respective descriptions.

Zoom Features

The theme "Zoom Features" is described as when a presenter or participant uses tools offered by the conferencing system to engage with participants. Zoom is the conferencing platform used during this meeting series. Among the many features in Zoom, the features used during OHS include: web camera, microphone, file attachment, and chat feature. Presenters and participants engaged with the Zoom features to share ideas and personal experiences.

Among the presenters that interacted during the series, majority interacted using the chat box. The ON show that most participants engaged with other OHS attendees by unmuting and turning on their cameras. Participants also typed questions and comments in the Zoom chat box. Throughout the OHS series, participants typed in the chat box, unmuted their microphones, turned on their camera,

and/or attached and shared a relevant document 13 times. An example is a participant who unmuted their microphone to speak about their experience and uploaded a file into the Zoom chat. The file was then accessible to participants and presenters if they wished to download it. Another participant, who did not unmute their microphone or turn on their camera, typed their question in the chat box during OHS #2.

Topics

OHS discussion topics appeared to enhance engagement, as well. Topics are the overarching discussion theme of each OHS. There were four predetermined topics for this series: OHS #1: Facilitating Online Mutual Support Groups and Wellness Activities; OHS #2: Cultural Competence, Cultural Awareness, and Cultural Integrity; OHS #3: Creating, Enhancing, and Sustaining a Resilient Peer Workforce; and OHS #4: Building a Recovery-Oriented System of Care. OHS presenters mentioned that provocative conversations arose, especially during the second OHS. During this OHS there was increased participant-to-participant and presenter-to-participant engagement, compared to other sessions. One participant also mentioned the following,

> *"What was most useful to me is that there is a need for thought-based support groups where people can engage with different cultures respectively."* (Source: QR)

Compared to OHS #1, #3, and #4, the ON shows that OHS #2 was the only session where participants engaged with other participants for the entirety of the session. Attendees shared personal experiences by responding to one another and to presenters. In response to how attendees could use the information shared at OHS #2, three participants expressed their comfort in initiating and engaging in conversations about different cultures. Survey respondents expressed their hope for more OHS sessions on other topics and the need for more support groups where people can engage with different cultures respectively.

Proficient Presenters

Proficient presenters are another theme that arose that increased engagement among participants. The theme proficient presenters are defined as presenters who are knowledgeable about topics, prepared, receptive to questions, and skilled at engaging participants. One participant mentioned that presenters were very helpful, informative, and encouraging. This was indicated by participants in the post-event evaluation forms. Seventy-five percent (n=6) of participants indicated they agreed with each of the following statements:

"*The presenters were knowledgeable about the subject matter."* (Source: QR)

In preparation for OHS, presenters received pre-submitted questions. The presenters then consolidated questions to minimize redundancy of discission segments. This was received well by participants as 75% (n=6) agreed that presenters were well prepared. With regard to presenters answering questions, 75% (n=6) of respondents agreed to presenters' receptivity to comments and questions. For both questions, one participant disagreed and one chose not to answer.

Table 3: Themes Associated with Evaluation Question #3: What aspects of OHS increased engagement among participants?

Theme	Description	Data Source	Example
Zoom features	When presenter or participant uses Zoom features to share experience or resources. This includes the camera, microphone, chat and file share features.	ON, DN	Participant unmutes to speak about experience and attaches a file to share a SAMHSA resource with participants and presenter. Source: DN
Topics	When OHS note taker or presenter mentions that topic increased interaction during session.	ON, GR, QR, DN	OHS presenter commented that there were *"provocative conversations."* Source: DN
Proficient Presenters	When participant indicates the presenters were knowledgeable, prepared, skilled, and answered questions.	ON, GR, QR	Seventy-five percent (n=6) of participants agreed to the following statement, "*The presenters were knowledgeable about the subject matter."* Source: QR

Evaluation Question #4: What were barriers to delivering OHS?

This final section will cover barriers encountered when delivering OHS. An analysis of all data sources was conducted to identify barriers to the delivery of OHS. Low interaction and external factors were the emerging themes. **Table 4** shows descriptions, data sources, and examples of these themes.

Low Interaction

OHS presenters led most discussion segments versus having participants engage in more dialogue. Over the span of four OHS, participants interacted with one another or presenters, 13 times. For the purposes of this evaluation, participant interaction includes unmuting microphone to talk, sharing files, or typing in the chat box.

The DN indicated presenters would have liked more interactive OHS. ON show that presenter-only led discussion segments occurred 23 times throughout the series. The note taker for OHS #1 and #3 made the following comments:

> *"Not much interaction. One participant made a couple of comments; but mostly the presenters discussed the comments."* (Source: ON)
>
> *"Not enough dialogue between presenters and participants during this session. [Presenters] asked for [participants'] input at the beginning and at the end of the session."* (Source: ON)

External Factors

Lastly, a few external factors influenced the delivery of OHS sessions. The recurrence of OHS, the duration of sessions, number of attendees, and abundance of webinars during this period could have operated as barriers. The sessions were hosted every two weeks for two months. Presenters recommended that the interval of sessions could be monthly. The ON suggested that the sessions could have been shorter as well. OHS #1 and #2 were two hours long, while OHS #3 and #4 were close to an hour long.

Another thing the presenters noted as barriers were external factors. OHS was hosted in June and July 2020, amid the COVID-19 pandemic. One presenter mentioned that participants may have been inundated with many webinar invitations from other organizations. Therefore, OHS attendance might have been influenced by the saturation of COVID-19 webinars being promoted at the same time OHS were being promoted. The series attendance was lower than anticipated, as explained by presenters. For future OHS, a presenter suggested distinguishing themselves from other organizations and virtual events. A method suggested by a presenter was targeted marketing for future OHS.

Table 4: Themes Associated with Evaluation Question #4: What were barriers to delivering OHS?

Theme	Description	Data Source	Example
Low interaction	When OHS note taker or presenter comment on the engagement of participants.	ON, DN	OHS note taker indicated that participants only interacted with presenter or other another participant 13 times. Source: ON
External factors	When OHS note taker, presenter, or participant feedback mention anything external to the actual delivery of session. (e.g. attendance numbers, abundance of webinars, targeted marketing, duration, recurrence of session, etc.)	ON, DN	Presenter comments that people are receiving so many emails and webinars… how do we connect with them during this time? Source: DN

Results Overview

The first evaluation question aimed to explore the demographics of participants. Analyzing the RR and GR showed that there was somewhat of a diverse group of attendees. Half joined from a southeastern state, while others joined from other parts of the United States. The most common race, sex, and education were white, female, and some college degree. The most common occupation was Peer Professionals. The most common employment setting indicated by participants was community health center. The second evaluation question addressed if OHS influenced the professional knowledge and skills of participants. Using GR and QR, participants indicated if their knowledge and skills enhanced

as a result of OHS and if OHS were relevant to their careers. Over 90% of attendees agreed to OHS enhancing knowledge, skills and found relevance to career. The third evaluation question explored what aspects of OHS influenced engagement. After an analysis of ON and feedback from presenters and participants, it was apparent that multiple factors impacted engagement. Zoom features, topic discussions, and having proficient presenters all enhanced engagement. The fourth and final evaluation question reviewed barriers to delivering OHS. The following themes appeared as barriers to delivering OHS: low interaction and external factors. All of the data sources were used to inform which aspects could have operated as barriers.

CHAPTER IV: DISCUSSION

The following chapter will summarize key findings, strengths and limitation of the evaluation, lessons learned and future considerations, and conclusion.

Key Findings

Office Hour Sessions served a purpose for Georgia Mental Health Consumer Network (GMHCN) presenters to discuss topics identified by CPS. The discussion topics identified for the series were: Facilitating Online Mutual Support Groups and Wellness Activities; Cultural Competence, Cultural Awareness, and Cultural Integrity; Creating, Enhancing, and Sustaining a Resilient Peer Workforce; and Building a Recovery-Oriented System of Care. Upon the completion of the OHS for CPS in the southeast region of the US, this evaluation was conducted with the purpose of assessing the delivery of the virtual series. Data were collected using the registration report (RR), observer notes (ON), debrief notes (DN), post-event evaluation data from the GPRA report (GR), and Qualtrics report (QR). The multiple data sources were reviewed and analyzed. The results of this evaluation suggest a few factors that influenced the delivery of OHS.

The duration of each OHS varied throughout the series. OHS #1 and #2 were two hours long, OHS #3 and #4 were one hour long. Sessions occurred every two weeks, starting the first week of June. As suggested in the DN by presenters, the duration and recurrence of sessions may have been more convenient if hosted monthly for an hour, rather than bi-monthly.

OHS #1 was the largest attended and participant attendance decreased thereafter. OHS #2 had the second-highest attendance and most interactive session among participants. Sharing resources and discussing ideas among the group increased interaction and the opportunity for participants to learn from one another.

It is unclear what specifically impacted the attendance, however, there are some possible factors as mentioned by presenters. One of the considerations was the abundance of virtual events at

the time OHS was promoted. The first OHS was hosted in early June, which was three months after the WHO declared a COVID-19 pandemic. Upon the onset of COVID-19, many mental health services and treatment centers closed and transitioned to providing services online. Similarly, GMHCN and the Southeast MHTTC transitioned to providing trainings and technical assistance virtually. The OHS presenter alluded to people being inundated with emails and webinar invitations during this period.

Another consideration that may have impacted attendance is the marketing strategy, as mentioned by a presenter. Recruitment and marketing strategies could be reflected upon to distinguish OHS within a saturated digital market of mental health trainings for CPS. A presenter suggested taking a more targeted marketing approach when inviting OHS attendees. When inviting participants to the OHS, the presenter suggested inviting Peer professionals specifically who work in the southeast region, rather than promoting the event to all participants in the listserv. While 84% of OHS attendees indicated their primary employment setting as mental health organization or service center, only 31% were Peer professionals. Fifty percent of participants also identified themselves as living in a state outside of the southeast region. Although this evaluation did not look at the demographics of all invited participants for OHS, it is possible that attendees from various regions and various occupations were invited to attend.

The needs assessment of CPS topics informed the topics of the four OHS. Of the four sessions, OHS #2 facilitated the most engagement compared to other sessions. The increase of engagement could have been influenced by the topic – cultural awareness, humility, and competence. Presenters also indicated OHS #2 was most impactful. The discussions were provocative, participants unmuted themselves, turned on their camera, and interacted for the entire duration of the meeting. The notes indicated that a participant and presenter shared relevant files as well. Even though OHS #1 had more attendees, OHS #2 prompted participants to interact more compared to other sessions.

The conferencing system used for this virtual OHS was Zoom. The flexibility of Zoom enhanced the opportunity for attendees to interact with one another. Zoom features enhanced engagement by offering participants multiple ways to interact. Participants shared files, and visually and audibly connected with each other and presenters.

In addition to the benefits of the conferencing system, presenters were knowledgeable about discussion segments and provided multiple opportunities to engage participants throughout the sessions. Beginning with OHS #2, presenters introduced the idea of inviting participants to turn cameras on at the beginning of sessions. Presenters were highly proficient on the topic matters as well. Not only was information verbally shared, but documents related to discussion topics were also distributed to session attendees, which assisted in the increased knowledge that participants reported from OHS.

Strengths and Limitations of Evaluation

One of the main strengths of this program evaluation is the variety of data sources. Gathering a diverse set of sources with both quantitative and qualitative data aided in triangulation, ultimately helping to strengthen the development of recommendations. For example, RR listed the location of participants, occupation, and employment setting. The RR did not, however, gather the educational level, gender, and racial identifiers of participants. Combining the GPRA report and RR strengthened the richness of data.

Similarly, combining the two post-event evaluation reports (GR, QR) provided valuable information. The benefit of the post-event evaluation is that the participants' responses were compiled and reported without any identifiers. GR included quantitative data and QR included data that was both qualitative and quantitative in nature. While the QR included open-ended comments from participants, qualitative questions yield the least control over the quality and quantity of data. Of all participants who completed the Qualtrics evaluation, not everyone responded to the open-ended questions. Of the available responses, some participants entered phrases, while others detailed their responses in full

sentences. Overall, the qualitative data increased data robustness. Qualitative participant data, which are the typed comments made by participants on the Qualtrics evaluation, provided clarity to some of the quantitative participant data. One of the questions on Qualtrics stated, *"What are two ways you can use the information from this Office Hour in your job?"* The participant comments to this question provided additional insight into what aspects of OHS was relevant to their career and influenced their professional skills. It also helped inform which topics were most impactful to attendees.

The data compiled during the OHS and the debrief with presenters were observation data. The observers noted what was shared by participants, the flow of conversations, discussion segments, interactions between attendees, and summarized highlights from each meeting. This process was not intrusive, nor did it disrupt the meeting.

While these sources retrieved rich data, feedback from presenters was slightly limited. The main source of understanding the perspective of presenters was the notes from the presenters debrief at the end of the OHS series. Input from presenters at the OHS series midpoint would have further informed this analysis.

Similarly, participant feedback limited. Among all OHS attendees, fewer than half accounted for evaluation respondents with 28% (n=11) of attendees completing GPRA and 21% (n=8) of attendees completed Qualtrics. Among the eight individuals that completed Qualtrics evaluation, fewer than half answered qualitative questions.

Lessons Learned and Future Considerations

When conducting OHS, the following considerations are recommending. Selecting proficient presenters, choosing relevant topics, renaming OHS, and receiving input from stakeholders.

I. Select Proficient Presenters

The first recommendation is to continue assigning skilled and knowledgeable presenters. In the OHS hosted by CPS, the presenters effectively led discussions on selected topics. Presenters were

prepared and organized for the sessions. This was shows by how well questions were addressed per discussion segment.

It is also recommended that presenters continue encouraging engagement among participants. Similar to this series, presenters could introduce themselves, and in turn, asking attendees to introduce themselves at the start of the OHS. During sessions, it is recommended for presenters to continue addressing participants by name. This not only identifies the participant, but also invites participant further into the conversation (Linabary, 2020; Mittleman, Briggs, & Nunumaker, 2000).

In addition to the introduction, presenters can segue into an ice breaker to further encourage participants to become familiar with one another (Linabary, 2020; Sherrod & Holland, 2021). Considering the emotional impacts of COVID-19, an ice breaker could include a brief mental health check-in. If future OHS have a larger number of attendees, the conferencing system's breakout room feature could provide a more intimate setting and time-efficient option.

Other tools such as screensharing and polls could also assist presenters in increasing interaction among attendees. After greeting attendees, presenters could share their screen for a brief, high-level overview of the meeting agenda or discussion segments. Another opportunity for presenters to share their screen would be to explain concepts or resources during sessions. If presenters choose, attendees could be granted screensharing access as well to explain relevant resources. As suggested by a CPS presenter, it is essential to fosters an OHS environment where everyone is an expert. The meeting conferencing system could aid presenters further implement the model of everyone sharing their expertise if they so choose.

II. Choose Relevant Topics

The second consideration when hosting OHS is to include topics relevant to current events and relevant to the profession of the target audience. One of the most engaging sessions was OHS #2. The topic was on cultural competency, awareness, and humility. Participants engaged the most with one

another and the presenters, compared to other sessions. Considering the increasing awareness of racial injustices in America, participants may have been inclined to ask questions and share more recent experiences surrounding race.

Similarly, the most attended session was about facilitating online mutual support groups and wellness activities. Due to the onset of COVID-19, most mental health services had shifted to telehealth services, which impacted how CPS engaged with their clients and other CPS. The timeliness of discussion on navigating technological privacy, security measures, and suggestions on facilitating virtual CPS groups were relevant matters, considering current events. Integrating relevant and current affairs when determining topics is suggested to enhance the usefulness of OHS.

Additionally, it is recommended to include participants in the topic selection process, similar to the Southeast MHTTC's strategy. Conducting a brief needs assessment to determine participants' needs, especially in moments of crisis. Developing a questionnaire that asks participants relevant trainings and resources they would find most useful. Then OHS presenters could select most popular topics identified by participants. If there are repeated discussion ideas, combining topics would be recommended to omit repetitive content. Targeted OHS helps to distinguish sessions especially when the virtual world of events is saturated. Identifying relevant topics and hosting OHS to meet the needs of CPS helps facilitate more valuable and engaged meetings (Linabary, 2020).

III. Consider Renaming "Office Hours" for CPS

When one thinks of an office hour meeting, it usually entails two groups: experts with answers and information seekers. An office hour meeting is to allow for the expert to further clarify discussion points not covered at a previous time (D'Anna, D'Arco, & Van Goethem, 2020). While there were CPS who led OHS discussions, the purpose of OHS was to also empower participants to share personal experiences on provided topics. Labeling the series as 'office hours' could be misleading to attendees. Meeting attendees could interpret the meeting to be solely led by presenters to address participants

questions. Although CPS presenters may have more access to resources or education on specific topics, the framework of peer support encourages sharing of individual experiences and mutual support. Therefore, leaving the name of OHS as is, could lessen the interaction and engagement among attendees. Further research is suggested when identifying alternate names for series.

IV. Receive Input from Stakeholders

Lastly, receiving feedback from stakeholders is highly recommended (Linabary, 2020). For this series, a needs assessment was conducted to understand the needs of participants. This refined topics for OHS. In addition to questions related to the topics, it is recommended that the organization queries the target audience's availability. Identifying their preferred meeting times could impact attendance. While it may be difficult to host sessions that accommodates all interested parties, the more information organizations receive from its target audience, the more effective the sessions could be.

After each OHS, participants completed feedback forms that asked about their gained knowledge and skills, as well as the relevance of OHS to their professional life. Additionally, a summative evaluation could have been conducted 6-months following the series. This evaluation would explore how participants applied information they received during the OHS in summer 2020. Furthermore, it would be helpful to understand if the knowledge and skills of participants were influenced by the presenters. Although the development and dissemination of the 6-month evaluation was not feasible during this evaluation, it is recommended.

Debriefing with presenters at the end of the series was highly valuable as well. They discussed the highlights and challenges of the series, as well as recommendations for future sessions. In addition to a post-series debrief with presenters, it is recommended to check-in with presenters after the first couple of sessions. In most cases, there might not be a need for major adjustment. However, presenters might have suggestions to improve the delivery of sessions after the first couple of session. Some of which may not have been considered prior to the start of OHS. A brief questionnaire could be sent to

presenters. Conducting formative and summative assessments of key OHS influencers helps ensure appropriate modifications are made and OHS objectives are met.

Conclusions

Upon the completion of virtual OHS facilitated for CPS during the COVID-19, there are suggested measures to deliver an engage participants. Virtual OHS can be used as a tool to share ideas and foster connections among mental health professionals, especially during a period of crisis. When developing OHS, consider topics relevant to the goals of participants and to current events. Presenters must be well-versed in identified topics. They must be skilled at engaging participants as well. Presenters should try to use a conferencing platform that offers participants multiple ways to engage. Receiving feedback from participants and presenters is also essential to understand areas of strength and needs for improvement. Evaluations immediately after the first session or at the mid-point of series can inform strengths and areas of improvement. With useful technology, targeted topic discussions, and skilled presenters, OHS can inform CPS who desire to connect with our mental health professionals and inform their professional practice.

APPENDIX A: IRB Memorandum

To: Emory Research Community

From: Emory IRB Office

Date: July 11, 2019

RE: Documentation for projects that do not require IRB review

Starting on July 15, 2019, the Emory IRB will create a new form to help investigators to determine if a study requires IRB review. In order to document this determination, the research team is invited to use our Non-Human Subjects Research Determination Electronic Form. This form will indicate if the study needs IRB submission or not. If not, the study team is expected to keep a copy of the form responses as an attestation of the researchers' intent for the project. The responses from the form and this memo can be provided to others as needed.

If you have any questions, please contact our office.

APPENDIX B: Data Source Examples

Data Source I: Registration Page Fields Example

Name:	
Email:	
State/Province:	
Organization:	
Job Title:	
Please enter the question you would like to ask the expert:	
If you have an additional question for the expert, please enter it here.	
If you have an additional question for the expert, please enter it here.	

Data Source II: Observation Notes Template Example

Southeast (HHS Region 4)
MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

Office Hour Observation Guide

Facilitators:	
Name of Office Hour:	
Date of Office Hour:	
Duration of Office Hour:	
Number of Participants:	
Note taker:	

Topics

Note to observer: To create another topic table, copy/paste the table below.

Topic:	
Topic source:	Pulled from submitted questions Question submitted in chat Facilitator raised the topic Participant asked question
Duration of discussion:	
Interaction between facilitator and participants	Facilitator talking Interaction between facilitator and participants Interaction between participants
Notes (topics discussed, interactions, materials shared, etc.):	

Training Delivery

	Yes	Somewhat	No	N/A	Comments
Organization					
Clear statement of purpose.					
Smooth transitions between topics and/or activities.					
Duration of office hour session was sufficient.					
Implementation					
Office Hour format set up supported learning.					
Provided opportunities for participants to actively participate.					

Additional Observations

After the training, record additional observations or reflections (e.g., strengths, areas for improvement).

Data Source III: Participant Feedback – GPRA Questionnaire Example

OMB No. 0930-0383

Expiration Date: 5/31/2022

Southeast (HHS Region 4)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Thank you for attending [Event Name] on [Date]

Public reporting burden for this collection of information is estimated to average 10 minutes per response to complete this questionnaire. Send comments regarding this burden estimate or any other aspect of this collection of information to the Substance Abuse and Mental Health Services Administration (SAMHSA) Reports Clearance Officer, Room 15E57B, 5600 Fishers Lane, Rockville, MD 20857. An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The control number for this project is 0930-0383.

Please print clearly in the boxes below using blue or black ink. Print only one number or letter in each square. Upper case letters only.

First letter in mother's first name: ☐ First letter in mother's maiden name: ☐

First digit of Social Security number: ☐ Last digit of Social Security number: ☐

For the following questions, please circle your response.

1. The information from this event has benefited my professional development and/or practice.

a. Strongly Agree

b. Agree

c. Neutral

d. Disagree

e. Strongly Disagree

2. I have used the information gained from this event to change my practice.

a. Strongly Agree

b. Agree

c. Neutral

d. Disagree

e. Strongly Disagree

3. I expect to continue using the information from this event in my future work.

a. Strongly Agree

b. Agree

c. Neutral

d. Disagree

e. Strongly Disagree

4. I have shared the information gained from this event with my colleagues.

a. Yes

b. No

5. What about the event was most useful in supporting your work responsibilities?

6. What has improved in your organization/practice because of this event?

7. How can the TTC Network improve its events?

8. If you made a change to your practice as a result of this training, please describe briefly.

9. What topics would you like to see offered by the TTC?

10. What learning format would you suggest for the trainings you would like to see offered?

Personal Code (please use uppercase letters):

First letter in mother's first name: ☐

First letter in mother's maiden name: ☐

First digit of Social Security number: ☐

Last digit of Social Security number: ☐

Thank you for completing our survey.

Data Source III: Participant Feedback – Qualtrics Questionnaire Example

Default Question Block

Thank you for participating in our **"Peer Services Consultation Office Hour"** series.
We value your input on this event. Please complete the additional questions below.

Please select the Peer Services Office Hour you attended.

Please select your state:

Please indicate your **level of AGREEMENT** with each of the statements below.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The Office Hour enhanced my knowledge in this topic area.	○	○	○	○	○
2. The Office Hour enhanced my skills in this topic area.	○	○	○	○	○
3. The Office Hour was relevant to my career.	○	○	○	○	○
4. The Office Hour was well organized.	○	○	○	○	○
5. My questions about the office hour topic were answered.	○	○	○	○	○

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
6. The facilitators were knowledgeable about the subject matter.	○	○	○	○	○
7. The facilitators were well prepared for the discussion.	○	○	○	○	○
8. The facilitators were receptive to participant comments and questions.	○	○	○	○	○

Please choose the response that represents how you feel about the structure of the Office Hour.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
9. I would prefer the facilitator(s) provide more information	○	○	○	○	○
10. I felt there was a good balance between facilitator-led information and time for questions and discussion.	○	○	○	○	○
11. I would prefer more time for questions and discussion.	○	○	○	○	○

12. How did you hear about the **Peer Services Office Hours**?

- ○ Southeast MHTTC listserv
- ○ Southeast MHTTC website
- ○ State Mental Health Department
- ○ Supervisor
- ○ Colleague
- ○ Social media
- ○ Other (please specify)

13. What about the Office Hour was most useful in supporting your work responsibilities?

14. How can the Southeast MHTTC improve its Peer Services Office Hours?

15. What are two ways that you can use the information from this Office Hour in your job?

1)

2)

Thank you for taking the time to provide your feedback!

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