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Recovery-Oriented Medicaid Services for Adults with Severe Mental Illness Part II

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June 2007

This publication was produced by
The Louis de la Parte
Florida Mental Health Institute

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Louis de la Parte Florida Mental Health Institute Publication
Agency for Health Care Administration (AHCA) series, 220-91,
Tampa, Florida

Recommended citation for the report:
Winarski, J, Thomas, G, and DeLuca, N, (2007). *Recovery-Oriented Medicaid Services for Adults with Severe Mental Illness – Part II.* Tampa, FL: Louis de la Parte Florida Mental Health Institute. University of South Florida.

Submitted to the Florida Agency for Health Care Administration under contract MED049.

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Executive Summary

Background

Florida's Medicaid authority recently developed and implemented new Medicaid services intended to promote the recovery and rehabilitation of adults with severe mental illnesses. These services are described in the Agency for Health Care Administration (AHCA) Community Behavioral Health Services and Limitations Handbook (AHCA Handbook) and are designed to replace other less rehabilitative approaches (Agency for Health Care Administration, 2004). Administrative service codes for the new services went into effect in October 2004.

As part of a study of the services described in the AHCA Handbook, the authors examined the implementation of psychosocial rehabilitation and clubhouse services (Winarsk1, Thomas, Dhont, & Ort, 2006). The study concluded that the AHCA Handbook service descriptions only provide general parameters for service delivery. Standards/guidelines are needed to provide a roadmap for effective program implementation as well as a foundation for program evaluation. In addition, the study concluded that the shift in some AHCA areas from fee-for-service financing to capitated systems, represented by Prepaid Mental Health Plans (PMHPs) and Health Maintenance Organizations (HMOs), has important implications for the delivery of rehabilitative recovery-oriented services.

Methods to operationalize recovery principles into objective practices and standards that can be used as a basis for evaluation are beginning to emerge (Anthony, 2000; Arns, Rogers, Cook, & Mowbray, 2001; Ridgway, Press, Ratzlaff, Davidson, & Rapp, 2003; Onken, Dumont, Ridgway, Dornan, & Ralph, 2004; O'Connell Tonodora, Croog, Evans, & Davidson, 2005). However, traditional models for financing mental health services are not always compatible with the structures and processes for delivering recovery-oriented services. As Florida makes the transition to prepaid plans and HMOs for financing public mental health service delivery, there is a clear need to define recovery; establish a baseline to guide service delivery, finance planning, and evaluation, and to gauge future progress.

Methods

This study aimed to determine the level of readiness in Florida's mental health system for implementation of recovery-oriented programs and services. First, the authors collected and reviewed recovery literature and other relevant publications (e.g., recovery-oriented service guidelines from other states). Next, interviews were conducted with representatives from the mental health authority in six different states that are recognized for their exemplary efforts to implement recovery-oriented services. Using this combination of source material, a framework for assessing recovery readiness in Florida was created and then

presented in a focus group comprised of a variety of local stakeholders, including consumers, service provider agencies, and managed care organizations. Based on focus group feedback, the framework was finalized into a survey instrument that was grounded in literature and experience of other states, while also reflecting the unique concerns and perspectives of local stakeholders. The final survey instrument addressed 5 key areas: (1) translating the recovery vision into reality; (2) guidelines and (3) financing for recovery-oriented services; (4) factors related to implementation; and (5) recovery-oriented system indicators.

After the survey instrument was finalized, it was used to conduct interviews with ten service provider agency representatives, three health maintenance organizations, and two prepaid mental health plans, sampling across the geographical and cultural backgrounds across the state. Data collected during these interviews were then reviewed for prominent themes within the five domains. Findings from the review of themes across all participants revealed the level of readiness for recovery-oriented services, while also suggesting a set of recommendations to enhance readiness for change in the state of Florida.

Results/Discussion

Surveys for service provider agencies were developed to provide a benchmark of Florida's progress in its mental health system transformation. The results provide information for developing system and program improvement strategies. We focused our examination on five major domains relevant to assessment of readiness for recovery-oriented services: recovery vision, guidelines, financing, implementation factors, and system indicators of recovery-oriented services.

1. Translating the Vision of Recovery to Reality

The results from surveys with service provider agencies and MCOs in Florida, and representatives from mental health authorities in other states suggest a growing recognition of the importance of the vision of recovery as a focal point for systems and program change. Common definitions for the recovery vision are also emerging but states face challenges of providing focused leadership and in facilitating a long term process of consensus building that is required to translate the vision into policies and practices.

The responses from both the service provider agencies and the MCOs demonstrated strong support for the concept of recovery. However, deep concerns were expressed about the lack of additional funding for recovery services and the lack of consistent state leadership at the state and federal levels. There is also concern that by focusing only on rhetoric, the principles of recovery can be used primarily as a means to reduce services, particularly in environments where there is pressure to control costs. Buy-in for the vision of recovery is clearly compromised if key stakeholders do not believe that it will be supported by policies and funding.

The agencies selected a range of models/practices used to support the delivery of recovery oriented services, including, the Copeland Center's Wellness and Recovery Action Plan (WRAP), Certified (ICCD) Clubhouse, Boston University's

approach to Psychiatric Rehabilitation, the Suncoast Region's Guide to Role Recovery for Behavioral Health, Illness Management and Recovery Toolkit (SAMHSA), and Solutions for Wellness Program (Eli Lilly).

2. Guidelines Supporting Recovery Oriented Services

Florida is at critical juncture in its process of mental health transformation. Our findings from conversations with in-state service provider agencies and MCOs, and representatives from other states demonstrate a clear need to develop recovery-oriented services guidelines. Without guidelines to support the implementation of recovery oriented services, it seems unlikely that service providers can maintain the momentum that has been achieved in the mental health transformation in making the transition to a recovery orientation.

Respondents from Florida provided valuable input on a structure and process for developing guidelines in state. However, gaps in the mental health system infrastructure present significant obstacles to developing statewide implementation of guidelines. A statewide approach to planning that includes both a top-down and bottom-up strategy for implementing guidelines appears to be the most viable approach in Florida's system of care. Key stakeholders in Florida's mental health system will not fully buy-in to a process for developing and implementing guidelines for recovery oriented services if they perceive a lack of commitment from state leaders.

3. Financing Recovery Oriented Services

Medicaid is the most critical source of public funding for recovery-oriented services in Florida, though funds from the state mental health authority (DCF) are an important complement. The Rehabilitation Option remains as the primary mechanism through which the state Medicaid Plan defines and funds these services. CMS clarifications about application of the Rehabilitation Option in the 2007 budget and the Home and Community-Based Services (HCBS) Plan Option may offer alternatives to improve and expand recovery-oriented services in the near future and should be fully explored. The cost benefits of shifting services from costly acute interventions to recovery-oriented services that focus on promoting healthy functioning in the community should be considered in any analysis of cost.

To best meet the challenge of funding recovery-oriented services in the current environment, the state mental health system needs a strategic plan that places financing within the context of goals and objectives and that includes representation from all of the key funding agencies. It should articulate a clear vision of recovery – a common language, establish service priorities based on an assessment of need and available funding resources, provide definitions of recovery-oriented services that can best match the requirements of funding sources, and establish a plan for monitoring and feedback.

The shift in some AHCA areas from fee-for-service financing to capitiated systems, represented by Prepaid Mental Health Plan (PMHPs) and Health Maintenance Organizations (HMOs) provides an important opportunity to

create greater flexibility in delivering recovery-oriented services. Managed care contracts should include expectations about achieving recovery-oriented outcomes, and should be developed with input from consumers.

CMS is encouraging states to provide for important beneficiary protections such as person-centered planning (Reed & Terrell, 2007). AHCA support for these core services is critical to authentic mental health transformation. Florida's self-directed care program is a prime example of promising new models that should be supported.

4. Successful Implementation of Recovery Oriented Services

Broad review of program implementation efforts demonstrates that models for service improvement are not sufficient to ensure its successful implementation. Implementation is a complex process that requires alignment of many factors at the practitioner, organization, and system level in order to achieve successful outcomes.

Using the framework offered by the National Implementation Research Network (NIRN; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005), mental health service providers were assessed on each of seven core implementation components that have been found to be critical for program success and sustainability. These core components (staff selection, preservice and inservice training, ongoing consultation and coaching, staff and program evaluation, facilitative administrative support, and systems interventions) were generally not incorporated into each agency's plan for its recovery-oriented services, though there was variability on each component and across the sample.

Each of the provider agencies have arranged for staff to get exposure to the basic principles and practices of recovery through attendance at training conferences. Some agency staff participated in training on specific models such as Certified Peer Specialists, Boston University's Psychiatric Rehabilitation model, and the Comprehensive, Continuous, Integrated System of Care (CCISC) Model for co-occurring mental health and substance use disorders. Training has been conducted on mostly on an ad-hoc basis and not as part of an implementation plan.

None of the agencies had formal policies or procedures to support coaching, supervision, or on-going support of staff to implement recovery-oriented services. Specific activities of note include working groups to promote recovery-oriented practices within the agency, including recovery principles and practices as part of employee orientation and in performance evaluations, and using a competency checklist for new employees that included questions about the principles of recovery.

There was only a very limited use of data related to recovery oriented services to inform administrative and clinical decision making. Some of the agencies implement consumer satisfaction surveys. Some programs are beginning to use the Recovery Oriented System Indicators (ROSI) and the Recovery Self Assessment (RSA) as a framework to assist with implementing and monitoring services.

Across the sample, there was little evidence that the core components for successful implementation were systematically integrated into agency program

planning, suggesting a clear need for attention to these key factors that facilitate successful implementation efforts.

5. Indicators of Successful Recovery-Oriented Services

To evaluate the degree to which existing services are congruent with a recovery orientation, a number of measures of recovery-oriented services were reviewed and the ROSI (Dumont, et al., 2006) was selected for its robust and well-grounded model of system-level recovery indicators. In the provider survey, each participating program was briefly evaluated on the following domains taken from the ROSI administrative-data profile: peer support, choice, staffing, and nature of services (including agency culture, coercion, and access).

Peer Support and Participation: Consumers participated in agency functions mostly as part of traditional mechanisms: satisfaction surveys, advisory groups, and consultation in areas that are identified as requiring consumer input. Consumers are at best serving in an advisory capacity but there is little evidence of equal partnership.

Choice: Providers reported a broadened service array to provide more choices, with a growing focus on consumer goals. However, choice was mostly limited to programs within the agency. In most cases, assistance in developing advanced directives had to be initiated by consumers.

Involuntary Treatment: Policies and procedures at service provider agencies focused mostly on how to deal with a crisis rather than preventing one. There were no plans for alternative strategies developed in collaboration with consumers to help reduce the need for involuntary treatment.

Access to Services: Service provider agencies have made a range of services available. Progress has been made in developing jail diversion programs and in providing integrated services for persons with co-occurring mental health and substance sue disorders. However, there is a need for more of these services, especially in rural areas, and many consumers do not have access because of lack transportation. There was no evidence of service provider agencies dealing systemically with trauma unless policies and services were part of a crisis or trauma care program.

Self Care: Service provider agencies utilize some program tools to help consumers take a greater role in managing illness, but there is no evidence that implementation is supported by supervision/coaching, or that activities are monitored. There is no way to know if consumers are meaningfully participating in and benefiting from these activities.

Treatment Planning: Person-centered approaches appear to occur mostly as part of specific recovery oriented activities. Treatment plans and other service activities appear to retain a medical focus. The consumer's participation in planning mostly involves providing a signature to the plan at designated periods. There was generally acknowledgement of the need to enhance staff buy-in while implementing person-centered planning processes across all programs.

Community Involvement: With few exceptions, there was little emphasis on helping consumers become more involved in roles outside of the mental health system.

Recommendations

Analysis of survey findings produced the following recommendations in each of the key areas assessed:

Vision

Require service provider agencies to include a definition of recovery-oriented services in their mission statements.

Guidelines

Convene a workgroup of key stakeholders in a structured process to develop recovery-oriented services guidelines. The overall goal should be to create a set of voluntary (non-mandatory) recovery service guidelines that will provide a frame of reference for future service implementation, monitoring/evaluation, research, and technical assistance/training.

Financing

Develop a strategic plan that places financing within the context of goals and objectives and that includes representation from all of the key funding agencies (e.g., AHCA and DCF).

Include three key recovery services in the state Medicaid plan (may be reimbursable through either the Rehabilitation Option or the HCBS Plan Option): Peer Specialists, Person Centered Planning and Self-Directed Care.

Require MCOs to use a portion of their administrative funds to support the development of recovery-oriented services.

Require MCOs to provide incentives for service provider agencies that develop plans to achieve recovery-oriented outcomes.

Implementation

Create a manual that provides an orientation to the principles and practices of recovery oriented services. In addition, it should provide a basic guide that describes the need to provide clinical and administrative support, as well as a process for monitoring and evaluation.

Implement pilot programs that will implement, monitor, and evaluate practices described in the recovery-orientation manual.

Require Medicaid behavioral health providers to increase consumer participation by supporting the following practices: include consumers on agency boards; involve consumers in the hiring and training of staff; describe how consumers, families, and staff will work collaboratively to change one or more of the agency's policies or programs; document strategies employed to reach out to consumers who have had negative experiences with the mental health system.

Indicators

Establish a subcommittee of the guidelines work group to select recovery-oriented indicators that can be used to guide system and program implementation.

Integrate recovery-oriented indicators into standard monitoring and quality assurance mechanisms.

Conclusions

It has been four years since the publication of Achieving the Promise, the report from President Bush's New Freedom Commission recommending the transformation of the nation's mental health system of care (New Freedom Commission on Mental health, 2003). Florida, like most states throughout the nation has taken steps to transform its system of care consistent with a vision of recovery. These steps have included a variety of planning and implementation activities taking place at the state and local levels, but they have not been guided by a common vision or an integrated plan for implementation and financing.

The psychosocial and rehabilitative clubhouse services supported by AHCA funds have been an important part of the state's mental health transformation efforts. The first part of this study focused on the delivery of these services. It documented a need for guidance to assist service provider agencies and consumers in assuming the new roles and responsibilities of recovery-oriented services. The second phase described in this report, examined the readiness of Florida's mental health system to move toward a recovery-orientation and organized findings in five critical domains (Vision, Guidelines, Financing, Implementation, and Indicators).

Translating the Vision of Recovery to Reality:

Florida is at a critical juncture in its mental health transformation. Without state level leadership to promote the vision of recovery and a commitment to support policies and practices consistent with the vision, much of the momentum gained from recent initiatives will be lost. Individual service provider agencies may continue to provide some recovery-oriented programs. However, without state level leadership and a plan for coordination, the opportunity to implement a state wide strategy for authentic system transformation will have passed.

Guidelines Supporting Recovery-Oriented Services:

Guidelines are the critical next step to translating the vision and principles of recovery into effective systems and programs. A statewide approach to planning that includes both a top-down and bottom-up strategy for implementing guidelines appears to be the most viable for Florida's system. To ensure success, guidelines need to develop strategies that acknowledge the system's strengths, as well as the limitations of the current mental health system infrastructure (e.g., issues related to staffing, funding, licensure, accreditation, data collection, and quality management).

Financing Recovery-Oriented Services:

There are opportunities to expand recovery-oriented services that are reimbursable under current finance structures. All of the options provided through CMS should be fully explored. In addition, the two key funding sources for public mental health services, AHCA and DCF should coordinate resources as part of a strategic plan. The potential for managed care organizations to provide programmatic structures and incentives to support recovery-oriented services needs to be fully utilized. The cost benefits of shifting services from costly acute interventions to recovery-oriented services that focus on promoting healthy functioning in the community should also be considered in any analysis of cost.

Successful Implementation of Recovery Oriented Services:

The successful implementation of recovery-oriented services requires a commitment to provide administrative support, training, supervision, and technical support over the long term. In addition, these core components need to be linked to a process of program monitoring, evaluation, and development. A plan for implementing recovery-oriented services that includes these core components should be integrated into program/practice guidelines.

Indicators of Successful Recovery-Oriented Services:

Measurement is a critical component of programs and systems that support effective implementation of recovery-oriented services. Findings from our survey provide important baseline information about the degree to which services in Florida's mental health system reflect a recovery-orientation. These findings should be applied as part of future planning and program development. In many ways, the findings from this survey are consistent with the first phase of the study that found both consumers and staff expressing struggles with the emphasis on greater consumer self-direction that is central to the implementation of recovery-oriented programs. All of the indicators reflect the degree to which new and more equal partnerships are forming between consumers and their care givers. System wide implementation of indicators that reflect a recovery-orientation is critical to charting the course for system improvement and authentic mental health transformation.

Background

The vision of recovery for people living with serious mental illnesses is fundamentally one of hope: hope that disturbing symptoms can be overcome; hope to become a meaningful participant in community; hope in the possibility of a life fully lived. In the recovery vision, the integrity of the person is paramount; mental illnesses and the symptoms associated with them pose challenges to the person but they do not define the person (Anthony, 1991; Degan, 1988; New Freedom Commission on Mental Health, 2003).

Florida's Medicaid authority recently developed and implemented new Medicaid services intended to promote the recovery and rehabilitation of adults with severe mental illnesses. These services are described in the Agency for Health Care Administration (AHCA) Community Behavioral Health Services and Limitations Handbook (AHCA Handbook) and are designed to replace other less rehabilitative approaches (Agency for Health Care Administration, 2004). Administrative service codes for the new services went into effect in October 2004.

As part of a study of the services described in the AHCA Handbook, the implementation of psychosocial rehabilitation and clubhouse services was investigated (Winarski, Thomas, Dhont, & Ort, 2006). The study described programs that were in transition, with both consumers and staff defining new roles and responsibilities. Participants identified a broad range of perceptions about the concept of recovery and how recovery-oriented services should be delivered. The study concluded that service descriptions such as those provided in the AHCA Handbook only provide general parameters for service delivery. Standards or guidelines are needed to provide a roadmap for effective program implementation as well as a foundation for program evaluation.

In addition, the study concluded that the shift in some AHCA areas from fee-for-service financing to capitated systems, represented by Prepaid Mental Health Plans (PMHPs) and Health Maintenance Organizations (HMOs), has important implications for the delivery of rehabilitative recovery-oriented services. In fee-for-service financing, there is a focus on discrete units of care defined by medical necessity. Capitated financing, on the other hand, can provide more flexibility while also being more compatible with the holistic approaches of recovery-oriented services (Day, 2006; Forquer & Knight, 2001). The definition of rehabilitative recovery-oriented services in HMO contracts is a critical determinant for how these services are delivered.

The implementation of recovery-oriented services is consistent with changes in public mental health policy taking place at both the state and national levels. These changes are the result of advances in our understanding about the course and treatment of psychiatric disorders. Longitudinal research has demonstrated that recovery is a reality for as many as two-thirds of individuals with serious mental illnesses (Harding, Zubin, & Strauss, 1987; Harding, Brooks, Ashikaga, Strauss, & Breier, 1987a). President Bush's New Freedom Commission also concluded that recovery from mental illness is now a "real possibility" and

identified recovery as the goal of a transformed system. The report recommends the transformation of the nation's approach to mental health care to ensure that our systems, programs, and services actively facilitate the process of recovery (New Freedom Commission on Mental Health, 2003).

Consistent with the findings of the President's Commission, states throughout the nation have initiated a process of improving the mental health system. Florida's Secretary for the Department of Children and Families (DCF) has convened a statewide interagency workgroup to spearhead a process for transforming the state's public mental health system into one that emphasizes recovery. These efforts have been guided by an emerging set of recovery principles (Substance Abuse and Mental Health Services Administration, 2005; NASMHPD/NTAC e-Report, 2004; Ralph, 2000; Jacobson & Greenley, 2001). Methods to operationalize these principles into practices and standards that can be used as a basis for evaluation are beginning to emerge (Anthony, 2000; Arns, Rogers, Cook, & Mowbray, 2001; Ridgway, Press, Ratzlaff, Davidson, & Rapp, 2003; Onken, Dumont, Ridgway, Dornan, & Ralph, 2004; O'Connell Tonodora, Croog, Evans, & Davidson, 2005). However, traditional models for financing mental health services are not always compatible with the structures and processes for delivering recovery-oriented services. As Florida makes the transition to prepaid plans and HMOs for financing public mental health service delivery, there is a clear need to define recovery; establish a baseline to guide service delivery, finance planning, and evaluation, and to gauge future progress.

Methods

The overall goal of this study was to determine the level of readiness in Florida's Mental Health System to implement recovery-oriented services, with the following specific objectives:

- Define core elements of recovery-oriented services that translate the vision of recovery into reality in the mental health system.
- Recommend a set of recovery standards (i.e., criteria) against which to measure the implementation of recovery-oriented services
- Identify financing structures that are compatible with recovery-oriented services
- Identify strategies to more effectively implement recovery-oriented services.

The study used literature review, key informant interviews, and focus group findings to construct an interview instrument that was used to elicit, from various stakeholder perspectives, the current state of readiness within Florida to implement recovery-oriented services.

The study followed a six-step method:

Step 1: Review recovery literature with special emphasis on emerging system/program standards and finance mechanisms

The authors reviewed the literature on emerging system/program standards, finance mechanisms, and outcome indicators that support recovery-oriented services. The review included professional and consumer publications, as well as documents produced as part of state-level transformation activities being conducted throughout the nation.

Step 2: Survey representatives from mental health authorities in states that represent exemplary approaches for supporting recovery-oriented services

The authors contacted representatives from mental health authorities in 6 states (Connecticut, New Mexico, Ohio, Oklahoma, Pennsylvania, and Washington) that were identified by the Substance Abuse and Mental Health Services Administration (SAMHSA) as implementing promising mental health system transformation initiatives (Substance Abuse and Mental Health Services Administration, 2005). The authors documented approaches implemented in these states that support recovery-oriented services.

Step 3: Conduct focus group with key stakeholders to provide input on the development of the study's interview instrument

The literature review and interviews with exemplary state mental health authorities provided a foundational understanding of key factors in implementing recovery-oriented services. To increase the relevance specifically to the Florida mental health service system, the authors conducted a focus group to solicit input on the development of the interview instruments that would be used in

the remainder of the current study of baseline readiness for implementation of recovery services in Florida. Focus group participants (N=17) represented the following stakeholder groups:

- HMO/PMHP (3)
- AHCA (1)
- Direct service providers (administrators and clinicians) (8)
- Florida mental health transformation planning group (1)
- Florida Peer Network (1)
- Department of Children and Families (DCF) (3)

During the focus group, all participants were invited to provide their opinions and recommendations regarding the findings from Steps 1 and 2 in a discussion facilitated by the first author. Proceedings were recorded and transcribed. The authors then consulted these data during the next step (instrument construction) to help connect the theoretical and exemplar information to the practical, firsthand experiences of local stakeholders.

Step 4: Construct interview instruments that will assist in determining the degree to which recovery standards are being implemented

Information gathered in Steps 1-3 was synthesized as part of the development of the interview instruments. Two instruments were created, one to be used with managed care organizations and the other targeted toward direct service providers. Both instruments encompassed the major domains believed to be necessary for successful program operation, including administration, financing, program development/planning, supervision, implementation, and monitoring.

Step 5: Conduct interviews with key stakeholders

Using the instruments developed in Step 4, we interviewed representatives from managed care organizations and prepaid mental healthcare plans (N = 5), as well as direct service providers (N = 10) to collect baseline data on readiness for recovery service implementation across the state of Florida. Interviews were conducted in person and telephonically, and focused on policies, procedures, program development/operations, and clinical interventions.

The following organizations participated:

- HMOs
  - Health Ease/Staywell (parent WellCare) of Tampa
  - AmeriGroup of Tampa
  - United Health Care of Sunrise
- PMHPs
  - Access Behavioral Health, AHCA Area 1
  - Florida Health Partners, AHCA Area 6

- Service Provider Agencies
  - Fellowship House, South Miami
  - Henderson Mental Health, Fort Lauderdale
  - Lakeside Behavioral Health Care, Orlando
  - Lee Mental Health, Fort Myers
  - Lakeview, Pensacola
  - Mental Health Care, Inc., Tampa
  - New Horizons of the Treasure Coast, Inc., Fort Pierce
  - Mental Health Resource Center, Jacksonville
  - Peace River Center, Bartow
  - Suncoast Center for Community Mental Health, Inc., St. Petersburg

The authors contacted representatives from each of these organizations to describe the project and solicit their participation. Once they agreed to participate, an interview time was arranged. Each interview was recorded and transcribed. Interviews typically lasted 1 – 2 hours.

Step 6: Analysis plan

The authors reviewed transcripts and their personal notes from the interview data collected in Step 5, extracting themes in each of 5 domains:

- Recovery Vision
- Guidelines
- Financing
- Implementation Factors
- System indicators of Recovery-Oriented Services

Once data were reviewed, each author provided a written summary of themes for the interviews he or she personally conducted. Authors met to discuss findings, identify commonalities, and to aggregate data from individual interview thematic summaries. The lead author collected all summaries and made the final synthesis of thematic summaries into the current framework, presented in the following section.

Results/Discussion

Based on the steps outlined in the methods section, the authors identified five major domains relevant to assessment of readiness for recovery-oriented services:

- Recovery vision
- Guidelines
- Financing
- Implementation factors
- System indicators of recovery-oriented services

These domains were used as the organizing framework when collecting data from survey participants as well as in its analysis. In this section, findings and implications for each domain are given, preceded by a brief rationale for its importance as supported by the literature review. Recommendations follow at the end of the section.

Domain 1. Translating the Vision of Recovery to Reality

Importance of the Recovery Vision

The hopeful and empowering vision of recovery is, unfortunately, contrary to common assumptions that have shaped mental health policy and practice for the past half century. According to these assumptions, mental illnesses follow a course of long-term deterioration in symptoms and functioning that inevitably limit meaningful participation in community life and lead to reduced expectations about the potential of persons with mental illnesses. Little hope was offered that the person could ever achieve a vital and satisfying life. Consumers of mental health services often felt diminished and demoralized by the very system designed to help them (Clay, 2005; Degan, 1988).

The vision of recovery for people with mental illnesses is important because it reflects our most current understanding about the nature and course of mental illnesses and because it allows us to develop policies and practices with the potential of being truly helpful (Harding, Zubin, & Strauss, 1987; Harding et. al., 1987a;). At its heart, the vision of recovery is about consumers having full participation at all levels of the mental health system, working as partners, and sharing both power and responsibility (Jacobson and Curtis, 2000; Mercer, 2006; Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). The role of recovery-oriented systems of care is not to judge who will and will not recover, but to ensure that we provide long term supportive relationships to those who enter our programs and systems (Degan, 1996b).

Moving from more traditional and limiting views of mental illness to a recovery vision requires clear articulation and supportive policies and practices, commonly referred to as mental health system transformation (New Freedom Commission on Mental Health, 2003). In a report providing guidance to State Mental Health Authorities, the National Association of State Mental Health Program Directors (NASMHPD) emphasized the importance of providing

leadership in developing a shared vision of recovery. In this same report, William Anthony, Executive Director for Boston University's Center for Psychiatric Rehabilitation identified statewide leadership as "the one variable that was within everyone's control but that if poorly implemented, becomes an impossible obstacle for statewide recovery initiatives" (NASMHPD/NTAC e-Report on Recovery, 2004). Defining a shared vision of recovery presents challenges for state leaders because of the need to incorporate diverse viewpoints into clear statements that can both inspire and provide the foundation for effective policies and practices (Jacobson & Curtis, 2000, Anthony 2003). State leadership in achieving buy-in for the vision of recovery is the critical first step to making it a reality (Ashcraft & Anthony, 2005; Bishop, A. & Dougherty, R. 2005).

Findings from State Surveys

The six states that participated in our survey described a long-term process that involved a change in culture as well as in systems and programs. Each state initiated a process for establishing group consensus: the use of focus groups, interviews with key stakeholders, and the development of working groups with special committees to address particular issues. These activities are consistent with those taking place as part of Florida's mental health transformation. In all cases, building consensus presented numerous challenges. Ohio and Pennsylvania described challenges with getting buy-in in county-based mental health systems, where participants in each county typically bring different perspectives. In some cases, key stakeholders did not participate in the process. In Connecticut, the representatives from state offices had meetings with CEOs and medical directors from service provider agencies and described difficulties with getting buy-in, particularly from the medical directors. New Mexico expressed concern that though service providers may verbally express support for recovery, they were still not confident that they had achieved buy-in.

Establishing a common definition of recovery had important implications for how each of the states translated the vision of recovery into policies and services. The Pennsylvania transformation plan describes the importance of understanding how the recovery vision cuts across all services: "At its core, recovery is not a new service tacked on to the array of more traditional mental healthcare programs...recovery is about fundamentally doing differently those things that we do every day" (Pennsylvania Office of Mental Health and Substance Abuse, 2005). Connecticut initiated a consumer-lead process to develop a set of guiding principles and values to inform the development of recovery standards. They describe recovery-oriented services as helping people achieve a meaningful life instead of simply eliminating symptoms (Davidson, et.al. 2005).

Florida Survey Findings

Service Provider Agencies

The survey of service provider agencies focused on how agencies defined recovery and whether recovery was part of the agency's mission. The survey also explored perceptions about the potential for improvement in the quality of life for consumers.

Each of the service provider agencies have had some exposure to recovery definitions through presentations and trainings provided as part of state wide mental health transformation activities and/or local and regional recovery conferences. Agencies described a broad range of definitions and most reflected concepts that have been described in both consumer and professional literature: a focus on personally valued goals, expecting people to get better, attending to the challenges of living successfully in community, offering consumers a choice from among a range of alternative services and supports, giving consumers more control over the treatment planning process, and creating partnerships among consumers and staff. One agency talked about creating a community for the people they serve.

Despite reporting a general understanding of recovery, most participants expressed some uncertainty about how they would know when they were providing recovery-oriented services. This lack of certainty was coupled with concerns about whether agencies would receive adequate reimbursement to make recovery-oriented services financially viable.

Managed Care Organizations (MCOs)

Each of the five MCOs was able to provide a clear description of how recovery services are different from other mental health services. Descriptions were consistent with professional and consumer literature, including an emphasis on consumer choice, the focus on personally important goals, the importance of role recovery, and the development of equal partnerships among consumers and caregivers. Each MCO described recovery-oriented services as being consistent with the mission and values of their organizations, emphasizing the overall well-being and functioning of consumers.

Impressions of Findings

The results from surveys with service provider agencies and MCOs in Florida, and representatives from mental health authorities in other states suggest a growing recognition of the importance of the vision of recovery as a focal point for systems and program change. Common definitions for the recovery vision are also emerging, but translating the vision to policies and practices requires strong/focused leadership and involves a long term process of consensus building. These efforts are critical to ensuring that transformation to a recovery orientation is authentic (Davidson, et. al., 2005; Davidson, L. et. al., 2006).

The responses from both the service provider agencies and the MCOs demonstrated strong support for the concept of recovery and the emergence of a common definition that is consistent with that found in the 2003 New Freedom commission report. However, consumer-self direction and promoting consumer independence from mental health services were important concepts conspicuously absent from some of the responses. Service providers expressed belief that recovery-oriented services will improve consumers' lives and most also believed that these services will reduce acute care costs. These opinions suggest that there is some hope that positive outcomes will be achieved, a critical step in realizing the vision of recovery.

Though there was strong support for the idea of recovery, the lack of additional funding for recovery services and lack of consistent state leadership were of deep concern to many participants. There is also concern that by focusing only on rhetoric, the principles of recovery will be used primarily as a means to reduce services; particularly in environments where there is pressure to control costs. Service provider and MCO buy-in is clearly compromised if they do not believe that recovery services will be supported by policies and funding.

Domain 2. Guidelines Supporting Recovery Oriented Services

Importance of Guidelines

Mental health system transformation and the vision of recovery represent a significant cultural shift in service delivery (Davidson, et. al., 2005). They have profound implications for how we plan, develop, manage, and fund mental health services. The vision of recovery can not be realized unless we begin to establish frameworks to guide our thinking and actions. Vision statements taken alone can sometimes lead to existing services simply being renamed (Jacobson & Curtis, 2000).

The first phase of this study described Florida's psychosocial programs in a process of transition, with both consumers and staff defining new roles and responsibilities (Winarski, et. al., 2006). This transition in roles is fundamental to cultural change and system transformation. AHCA's administrative service codes, though essential for defining services, do not sufficiently support the significant transitions to a recovery-oreinted system (Agency for Health Care Administration, 2004); therefore, the creation of formal guidelines emerges as a critical next step to translating the vision, principles, and basic definitions of recovery into effective systems and programs.

Guidelines provide a structure and a process to help stakeholders in designing systems that are truly responsive to the needs of mental health consumers. They also provide a systematic way of thinking about quality improvement and management of recovery-oriented services (Sowers, 2005). In addition, guidelines can provide a stimulus for creative ideas and a reference point for service provider agencies in developing specific strategies.

It is important to note that regardless of design, guidelines do not substitute for the infrastructure that is needed to ensure the effective implementation of recovery-oriented services. Guidelines provide the map, but getting to the destination also requires a network of roadways. The lack of mechanisms to support adequate staffing, standardized training, implementation protocols, and accountability mechanisms for evidenced-based psychosocial treatments has been identified as one of the most serious infrastructure problems in mental health services (Patel, Butler, & Wells, 2006). These deficits can undermine quality even when the best guidelines are available.

Findings from State Surveys

Connecticut and Pennsylvania were the only two states in our survey that operationalized the vision of recovery by developing specific guidelines or

standards. Pennsylvania reported that even with standards, creating a clear, marketable vision of recovery has been difficult. They reported a lack of consistency among the counties in how recovery was defined and operationalized; some service providers viewed recovery as something they were already doing (Pennsylvania Office of Mental Health and Substance Abuse, 2005 & 2006). The standards were not mandatory or tied to funding, but were designed to provide a point of reference for counties and service provider agencies. The state has encouraged the counties to focus on any one of the recovery-oriented standards as a starting point for implementation. However the process still helped to support major initiatives in peer services, supported housing, supported employment, and advanced directives. Pennsylvania also plans to use consumer satisfaction teams to help monitor the implementation of specific standards but have not yet reached consensus on the questions for the instrument.

Connecticut is using recovery standards to help guide statewide training on the principles and practices of recovery-oriented services. They report that that even after statewide conferences, consensus-building retreats and the creation of a Recovery Institute, providers were not always certain about how to implement recovery-oriented services (Connecticut, 2006).

Ohio has not yet developed statewide standards/guidelines but has developed a common recovery assessment tool. Washington is at the initial stages of defining recovery-oriented services and noted that consumers have clearly articulated services that they find to be most helpful.

The following are the major domains for recovery standards implemented by the states of Connecticut and Pennsylvania:

Connecticut

- Primacy of participation
- Promoting access and engagement
- Ensuring continuity of care
- Employing strength-based assessments
- Offer individualized recovery planning
- Functioning as a recovery guide
- Community mapping and development
- Identifying and addressing barriers to recovery
- Training and staff development

Pennsylvania

- Validate personhood
- Person-centered decision-making and choice
- Connection
- Self-care, wellness, and meaning

- Rights and informed consent
- Peer support and self-help
- Participation, voice, governance, and advocacy
- Worker availability, attitude, and competency
- Addressing coercive practices
- Outcome evaluation and accountability

Florida Survey Findings

Service Provider Agencies

The survey asked respondents about the need for guidelines that would support the implementation and evaluation or recovery-oriented services, and about the kind of process that would best support the development of guidelines.

There was universal agreement about the need for guidelines to create a common language and framework to support recovery oriented services. There was also almost universal agreement about the need to make them non-mandatory and independent from funding, unless new funding was allocated specifically for recovery oriented services. Respondents emphasized the need to operationalize principles of autonomy and consumer self-direction and to develop standards for consumer involvement in agency decision making.

Service provider agencies support the use of guidelines for recovery oriented services because they clarify expectations for service delivery. However, they also expressed reluctance because of difficult experiences with previous efforts to implement statewide guidelines. The following major themes were expressed about the structure and process for developing recovery oriented service guidelines:

Guideline Structure

- **Purpose:** Guidelines provide the framework that is necessary to support planning, implementation, and evaluation of recovery oriented services.
- **Non-Mandatory:** Agencies believed that non-mandatory guidelines would be implemented voluntarily by many service provider agencies.
- **Flexible:** Guidelines should apply state wide while also allowing enough flexibility to accommodate differences among specific communities and agencies.
- **Link to New Funding:** It could be useful to tie the guidelines only to new/additional funding.
- **Use Existing Guidelines as a Reference:** Agencies identified other documents to assist in the development of guidelines, including SAMHSA's recovery principles and the USPRA ethical guidelines developed for psychiatric rehabilitation practitioners.
- **Multi-Dimensional:** Concerns were expressed about standards becoming too prescriptive, with the effect of reducing consumer choice.

- **Interagency Collaboration:** Guidelines would provide a useful framework to help facilitate information exchange between agencies with respect to policies and practices.

Process for Developing Guidelines

- **Broad Stakeholder Participation:** Most service provider agencies recommended that a broad range of constituents participate in the process of developing guidelines including, MCO's, DCF, provider agencies, consumers, and family members.
- **Recovery Expertise:** Participants in the process for guideline development should have expertise in recovery-oriented services. One agency mentioned the importance of learning from other states.
- **Concern about Funder Participation:** The planning process should recognize that some provider agencies will not be forthcoming in discussions that include representatives from funding agencies. There was concern that funding support could be compromised if service provider agencies express opinions not shared by funding agencies.
- **Objective Leadership:** The process should be lead by a person who is objective and who has no political or financial agenda.
- **Consumer Leadership:** Consumers should play a prominent role in the process.

Managed Care Organizations (MCOs)

All of the MCOs supported the development of a standard or guideline that would help direct planning and implementation of recovery oriented services. Standards/guidelines were described as essential to creating clear expectations for service delivery and for rating MCO performance. The respondents identified key domains for developing standards/guidelines: type of service that may be provided, qualifications of practitioners of service, frequency and rate of service, specifications for other services that may be combined, the purpose of services, eligibility criteria, a basic reimbursement/fee schedule, and desired outcomes.

MCOs expressed interest in moving beyond consumer satisfaction instruments and toward more complex and informative recovery-oriented measures, (e.g., the Recovery Oriented Systems Indicator (ROSI) (Dumont, Ridgway, Onken, Dorman, & Ralph, 2006). Guidelines would also be helpful in establishing "apples to apples" comparisons in HMO performance ratings. One respondent emphasized the need to operationalize principles of autonomy and consumer self-direction; another described the need to develop standards for consumer involvement in agency decision making.

Most MCOs surveyed are not currently collecting data specific to the delivery of recovery oriented services. However, one PMHP uses the ROSI and collects data on consumer involvement. One HMO monitors the degree to which treatment plans are directed by consumers and families. One of the PMHPs integrated recovery principles into clinical care criteria and monitored the hiring of certified peer specialists.

Participants suggested that AHCA/DCF collaborators, provider and consumer groups, and the state's Transformation Working Group should lead the process for creating standards and/or guidelines. Participants identified a broad range of individuals who should participate in the process of development: consumers, representatives for recovery and resiliency groups, AHCA, DCF, providers of mental health, housing, and vocational services, MCOs, the Department of Professional Regulation, the Advocacy Center, representatives from support associations such as National Association for the Mentally Ill (NAMI) and Depression and Bi-Polar Alliance (DBSA), and experts on recovery-oriented services.

Impressions

Findings from both within the state and from states that are mental health transformation grantees demonstrate a clear need to develop recovery-oriented services guidelines. Participants expressed preference for voluntary guidelines built upon the principles of role recovery already developed in Florida's mental health transformation process.

Momentum that has been built as part of the transformation effort can be lost: service provider agencies are challenged by adjustments to Medicaid reform, a capitated service system, and state-level leadership changes. Without guidelines to support the implementation of recovery-oriented services, it is unlikely that service providers will be able to substantially improve their philosophy or practices.

With the exception of the delivery of medication, most mental health therapies are delivered with limited infrastructure support (Patel, et. al., 2006). Developing recovery-oriented guidelines is an important first step in helping systems and programs move from "rhetoric to routine" (O'Connell, et. al., 2005), from a disparate range of activities delivered without a clear vision, to a coherent system guided by a common vision.

Florida survey participants support the development of guidelines for implementing recovery-oriented services. Participants from Connecticut and Pennsylvania provided good examples of how to facilitate a process of building consensus in developing recovery-oriented guidelines. Respondents from Florida provided valuable input on a structure and process for developing guidelines in state. Some valuable lessons learned include:

- The process should be inclusive of a diverse range of expertise and perspectives and must be perceived as inclusive.
- Consideration should be given to tying guidelines to recovery-oriented outcome measures that would monitor the progress of service provider agencies in creating a recovery-oriented culture and in helping consumers achieve personally valued goals.
- Guidelines should also include a menu of actions and a listing of administrative/clinical supports that will be needed to ensure successful implementation.

Gaps in the mental health system infrastructure present significant obstacles to statewide implementation of guidelines. Both Connecticut and Pennsylvania developed non-mandatory guidelines and had not yet prescribed a strategic plan for implementation. Consequently, they described challenges in coordinating activities across multiple counties/localities. These same challenges were also echoed in our interviews with states that had not yet developed guidelines, and were anticipated by Florida survey respondents.

The role of the state mental health authority should be to provide guidelines for defining recovery, promote the importance of recovery-oriented outcomes, and provide service provider agencies with concrete steps to achieve these outcomes. A statewide approach to planning that includes both a top-down and bottom-up strategy for implementing guidelines appears to be the most viable for Florida's system. The state can be most effective by providing an infrastructure for state level planning that includes a broad base of stakeholders, but that also includes local planning bodies to address implementation issues. Counties/localities should establish priorities as part of a local planning process. The state may provide the map, but local entities need to determine the best strategy to succeed within the limitations of current infrastructures (e.g., issues related to staffing, funding, licensure, accreditation, data collection, and quality management).

It is important to note that service provider agencies in Florida are not likely to support mandatory guidelines/standards if they are perceived as adding another layer of regulation and if the services described are not supported with funding. It will also be important to consider how financial incentives can be created to support the implementation of guidelines.

Participants throughout Florida were concerned that polices regarding recovery and mental health transformation may not endure, and that the state may change direction in a few years. Stakeholders in Florida's mental health system will not fully buy in to a process for developing and implementing guidelines for recovery-oriented services if they sense a lack of commitment from state leaders.

Domain 3. Financing Recovery Oriented Services

Importance of Financing

The public mental health system serves a disproportionate share of individuals with moderate to severe mental illnesses (Petel, et al., 2006). These are typically persons who are most vulnerable to the effects of biological, psychological, and social stresses, and who face some of the greatest challenges on the road to recovery. Medicaid is the primary resource to support services for these individuals. The report by the Bazelon Center for Mental Health Law on funding mental health rehabilitative approaches under Medicaid points out that "the mandatory Medicaid services such as inpatient hospitalization, physician services, and pharmaceuticals represent a major portion of the state's available financial and management resources…if used wisely, it can support expansion of evidenced-based practices that support consumers in their recovery" (2001).

The Bazelon Center report also points out that states face significant challenges in supporting these practices, due to requirements such as medical necessity of services, existing federal standards, pressures to reduce costs, and the need to create mechanisms to ensure quality care. Medicaid-reimbursable services alone cannot provide for a full array of recovery-oriented services. Developing the financial resources to support publicly funded recovery oriented services will clearly require careful planning within the state Medicaid office, but also coordination among other state human service agencies and key stakeholders such as consumers, families, providers, and practitioners (Bazelon Center for Mental Health Law, 2001).

The President's New Freedom Commission report (2003) included a Medicaid subcommittee to identify issues and make recommendations relative to goals of mental health system transformation; they recommended changes in the areas of access, service delivery, service coordination, and quality (Appendix 1). The Medicaid subcommittee concluded that it was now up to community stakeholders to "create demand and support" at the state level to implement the Commission's recommendations. "Federal leadership is essential, but at this point Medicaid changes to implement best practices and other related recommendations of the commission can be designed and implemented only at the state level" (Day, 2006). Because of the more than $40 billion in cuts in federal Medicaid expenditures over the next five years as part of the 2006 Deficit Reduction Act, mental health transformation activities will need to be accomplished with fewer dollars (Day, 2006).

Florida, like most states, covers recovery-oriented services for persons with mental illnesses through the Rehabilitation Option in the Medicaid State Plan. Section 1905(a) of the Social Security Act defines rehabilitation services and makes clear that medical necessity for rehabilitation services is based on functional criteria rather than diagnosis alone. The psychosocial rehabilitation and clubhouse services described in the AHCA Handbook fall under the Rehabilitation Option (Agency for Health Care Administration, 2004). The Rehabilitation Option provides some flexibility for states to include recovery-oriented services in their state plan, but can also create uncertainty about what is an allowable service. In addition, regional offices can differ somewhat in their interpretation of federal rules (Bazelon Center for Mental Health Law, 2001).

All of the recovery-oriented services reimbursable under the state plan can also be supported through the managed care delivery systems under the 1915(b) managed care waiver. In Florida, managed care organizations utilize the same AHCA Handbook to define reimbursable services that is used in the fee-for-service system (Agency for Health Care Administration, 2004). Capitated finance structures can provide states with greater flexibility in supporting recovery-oriented services, while still delivering services that fall within the parameters of the rehabilitation option. In addition, the 1915(b) waiver allows states to request a waiver permitting the use of cost savings that can be applied to support the implementation of recovery-oriented services (Forquer and Knight, 2001).

Representatives from the Centers for Medicare and Medicaid Services (CMS) Center for Medicaid and State Operations made a presentation on Medicaid and Recovery at the U.S. Psychiatric Rehabilitation Association's 32nd Annual Conference in Orlando, FL. They indicated that the President's 2007 budget proposal seeks to clarify and refine the rehabilitation benefit through a regulation that will define allowable services and exclude payment for services that are intrinsic to programs other than Medicaid, such as foster care, juvenile justice and education. These clarifications may result in greater available resources for recovery-oriented services in the mental health system (Reed and Terrell, 2007).

In addition, CMS is encouraging States to provide for important beneficiary protections such a person-centered planning and maintenance of case records; however, plans need to identify rehabilitation objectives that would be achieved in terms of measurable reductions in a diagnosed physical or mental disability, and in terms of restored functional abilities (Reed & Terrell, 2007). Person-centered planning is a cornerstone for the implementation of recovery-oriented services. Methodologies to support implementation, monitoring, and quality assurance are available (Adams & Grieder, 2005).

Starting in January 2007, a new Medicaid benefit offered as part of the Home and Community-Based Services (HCBS) Plan Option: Section 6068 of the Deficit Reduction Act of 2005, allowed states to provide home and community services for persons with mental illness as a state plan service, without requiring an HCSB waiver (Tritz, K., 2006). States still must seek federal approval to alter their standard Medicaid package, but once completed, no further permission to offer the expanded benefits is required. States have often had difficulty in meeting the HCSB waiver requirements for budget neutrality because of a lack of federal Medicaid institutional expenditures to transfer to community care (Bazelon Center for Mental Health Law, 2007).

Though the services covered under this state plan option are also covered under the rehabilitation option, the option to pay for those services as part of a bundled package, rather than day rates with 15 minute increments of services can be a significant advantage in supporting recovery-oriented services. States may now also provide home and community based care to indidvudlas who may not yet be at risk for institutionalization. (Bazelon Center for Mental Health Law, 2007). Iowa is the first state to add HCSB for persons with mental illnesses as part of its Medicaid plan. They have elected to offer case management and habilitation services, supported by a person-centered plan (United States Department of Health and Human Services, 2007). Florida may find value in reviewing the federally approved Iowa plan in developing a state plan that can better support recovery-oriented services.

It has been suggested that the provisions of the Deficit Reduction Act could create incentives needed to move toward the development of a standard national benefit plan for persons with serious mental illness, similar to those implemented for persons with physical and developmental disabilities (Day, 2006). Such a plan would help to ensure that services that are most effective in achieving recovery-oriented outcomes are funded.

Mental health advocates have described the need for financing models that make staff accountable to individuals with mental illness rather than to service provider agencies (Cook & Jonikas, 2002). Florida's self-directed care program is a prime example and has been recognized nationally. In addition, states can use the contracting process to establish requirements and create incentives for the implementation of recovery-oriented services (Pennsylvania, Office of Mental Health and Substance Abuse Services, 2006). Kentucky is an example of a state using a recovery-oriented, performance-based contract that requires at least half of the staff of mental health providers be trained in supported employment.

In summary, Medicaid is an important source of funding for supporting recovery-oriented services for persons with mental illnesses, but other resources are required to provide the full array of services. Coordination with the state mental health authority and other key stakeholders is critical. The Rehabilitation Option defines the types of services that are reimbursable, but careful planning with Medicaid regional offices can help to expand the service array and still ensure reimbursement. Managed care plans have the potential to be more flexible in supporting services that achieve recovery-oriented outcomes. CMS is recommending changes to the 2007 budget that can increase support for recovery-oriented services; however this must be viewed in context of the overall Medicaid funding cuts described in the Deficit Reduction Act. CMS is also encouraging the implementation of practices that are a critical part of recovery-oriented mental health systems, such as person-centered planning. A new Medicaid benefit offered as part of the HBCS Plan Option allows for more flexible funding that may be used support recovery-oriented services in the future. Self-directed care offers Medicaid an important alternative model for supporting the recovery of persons with serious mental illnesses.

Findings from State Surveys

Connecticut's mental health services funding is managed through Administrative Services Organizations (ASOs). The system is not capitated, but rather creates incentives for a case utilization management process based on clinical determinations for care. Incentives are based on psychosocial rather than medical criteria. Penalties are imposed for poor performance and lack of timeliness. Cost is managed by focusing on clinical appropriateness of services and good clinical outcomes. Intensive case management is targeted to high service users and managed through a centralized ASO computer system. Connecticut is also investigating the Medicaid benefit offered as part of the Home and Community-Based Services (HCBS) Plan Option to support recovery-oriented services.

New Mexico created a Behavioral Health Collaborative in 2003 based on a gap analysis and a process of consensus building among key stakeholders. It provides a unique example of a unified system with standard service definitions and access criteria, and coordinated strategies for funding and implementing evidenced-based practices (Hyde, 2004). The collaborative includes 15 cabinet level departments. Since 2006, Value Options has been the single state entity for contracting behavioral health services. A performance and accountability contract

has been developed with six goals, one for behavioral health. New Mexico has made significant progress in breaking down administrative silos and in developing better inter-agency collaboration. However, the process of achieving buy-in with key stakeholders has been an ongoing and challenging process.

Ohio has a county based system (88 counties) with 50 mental health boards responsible for planning and administration of mental health services, including recovery-oriented services. The state supports the counties with block grant funding and implements a competitive process in which the boards respond to Requests for Proposals (RFPs). The process was described as challenging to manage. Consumers function in key leadership positions.

In Oklahoma, the state Medicaid office and mental health authority are collaborating to develop a plan to support recovery-oriented services and promote better services integration. Both offices are examining policy language and program rules that are not consistent with a recovery-orientation. A clinical workgroup has been created to develop the model for implementing recovery-oriented services. Workgroups focusing on finance, information systems, quality assurance, and policy will develop strategies to implement the model.

Pennsylvania provided a $20,000 incentive for service provider agencies to include recovery in their mission statement. They are also planning to link incentives to performance indicators and to structure the contracting process to promote mental health transformation and recovery. Pennsylvania also permits capitated dollars not spent on required services to be spent on recovery-oriented services. Pennsylvania is planning to add peer support and mobile treatment services to its Medicaid plan.

Washington reports that it has added peer support, supported employment, and clubhouse services to the state Medicaid plan. Washington's managed care contract includes requirements to provide recovery-oriented services.

Florida Survey Results

Service Provider Agencies

Support for Funding/Potential for Cost Offset

There was universal acknowledgment among providers that recovery services, defined as services that focus on housing, employment, friendship, and a successful life in the community, should be funded. They also believed that these services improved quality of life for consumers. Most believed that resources devoted to recovery services would be off set by reductions in acute care services for those consumers. However, one agency reported that it had not seen a decrease in acute care to date. The provider agencies were less sure about cost off set for other services, but one anticipated a reduction in the need for long-term state hospital care. Another anticipated a reduction in jail and court costs through improved mental health services for people in forensic settings. However, one agency reported that it had not seen a decrease in acute care to date. The provider agencies were less sure about cost off set for other services, but one anticipated a reduction in the need for long-term state hospital care. Another anticipated

a reduction in jail and court costs through improved mental health services for people in forensic settings.

Application of Funding

Service provider agencies reported that they were offering as many recovery services as possible under the current funding levels. Some respondents were uncertain about what they would do differently if funding were more flexible while others indicated they would maintain current levels of services. New funding was identified as critical to increasing the number of people being served. These funds would more often be used to expand current recovery services such as Comprehensive Community Support (CCST) teams and supportive housing and employment programs rather than develop new programs. New funding would also be used to reduce caseloads. Service provider agencies also identified the need to find more money within the system to support access to critical resources such as consumer transportation and front-end housing costs. One agency reported being pressured by MCOs to reduce services to people who were doing better.

Funding and Administration

Concerns about administrative duties related to funding and billing were identified by several providers. One agency dealing with a new PMHP described having to devote significantly more staff time to completing the paperwork required for payment and facing much longer delays in getting payment. Several agencies expressed concern about the staff time that it takes to deal with multiple funders. Another agency talked about being preoccupied with financial survival since the recent implementation of Medicaid reform in its district.

Managed Care Organizations

All of the MCOs agreed that it was possible to make consumer outcomes such as housing, employment, and friendships a priority under current managed care contracts, but they all also agreed that it was very difficult. Two respondents said the cap under existing contracts was inadequate; one said the cap was adequate except in District 8. The most significant financial challenges identified by the MCOs included the following:

- Definitions of Medical Necessity

  Many of the services required to achieve outcomes of recovery oriented services extend beyond medical necessity and involve the person's overall wellbeing. Definitions of services based on medical necessity limits the flexibility to deliver services that address the whole person.

- Definitions in the AHCA Handbook

  The AHCA Handbook provides for rehabilitative activities that include skill development and achieving outcomes related to vocational goals. Most respondents felt that the handbook did not allow sufficient flexibility to deliver a more comprehensive array of recovery oriented services. One person talked about the need for an active dialogue with AHCA to solve funding problems as they come up. Participants acknowledged AHCA's concern that CMS could disallow these types of services and require a return of funds used to support them.

- Poor Coordination between AHCA and DCF.

  Two MCOs pointed to the need for better collaboration between AHCA and DCF. They expressed concern about conflicting rules that create administrative burdens and that have the effect of diverting limited resources.

Impressions

Medicaid is the most critical source of public funding for recovery-oriented services in Florida, though funds from the state mental health authority (DCF) are an important complement. The Rehabilitation Option remains as the primary mechanism through which the state Medicaid Plan defines and funds these services. CMS clarifications about application of the Rehabilitation Option in the 2007 budget and the Home and Community-Based Services (HCBS) Plan Option may offer alternatives to improve and expand recovery-oriented services in the near future and should be fully explored. Iowa's implementation of the HCSB Plan Option can provide valuable lessons. In addition, the benefits of shifting services from costly acute interventions to recovery-oriented services that focus on promoting healthy functioning in the community should be considered in any analysis of cost.

There are challenges to funding mental health services and recovery-oriented services in particular: cuts in overall Medicaid expenditure, lack of federal funds to support mental health transformation, defining recovery-oriented services that are compatible with definitions of medical necessity, and differences of interpretation in applying the Rehabilitation Option among regional CMS offices. To best meet the challenge of funding recovery-oriented services in the current environment, the state mental health system needs a strategic plan that places financing within the context of goals and objectives and that includes representation from all of the key funding agencies. It should articulate a clear vision of recovery, establish service priorities based on an assessment of need and available funding resources, provide definitions of recovery-oriented services that can best match the requirements of funding sources, and establish a plan for monitoring and feedback. The implementation of guidelines can be most effective within the context of such a plan. Guidelines provide a valuable framework to assist with strategies for allocating limited funds not only to support existing services but to develop new services that can help realize the vision of recovery. Guidelines also help to ensure that services are delivered at an acceptable level across the system.

The need for flexible funding to implement recovery-oriented services was a common theme expressed by both service provider agencies and managed care organizations. An examination of current administrative services codes and an exploration of alternative services by AHCA should be considered in developing service descriptions for the future. However, the first phase of this study identified an incomplete awareness among some service providers about the knowledge and skills required to effectively implement recovery programs. Training and technical assistance could help these individuals to more fully realize the possibilities for providing recovery-oriented services within the current service descriptions.

The shift in some AHCA areas from fee-for-service financing to capitiated systems, represented by PMHPs and HMOs provides an important opportunity to create greater flexibility in delivering recovery-oriented services. The Community Behavioral Health Services and Limitations Handbook currently defines services provided under both fee-for-service and managed care systems. Consequently, the potential benefit of managed care to create incentives to achieve recovery-oriented outcomes is not fully realized. The participants in our survey are all supportive of a recovery-oriented mental health system and should be engaged in developing strategies that can help to move the system forward. Managed care contracts should include expectations about achieving recovery-oriented outcomes, and should be developed with input from consumers. In addition, PMHPs and HMOs should be considered critical partners in the state's mental health transformation.

Person-centered planning is one of the most critical recovery-oriented services because it ensures that consumers are fully engaged in partnership with the mental health system. This level of engagement is one of the most significant predictors of successful outcomes and contributes significantly to the efficient use of services and other resources (Assay and Lambert, 2006). CMS is encouraging the implementation of person-centered planning. AHCA should strongly consider making person-centered planning part of the Medicaid state plan.

Self-directed care is an important recovery-oriented model and Florida leading the nation in its development. Continued support from AHCA is critical to its success and to the success of the mental health transformation process.

The states that participated in this study are different from Florida in many ways: population/demographics; client needs, and administrative structures, among others. But each of the states that participated in the survey are implementing innovative strategies worthy of consideration. Many states have taken the charge of the New Freedom Commission seriously and are making significant systems improvements. Florida and all of the states will benefit from sharing innovations.

Concerns expressed by service provider agencies about administrative burdens related to billing multiple funding sources are also noteworthy. To the greatest degree possible, there should be consistent management processes. There should also be an account of the resources needed to respond to administrative changes (e.g., time for training and supervision). An infrastructure that reduces administrative burden helps create a more fertile ground for meaningful change.

Domain 4. Successful Implementation of Recovery Oriented Services

Importance of Implementation/Next Steps for Florida

Mental health policy makers, services providers, and consumers from throughout Florida have taken initiative to transform Florida's mental health system to one that supports recovery. Significant among these initiatives has been the implementation of a Transformation Working Group, lead by Florida's Mental Health and Substance Abuse Corporation. This group brings together senior policy makers from across state agencies to address policy and practice issues that effect persons with mental illnesses. These agencies include those who are directly responsible for mental health policy, as well as agencies that are affected by mental health issues (e.g., the Department of Education). The Department of Children and Families (DCF) took the lead on several key initiatives including: the development of a Department of Consumer and Family Affairs, the development of state and regional Recovery and Resiliency Task Forces to target the needs of mental health consumers at the local level, and mental health transformation video conferences to provide education and opportunities for information sharing about the implementation of recovery- oriented services. Service provider agencies and organizations have also supported conferences and training sessions to support the delivery of recovery-oriented services.

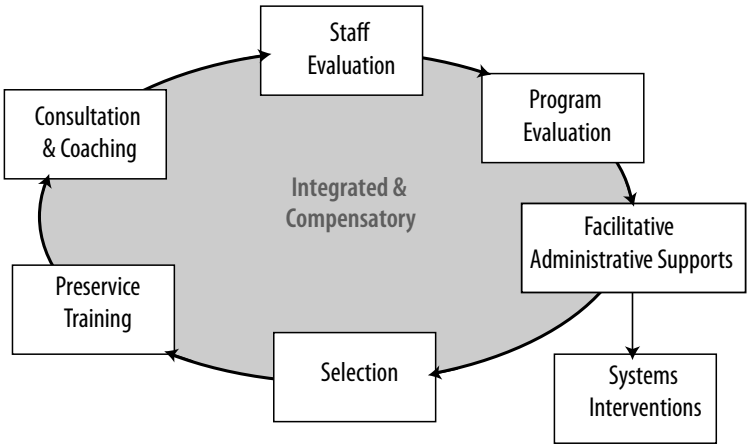
Surveys with service provider agencies were developed to provide a benchmark of Florida's progress in its mental health transformation as reflected in the implementation of recovery-oriented services. The results provide information for developing system and program improvement strategies. We focused our examination on two critical areas:

- Core components of service implementation that are critical to success.
- Outcome indicators of system transformation that reflect an authentic recovery orientation.

Core Components of Implementation

Implementation is a complex process that requires alignment of many factors at the practitioner, organization, and system level in order to achieve short term success and also to be sustainable in the long term. The National Implementation Research Network (NIRN) conducted a wide-reaching review of literature to identify commonalities of successful implementation efforts (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Their review identified seven core implementation components that are critical for success and sustainability: staff selection, preservice and inservice training, ongoing consultation and coaching, staff and program evaluation, facilitative administrative support, and systems interventions (see Figure 1). In successful implementation efforts, all of these components must be present to some degree.

Figure 1
Core Implementation Components



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This model of core implementation components provides a useful framework to help assess Florida's readiness for implementation of recovery-oriented services. For example, NIRN review of experimental studies revealed that providing guidelines, policies, or educational information alone were not effective at producing change; nor was practitioner training alone effective (Fixsen et al., 2005). Therefore, in this survey of readiness for recovery-oriented services, it was important to determine whether participating organizations had moved beyond a narrow conceptualization of how best to implement recovery-oriented services, to one that sufficiently addresses the multiple critical factors required for implementation. Thus, the survey included several items to assess each participating agency's readiness for implementation of recovery-oriented services in relationship to these core components.

Florida Survey Findings

Selection of Recovery-Oriented Service Models

The agencies selected a range of models/practices used to support the delivery of recovery oriented services, including:

- The Copeland Center's Wellness and Recovery Action Plan (WRAP)
- Certified (ICCD) Clubhouse
- Boston University's approach to Psychiatric Rehabilitation
- The Suncoast Region's Guide to Role Recovery for Behavioral Health
- Illness Management and Recovery Toolkit (SAMHSA)
- Solutions for Wellness Program (Eli Lilly)

Support for the Implementation of Recovery Oriented Services

The survey asked respondents to describe how service provider agencies are supporting effective delivery of recovery-oriented services through activities such as training, coaching, and performance evaluation.

Orientation/Training

Each of the provider agencies have arranged for staff to get exposure to the basic principles and practices of recovery through attendance at training conferences. All participated in the mental health transformation video conferences provided by DCF and described them as providing valuable information, as well as an opportunity to learn from each other. Some of the agencies have gone beyond basic orientations to provide on-going training. Some agency staff participated in training on specific models such as Certified Peer Specialists, Boston University's Psychiatric Rehabilitation model, and the Comprehensive, Continuous, Integrated System of Care (CCISC) Model for co-occurring mental health and substance use disorders. In some cases, staff who receive training are expected to train other staff. Training has been conducted on mostly on an ad-hoc basis and not as part of an implementation plan.

Staff Support

The service provider agencies described the kind of support provided for staff to implement recovery oriented services. Specific activities of note include one agency that met with all staff to discuss their thoughts and feelings about recovery and how the agency could become more recovery-oriented. Several agencies had created working groups to promote recovery-oriented practices within the agency. Four agencies included recovery principles and practices as part of employee orientation and in performance evaluations. One of these agencies used a competency checklist for new employees that included questions about the principles of recovery. One agency incorporates concerns expressed by its member forum into staff supervision. None of the agencies had formal policies or procedures to support coaching, supervision, or ongoing support of staff to implement recovery services.

Utilization of Data for Support

There was very limited use of data related to recovery oriented services to inform administrative and clinical decision making. Some of the agencies implement consumer satisfaction surveys. Some programs are beginning to use the Recovery Oriented System Indicators (ROSI) and the Recovery Self Assessment (RSA) instruments to assist with monitoring services. There is no longitudinal data showing whether these agencies have been successful in creating more recovery-oriented services. One program used items from the ROSI in its consumer satisfaction surveys. Other agencies are not collecting any data related to recovery-oriented services other than what is captured by the FARS. FARS is a prime source of outcome data for all of Florida's programs and provides some information on client functioning that can be used to support the delivery of recovery services.

Impressions of Findings

The service provider agencies are beginning to implement various recovery-promoting practices. Staff receive some support in delivering these services through training conferences and clinical supervision; however, there was little evidence that the core components for successful implementation were integrated into agency program planning, such as an ongoing plan to provide coaching, outcomes monitoring, or program evaluation that would be used to inform continued development and implementation of recovery-oriented services.

Changes in culture are a critical part of creating effective recovery-oriented programs. Efforts to change agency culture by incorporating the core recovery principles of respect, collaboration and empowerment into day-to-day practices posed significant challenges. Meaningful culture change and successful implementation of recovery-oriented services will require a commitment to provide administrative support, training, supervision, and technical support over the long term. In addition, these activities need to be linked to a process of program monitoring, evaluation, and development. Recovery-oriented guidelines and a common outcome monitoring instrument would prove useful in supporting program implementation. In addition, tracking recovery-oriented process outcomes (e.g., the number of consumers who know what is in their treatment plan, who believe they can recover, and who believe that staff think they can recover) would help to guide effective implementation.

Domain 5. Indicators of Successful Recovery-Oriented Services

Importance of Indicators

Measurement is an important component of any successful implementation effort; the reasons are several: (1) to communicate program standards; (2) to monitor services over time; (3) to compare programs; (4) to establish (or make comparisons against) norms; and (5) to provide feedback for developmental purposes. With these factors in mind, a number of existing measures of recovery-oriented services were reviewed. We applied the findings from this review to inform the selection of the measures that we used in this study's service provider agency survey. The results will assist in determining next steps in advancing Florida's mental health system toward a recovery orientation.

Considerable efforts have been made in the past decade to help define recovery and finding ways to measure it meaningfully. A foundation for the processes for measuring psychosocial rehabilitation outcomes was laid out in a toolkit that emphasized the importance of using measures that are simple, straightforward, objective, rooted in research, and reflecting useful outcomes for consumers (Arns, Rogers, Cook, Mowbray et al., 2001; IAPRS, 1995). In this spirit, the Human Service Research Institute (HSRI), in a major effort that specifically focused on recovery, produced a compendium of relevant measures that had been identified and reviewed systematically (Campbell-Orde, Chamberlin, Carpenter, Leff, 2005). In all, the HSRI project identified 13 existing measures, 9 of which measure recovery at the individual level, while the remaining 4 instruments measure recovery-orientation of mental health service systems/environments. The review

concluded that the current array of recovery measures are highly accessible and offers a good range of options; in addition, most are well-grounded in consumers' experience/expertise and several have also undergone psychometric testing.

Of the four measures that provide assessment of system-level recovery orientation (consistent with Florida's transformation effort), the Recovery Oriented Systems Indicator (ROSI; Dumont et al., 2006) was the only instrument to collect both consumer self-report data as well as objective, administrative data at both provider and mental health authority levels. In addition to a strong commitment to psychometric development, consumer leadership and input has been critical at all stages of ROSI development, leading to a product that is well-informed by direct consumer experience. Thus, of the existing systems-level measure, the ROSI emerged as the most robust and potentially useful instrument for contributing to the Florida recovery movement.

Recovery Oriented Systems Indicators (ROSI)

The ROSI was selected to guide assessment of participating programs to determine the degree to which their current practices were consistent with recovery-oriented services. Specifically, the administrative data profile from the ROSI emerged as the preferred instrument based on several factors: (1) the significant participation of mental health consumers at every step of its development; (2) its reliance on objective, rather than subjective, data; (3) its inclusion of administrative-level indicators (rather than purely consumer-level data) that can serve as a management tool to monitor performance and improvement in key areas; (4) its congruence with existing program evaluation processes, i.e., some Florida mental health service providers have already used the ROSI to assess their programming, and the ROSI is receiving interest nationally as a useful measure of recovery orientation at both consumer and agency/system levels. The survey questions focused on the following domains taken from the ROSI administrative-data profile: peer support, choice, staffing, and nature of services (including agency culture, coercion, and access).

Florida Survey Findings

Service Provider Agencies

Peer Support and Participation

There was general support for consumers to provide peer support; some of the agencies employ consumers and expressed interest in expanding consumer-led services; however, there was concern about issues related to liability and whether insurers would cover consumer staff. One agency created a peer to peer network to promote peer support outside of the agency. Another was looking forward to working with an independent agency that was created in its district to provide peer support. A third agency expressed an interest in hiring consumers both on a full-time and as-needed basis.

Agencies were asked about whether they had an affirmative action policy to promote the hiring of persons with mental illness and whether they would give preference to consumers who were equally qualified for job positions. None of

the agencies had such a policy or expressed an interest in creating one. They all adhered to policies that were non-discriminatory and designed to give consumers at least equal consideration. Some agencies believed that being a consumer could make people better qualified for case management and advocacy positions and pointed out that there are often non-disclosed consumers at the agency in a variety of positions. One agency uses consumers to provide some of its psychoeducational classes. Agencies did not describe any consumer involvement with hiring staff and only a few involved consumers in training staff.

There was no evidence of consumer involvement in major decisions such as the allocation of resources (e.g. funding and staff time). None of the agencies included consumers in the review of annual contracts and, with a few exceptions, their participation on boards appeared limited to participation in consumer advisory groups and not agency boards. Some agencies used satisfaction surveys as a second means of getting feedback from consumers, but here again there was no evidence of consumers being involved in using this data to make major changes in an agency.

Choice

Agencies were asked to describe program activities that give consumers more choices, and specifically about whether they support the development of advanced directives, education about choices, and staff support for consumer choices.

Some agencies have changed program rules that restrict consumer choice (e.g. requiring people to use one service to get a second). The agencies that provide psychoeducation increase consumer choice by offering more courses on more topics. Some agencies have enhanced focus on providing quicker access to services and on honoring the consumers' right to choose service goals. One agency enhanced choice by opening a clubhouse as an additional service and not as a replacement for other services. The drop-in center, supported employment programs, and psychiatric rehabilitation programs at this agency continued to provide services. Only one agency mentioned a procedure that supports consumer choice of staff.

Most of the agencies provided materials to consumers about how to prepare advanced directives for care and provide assistance with preparation for consumers who request it. With the exception of one agency that stated all consumers had an advanced directive, the number of consumers with advanced directives was not known or reported.

There was no evidence that consumers were being given information about alternative treatment modalities and very little evidence that agencies were providing education to consumers about how to make good choices, or about alternative services and community supports available to support recovery. In many cases, it is not clear whether there were alternative services and supports in the community. Some agencies informed consumers about all of the services provided by the agency, e.g. outpatient staff visit consumers in inpatient facilities to inform them about services available after discharge.

Involuntary Treatment

None of the agencies had a plan in place to reduce involuntary treatment. However, agencies identified plans to reduce seclusion and restraint in crisis stabilization units (CSU) and short-term residential treatment units (SRTs), to educate families about guardianships, and to help consumers develop skills to become their own payees. One agency is making special efforts to ensure that surrogate decision-makers are truly representing the wishes of the consumer and not the agency or the surrogate.

Access to Services

The agencies were asked about the availability of services that focus on jail diversion, the integration of services for people with co-occurring mental and substance abuse disorders, the types of services that address trauma.

All of the agencies conducted a variety of program activities that focus on jail-diversion, including competency restoration activities, crisis response teams, placing staff at jails, and hiring forensic specialists on staff. Each of the agencies conducted some program activities for persons with co-occurring mental and substance abuse disorders, including dual recovery groups. Some of the agencies had orientation/training in models for treating individuals with co-occurring mental health and substance use disorders. Issues of trauma were addressed in specialized programs such as CSU, rape recovery centers, and domestic violence programs, but not as part of standard mental health programming. Some of the agencies trained staff in dialectical behavior therapy (DBT).

Self Care

The agencies were asked about activities that help consumers take a greater role in managing their illness, and their overall physical and mental health. Activities included those listed in the implementation section, including WRAP training, Team Solution for Wellness training developed by Eli Lilly, education in medication and symptom management strategies identified in SAMHSA's toolkit, and other less structured educational activities. There was no indication about how many consumers had a relapse prevention plan and whether consumers used these plans.

Treatment Planning

The agencies were asked to describe how a focus on recovery orientation would affect the process of treatment planning. All of the agencies viewed treatment planning as continuing to become more person-centered. They described treatment planning for outpatient services as medically modeled, while recovery-oriented programs such as supported employment/housing have more recovery-oriented planning. Some agencies are paying more attention to including input in the consumer's own words in the treatment plan and trying to make the planning process more collaborative. There was some acknowledgement that it would take time to get all staff to buy into a truly collaborative approach. Some agencies are also paying more attention to the consumer's strengths. One agency commented on the need to better link the consumer's strengths to the consumer's goals. There was no evidence of a systematic effort to make treatment planning more strength-based.

Community Involvement

The agencies were asked to describe if they were helping to strengthen consumers' natural support systems and whether they were providing education or other kinds of support to family members. All of the agencies provide psychoeducational programs for consumers, involve families, and attempt to strengthen consumers' connections outside the mental health system (e.g. by inviting families and community representatives to the agency). All agreed that these activities were limited and needed to be expanded. One agency opened a Wellness and Recovery Center that helps consumers develop friendships in the community. With the exception of agencies that placed a strong emphasis on employment, linking consumers to community organizations and activities outside of the mental health system was not a priority.

Impressions of Findings

Peer Support and Participation

Service provider agencies support peer participation in principle, as evidenced by hiring of consumers for some positions and an expressed interest in supporting consumer led services. Barriers include a lack of formal policy or procedures that address consumer participation, hiring processes, and very limited participation of consumers in decision making roles: staff hiring, management/supervision, participation on agency boards.

Consumers participated in agency functions mostly as part of traditional mechanisms: satisfaction surveys, advisory groups, and consultation in areas that are identified as requiring consumer input. Consumers are at best serving in an advisory capacity but there is little evidence of equal partnership.

Choice

The service array has been broadened to provide more choices and there is a growing focus on consumer goals. However, choice was mostly limited to programs within the agency. Choices should extend beyond the agency to services and supports available in the community. There should be education for consumers on goal setting and on making good choices (e.g., choose, get, keep model).

In most cases, assistance in developing advanced directives had to be initiated by consumers. Agencies provide information and assistance if consumers request it but it did not seem to be a high priority. There should be a plan to engage and educate consumers about the development of advanced directives.

Involuntary Treatment

Polices and procedures at service provider agencies focused mostly on how to deal with a crisis rather than preventing one. Acute unit policies to reduce seclusion and restraint are valuable, but there should be a plan of alternative strategies developed in collaboration with consumers to help reduce the need for involuntary treatment.

Access to Services

Service provider agencies have made a range of services available. Progress has been made in developing jail diversion programs and in providing integrated services for persons with co-occurring mental health and substance use disorders; however, there is a need for more of these services, especially in rural areas, and many consumers do not have access because of lack transportation.

There was no evidence of service provider agencies dealing systemically with trauma unless policies and services were part of a crisis or trauma care program. It does not seem to be a systematically addressed in general mental health programs.

Self Care

Service provider agencies utilize useful program tools to help consumers take a greater role in managing illness, but there is no evidence that implementation is supported by supervision/coaching, or that activities are monitored. There is no way to know if consumers are meaningfully participating and benefiting from these activities.

Treatment Planning

Person-centered approaches appear to occur mostly as part specific recovery-oriented activities. Treatment plans and other service activities appear to retain a medical focus. The consumer's participation in planning mostly involves providing a signature to the plan at designated periods. However there is acknowledgement of need to get staff buy-in and to implement person-centered planning processes across all programs.

Community Involvement

With few exceptions, there was little emphasis on helping consumers become more involved in roles outside of the mental health system. Education for consumers and family members focused on issues related to illness and medication. Helping consumers with the process of being meaningful participants in community life is a core component of recovery-oriented services and is an area that requires greater attention.

Recommendations

Vision

1. Require service provider agencies and managed care organizations that receive AHCA funding to include a definition of recovery-oriented services in their mission statements. The statement should recognize the importance of personally valued goals (e.g. a meaningful life) and consumer-driven services.

Guidelines

1. Convene a workgroup of key stakeholders in a structured process to develop recovery-oriented services guidelines. The overall goal should be to create a set of voluntary recovery service guidelines that will provide a frame of reference for future service implementation, monitoring/evaluation, research, and technical assistance/training.

2. Participants in the workgroup should include representatives from AHCA, DCF, MCOs, service provider agencies, consumers, and family members.
3. Guidelines should include the following characteristics.
    - Describe specific domains (e.g. expectations, consumer participation, peer support, person-centered planning and choice, employment, etc.)
    - Provide specific options for implementing services in those domains and list administrative/clinical supports needed for successful implementation.
    - Describe services and supports that consumers will need to achieve personally valued goals, with special attention to services not covered by Medicaid.
    - Include a plan for utilizing guidelines.

Financing

1. Address Financing as Part of Statewide Strategic Plan

    To meet the challenge of funding recovery-oriented services in the current economic environment, the state mental health system needs a strategic plan that places financing within the context of goals and objectives and that includes representation from all of the key funding agencies (e.g., AHCA and DCF). The plan should include the following characteristics:
    - Articulate a clear vision of recovery
    - Establish service priorities based on an assessment of need and available funding resources
    - Provide definitions of recovery-oriented services that can best match the requirements of funding sources
    - Establish a plan for monitoring and feedback
    - Evaluate the efficacy of a recovery-oriented services benefits package.
2. Include three key recovery services in the state Medicaid plan (may be reimbursable through either the Rehabilitation Option or the HCBS Plan Option):
    - Peer Specialists
    - Person-Centered Planning
    - Self-Directed Care
3. Require MCOs to use a portion of their administrative funds to support the development of recovery-oriented services
4. Require MCOs to provide incentives for service provider agencies that develop plans to achieve recovery-oriented outcomes. The following is an example:
    - In Year 1, the agency may receive incentive for providing evidence of a plan that describes how it will improve in one or more recovery-related domains. The plan should include a strategy for implementation, outcomes, and process for measuring outcomes.

- In subsequent years, the agency may receive incentives for demonstrating progress in the selected recovery domains.
    - Recovery-oriented guidelines can provide a useful framework for implementing an incentive process.

Implementation

1. Create a manual that provides an orientation to the principles and practices of recovery oriented services. In addition, it should provide a basic guide that describes the need to provide clinical and administrative support, as well as a process for monitoring and evaluation.
2. Implement pilot programs that will implement, monitor, and evaluate practices described in the recovery-orientation manual.
    - Target AHCA areas and service provider agencies that have demonstrated exemplary practice.
3. Require Medicaid behavioral health providers to increase consumer participation by supporting the following practices:
    - Include consumers on the agency board.
    - Involve consumers in the hiring and training of staff.
    - Describe how consumers, families, and staff will work collaboratively to change one or more of the agency's policies or programs.
    - Describe how they will reach out to consumers who have had negative experiences with the mental health system.

Indicators

1. Establish a subcommittee of the guidelines work group to select recovery-oriented indicators that can be used to guide system and program implementation.
2. Integrate recovery-oriented indicators into standard monitoring and quality assurance mechanisms.

Conclusions

It has been four years since the publication of Achieving the Promise, the report from President Bush's New Freedom Commission recommending the transformation of the nation's mental health system of care. It is the most important mental health policy document of the last 25 years and has been the catalyst for systems improvement activities throughout the country. The commission assessed our mental health system as "fragmented and in disarray leading to unnecessary and costly disability, homelessness, school failures and incarceration" and recommended fundamentally transforming service delivery based on a vision of recovery (New Freedom Commission on Mental health, 2003). The Commission's Report and the documents of its subcommittees provide valuable guidance for translating the vision of recovery into policies and practices. Unfortunately, with the exception of a small number of state incentive grants, the federal government did not provide additional funds to support the transformation. States that wish to take up the charge must do so with existing resources.

Florida, like most states throughout the nation has taken steps to transform its system of care consistent with a vision of recovery. These steps have included a variety of planning and implementation activities taking place at the state and local levels, but they have not been guided by a common vision or an integrated plan for implementation and financing. The psychosocial and rehabilitative clubhouse services supported by AHCA funds have been an important part of the state's efforts. The first part of this study focused on the delivery of these services. It documented a need for guidance to service provider agencies and consumers to assume new roles and responsibilities in making the transition to recovery-oriented services. The second phase examined the readiness of Florida's mental health system to move toward a recovery-orientation and organized findings in five critical domains (Vision, Guidelines, Financing, Implementation, and Indicators).

Translating the Vision of Recovery to Reality

Our discussions with Florida's service provider agencies and managed care organizations suggest support for the concept of recovery for people with mental illnesses and the emergence of a common understanding of its meaning. Our discussions with other states emphasized the need to translate the vision into reality by engaging stakeholders from throughout the state in a process of consensus building based on a guiding framework.

Florida is at a critical juncture in its mental health transformation. Without state level leadership to promote the vision of recovery and a commitment to support policies and practices consistent with this vision, much of the momentum gained from recent initiatives will be lost. Individual service provider agencies may continue to provide some recovery-oriented programs. However, without state level leadership and a plan for coordination, the opportunity to implement a state wide strategy for authentic system transformation will have passed.

Guidelines Supporting Recovery-Oriented Services

Guidelines are the critical next step to translating the vision and principles of recovery into effective systems and programs. A literature on the core elements for guidelines of recovery oriented-services is emerging, and the experiences of other states provide valuable lessons about the process of development and implementation. A statewide approach to planning that includes both a top-down and bottom-up strategy for implementing guidelines appears to be the most viable for Florida's system. The state can be most effective by providing an infrastructure for state level planning that includes a broad base of stakeholders, but that also includes local planning bodies to address implementation issues. To ensure success, guidelines need to develop strategies that acknowledge the system's strengths, as well as the limitations of the current mental health system infrastructure (e.g., issues related to staffing, funding, licensure, accreditation, data collection, and quality management).

Financing Recovery-Oriented Services

It is not possible to predict whether additional federal funds will be devoted to mental health/recovery-oriented services. However, states have the opportunity to expand recovery-oriented services that are reimbursable under current finance structures. All of the options provided through CMS should be fully explored. In addition, the two key funding sources for public mental health services, AHCA and DCF should coordinate resources as part of a strategic plan. Such a plan can help to ensure that state wide service priorities are based on an assessment of need, that we develop definitions of recovery-oriented services that can best match the requirements of funding sources, and that utilization of all available funding resources are maximized.

The potential for managed care organizations to provide programmatic structures and incentives to support recovery-oriented services needs to be fully utilized. Managed care contracts should include expectations about achieving recovery-oriented outcomes and should be developed with input from consumers. The cost benefits of shifting services from costly acute interventions to recovery-oriented services that focus on promoting healthy functioning in the community should also be considered in any analysis of cost.

Successful Implementation of Recovery Oriented Services:

Successful implementation of recovery-oriented services requires a commitment to provide administrative support, training, supervision, and technical support over the long term. In addition, these core components need to be linked to a process of program monitoring, evaluation, and development. Training is commonly provided by service provider agencies to develop staff competencies, but its benefits can not be realized without additional supports. Some of the service provider agencies applied some of the core implementation components (e.g., training), but there was little evidence of these being systematically integrated into a program plan. A plan for implementing recovery-oriented services that includes these core components should be integrated into program/practice guidelines.

Indicators of Successful Recovery-Oriented Services

Measurement is a critical component of programs and systems that support effective implementation of recovery-oriented services. We selected the Recovery Oriented Systems Indicator (ROSI) for inclusion in this study because it provided valuable indicators of system level performance and because the instrument has been used as an evaluation instrument by service provider agencies in Florida. It will be important for Florida's mental health system to establish consensus among key stakeholders on the kind of indicators that will be used to monitor performance and to be certain that they are consistent with program/practice guidelines.

Findings from our survey provide important baseline information about the degree to which services in Florida's mental health system reflect a recovery-orientation. These findings should be applied as part of future program planning and development. In many ways the findings from this survey are consistent with those from the first phase of the study that found both consumers and staff expressing struggles with the emphasis on greater consumer self-direction – a central tenant of recovery-oriented programs. All of the recovery-oriented indicators are designed to guide programs and systems toward new and more equal partnerships between consumers and their care givers. System wide implementation of indicators that reflect a recovery-orientation is critical to charting the course for system improvement and authentic mental health transformation.

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Appendix 1: Medicaid policies and action steps recommended by the President's New Freedom Commission on Mental Health.

Policy area and recommendation	Action steps
Access: improve Medicaid Recipients' access to needed and desired best-practice mental health services.	Use presumptive eligibility to facilitate access to needed benefits for people with mental illness or serious emotional disturbance. Establish a principle of parity of mental health coverage with general medical care benefits within Medicaid plans and waivers and between Medicaid and Medicare. Assure retention and flexibility of Medicaid coverage for people who are moving toward work and self-sufficiency and for people who are overcoming functional limitations through recovery.
Service delivery: foster the development and implementation of evidence-based practices and models at the state level and increase integrated community services while reducing institutional or out-of-home care. Out of home care includes residential treatment facilities and foster care.	Provide federal policy guidance to states to incorporate evidence-based service definitions in Medicaid plans for adults and youth. Support Medicaid waivers and related demonstration programs that stimulate integration of funding streams and provide financial incentives for the implementation of best practices. Expand federal financial incentives for community-based care as opposed to institutional care. Explore additional flexible financing mechanisms, including payments for recovery-based outcomes, which could further stimulate adoption of best practices at the state level.
Service planning and coordination: enhance coordination, collaboration, and data-driven planning activities between Medicaid and other federal and state funding streams and service program requirements.	Provide federal guidance to improve state-level planning and coordination among state agencies that administer Medicaid and other related public mental health service programs for adults and youths. Encourage state governors to exercise leadership in planning state mental health system improvement strategies across all aspects of state government (for example, housing, employment, criminal justice, juvenile justice, child welfare, and public health). Ensure improved data collection and reporting among Medicaid and other federal and state funding streams for mental health services.
Quality and consumer responsiveness: increase the degree to which Medicaid-funded services respond to consumers' needs and choices and continuously improve methods for service delivery to high-priority Medicaid mental health consumers.	Promote consumer choice and control though recovery-oriented service models, including peer supports. Foster early identification and intervention for youths with potential serious emotional disturbance. Enhance the integration of primary health and mental health under the Medicaid program (with and initial emphasis on primary health interventions for depression).