

# Real Choice Systems Change Grant Program

*Initiatives of the  
FY 2004 Mental Health  
Systems Transformation Grantees*



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# **Initiatives of the FY 2004 Mental Health Systems Transformation Grantees**

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## Executive Summary

Mental illness is the leading cause of disability in the United States, and serious mental illnesses such as schizophrenia, bipolar disorder, and severe depressive disorders can be especially disabling if undiagnosed or untreated. Individuals with serious mental illnesses experience substantial limitations in major life activities, at home, at work, and in the community. Each year, approximately 6 percent of the U.S. population experiences a serious mental illness.

The delivery of publicly funded mental health services has evolved over the past decades from a system that consisted of large state-run mental institutions, funded solely with state funds, to a community support system (CSS) that strongly emphasizes support for individuals in the community rather than confining services to fixed-site clinics and offices. The CSS philosophy recognizes that individuals with serious mental illnesses frequently need supports beyond treatment and clinical services to help them live successfully in community settings. The CSS framework includes traditional mental health services, which have been enhanced by the development of a wider array of effective medications to treat mental disorders, improvements in medication management, and the identification of “evidence-based practices” (EBPs) that have demonstrated efficacy and cost-effectiveness in securing positive outcomes for individuals with serious mental illnesses.

An evidence-based practice is a method to address a condition, which meets scientific and stakeholder criteria for safety, effectiveness, and cost-effectiveness. EBPs translate research findings into practice. The deployment of EBPs is widely regarded as central to improving health care quality. There are now six recognized adult mental health EBPs: Assertive Community Treatment (ACT), Family Psychoeducation, Integrated Dual Disorders Treatment, Illness Management and Recovery Program, Medication Management Approaches in Psychiatry (MedMAP), and Supported Employment.

Several of these evidence-based practices have a strong recovery component. Recovery is a compelling paradigm for supporting individuals with serious mental illnesses. Recovery has its roots in the fundamental principles of the community support system concept and stresses how crucial it is for people with mental illnesses to assume responsibility for and control of their lives by making decisions about their services. Recovery shares many of the same philosophical underpinnings as those of the broader self-direction movement among people with disabilities of all types who are asserting greater authority over service provision and assuming personal responsibility for improving the quality of their lives.

Peer support is an essential component of a recovery-oriented service system. The term peer support refers to social and emotional support—frequently coupled with help to perform daily living tasks—that is mutually offered or provided by persons having a mental

health condition to others with a similar or different condition, to bring about a desired social or personal change. Other examples of recovery-oriented services include Wellness Recovery Action Planning (WRAP), Pathways to Recovery, and Peer Bridgers.

The principles of recovery and the emergence of evidence-based practices are exerting a strong influence on the provision of publicly funded community mental health services. Beginning in 2000, the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Robert Wood Johnson Foundation co-led a nationwide effort to promote the application of evidence-based practices. Many states have launched initiatives to introduce and expand the use of these practices in their community mental health systems. Several states, including Georgia and Michigan, have made progress in redesigning their coverage of Medicaid mental health services to incorporate the essential principles of recovery.

### **Mental Health Systems Transformation Grants**

In September 2004 CMS provided \$3.6 million to fund Mental Health Systems Transformation (MHST) grants to encourage states to develop mental health systems infrastructure to implement and sustain evidence-based and recovery-oriented practices. Grants were awarded to 12 states under the Systems Change grants program: Delaware, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, and Virginia.

The primary purpose of the grants was to help states increase their capacity to deliver evidence-based practices and to adopt a recovery orientation in order to better serve individuals with mental illness receiving Medicaid-funded services. Another purpose was to help states to better align their Medicaid and mental health systems to collaborate with one another and with other stakeholders. States were permitted to use grant funding flexibly to achieve their goals.

This report describes the 12 MHST Grantees' initiatives, with a focus on implementation issues and challenges and how they addressed them. Four Grantees focused solely on evidence-based practices, six on recovery practices, and two on both.

### **Implementing Recovery-Oriented Initiatives**

All of the eight Grantees with recovery initiatives focused their efforts on developing, implementing, and/or sustaining various methods for providing peer support—defined as supports and services provided by consumers on a volunteer or paid basis, whether in the traditional mental health system or through consumer-/peer-operated programs or activities.

Several Grantees developed curricula and trained individuals with mental illness to be employed in specific recovery-focused roles in the mental health system. States use different names for these roles (e.g., a recovery support specialist in Oklahoma, a certified intentional peer support specialist in Maine). States confronted some operational issues when providing training, such as provider reluctance to lose revenue when allowing peer support specialists to participate in training. With the exception of such operational issues, Grantees did not report any major challenges in conducting training. However, in some states, individuals who received training could not find employment because these states did not determine beforehand where trainees would work.

Grantees identified several major provider-related challenges that impede the overall adoption of a recovery orientation and the incorporation of peer support services, specifically, in the mental health services system. These challenges included a lack of knowledge of or interest in recovery concepts, practices, and skills; skepticism about the recovery concept; resistance to giving up control and working collaboratively with individuals they perceive as “clients”; negative views about individuals with mental illness; and reluctance to hire individuals with mental illness. Many of these challenges are interrelated, and all must be addressed if states want providers in their mental health systems to promote recovery. Grantees developed and conducted a wide range of education and training initiatives to address provider-related challenges. In addition to education and training on recovery-oriented practices, providers often need technical assistance to support the development of peer support and peer-operated services.

Peer support staff face challenges when working for traditional providers who have never encountered service users as staff members. These challenges can include the expression of negative attitudes and disrespectful comments from non-peer staff about peer support staff or consumers. Such challenges can create discomfort and workplace conflicts, and some organizations provided mentoring for peer support staff to address these conflicts or developed peer support staff networks.

Several Grantees worked to develop reimbursement policies for peer support services, but not all Grantees succeeded in securing Medicaid reimbursement for these services. Activities included developing a Medicaid State Plan amendment (Pennsylvania) or a service description and associated Medicaid billing codes for peer-operated drop-in centers (Oregon). Several Grantees mentioned inadequate funding—and a lack of Medicaid reimbursement in particular—as the reason their state could not offer or expand recovery services, particularly peer support. Several noted that because CMS no longer allows bundled billing for ACT services, they were less able to employ peer support staff on ACT teams. Several Grantees said that their state’s plans to submit State Plan amendments to obtain Medicaid funding for peer support services have been put on hold until issues related

to Medicaid coverage of services under the Rehabilitation and Targeted Case Management options are resolved.

Employing Medicaid to underwrite mental health services involves “finding the fit” between the services and supports that a state has identified as critical to meeting the needs of individuals with serious mental illnesses and Medicaid program requirements. Several states have done so successfully. For example, Michigan’s grant staff noted that the Section (§) 1915(b) waiver authority affords considerable flexibility to fund a wide range of recovery-oriented services, including peer support specialists and peer-operated programs such as drop-in centers.

States and provider organizations sought to determine the extent of an organization’s recovery orientation in order to identify areas for improvement. Several types of tools are available for this purpose, including the Recovery Enhancing Environment tool, the Recovery Oriented System Indicators tool, and the Fidelity Assessment Common Ingredient Tool. Several Grantees used one of these tools to help various entities in the mental health services system assess their recovery orientation and identify areas for improvement.

Several Grantees noted that both states and the federal government need to revise existing policies to facilitate and promote infrastructure development and bring about systems change to support a recovery orientation in the public mental health system. States can make some changes without federal approval, but others require action by CMS and SAMHSA.

### **Implementing Evidence-Based Practices**

Several evidence-based practices are recognized by SAMHSA as having demonstrated efficacy and cost-effectiveness in securing positive outcomes for individuals with serious mental illnesses. Yet the practices validated by research are not widely offered in mental health practice settings. One possible explanation for this gap between knowledge and practice is that states need a robust infrastructure to support delivery of these practices, but developing this infrastructure is costly and challenging. Essential elements of infrastructure development include active stakeholder involvement; sustained provider training and follow-up clinical supervision; adequate funding for start-up and sufficient reimbursement for implementation; practical methods and funding to monitor implementation to improve quality; and alignment of federal, state, and provider policies and structures to support practice implementation.

The more elements of a service system that can be employed to support change and reduce resistance, the more likely that practice improvements will occur.

Six of the MHST Grantees had initiatives to implement evidence-based practices in their state's mental health system, focusing on provider training and supervision; developing reimbursement methods; and developing monitoring methods to ensure that evidence-based services are being provided with high fidelity (i.e., in accordance with implementation instructions).

### ***Provider Training and Supervision***

Changing how clinicians practice is a challenging task. Research has shown that education alone does not strongly influence their practice behaviors and that additional efforts are needed, including providing clinicians with supervision and feedback. Both North Carolina and Minnesota developed methods for providing ongoing consultation. Delaware developed a manual to facilitate the adoption of family psychoeducation by providing a visible reminder for therapists to use the evidence-based practice. As with training for peer support staff, providers were reluctant to have their clinicians participate in training because the time off led to revenue losses. New Hampshire and Minnesota developed additional funding to cover the cost of ongoing consultation and follow-up; New Hampshire is in the early stages of developing credentialing procedures and standards for providers of Illness Management and Recovery practices.

### ***Ensuring Reimbursement for Evidence-Based Practices***

To facilitate the adoption of new practices—and to track their delivery—some states developed separate billing codes for specific practices; for example, Delaware established a separate billing code for Family Psychoeducation. North Carolina explored the possibility of developing multiple billing codes and “pay for performance” initiatives.

Several grant staff noted that Medicaid's inability to reimburse *all* EBP components makes it difficult for providers to furnish the practices with high fidelity. Virtually all of the Grantees implementing evidence-based practices said that the SAMHSA tool kits for some practices include recovery-oriented components that frequently are not billable to Medicaid. However, several states recognize the need to find other funding sources to cover services that Medicaid will not reimburse. North Carolina developed multiple reimbursement codes to ensure that providers are able to bill for all service components of the Integrated Dual Diagnosis Treatment tool kit. Having to use multiple codes results in a complex billing structure, but it ensures coverage for all of the components of the practice.

### ***Ensuring the Quality of Evidence-Based Practices***

Research indicates that when mental health programs attempt to implement evidence-based practices, the quality of the implementation strongly influences outcomes (i.e., programs that have the higher fidelity to the defined practice tend to produce superior clinical results).

This finding suggests that efforts to promote evidence-based practice must include fidelity measures and self-correcting feedback mechanisms.

Researchers have developed various measures and instruments to assess the fidelity of the implementation process. These include the tool kits from SAMHSA for each evidence-based practice and the General Organizational Index, which measures a set of general operating characteristics of an organization that are hypothesized to be related to its overall capacity to implement and sustain any evidence-based practice.

States recognize the need to ensure regular monitoring of provider practices. However, fidelity assessments are expensive, and providers cannot afford to conduct them on an ongoing basis. North Carolina and New Hampshire provided funding to support monitoring. Some Grantees also developed structured processes to support fidelity measurement. No Grantee was monitoring consumer outcomes as a quality measure.

## **Conclusions**

Although SAMHSA has approved six evidence-based practices and encouraged their adoption, to date, science is far ahead of practice. Some states have taken the lead and made progress in the delivery of both evidence-based and recovery practices, but others are still in the very early stages of implementation. Although the 12 states that received MHST grants have unique service delivery systems and are at different stages in the systems transformation process, they faced similar challenges. Even with these challenges, all made significant progress in developing the infrastructure to support evidence-based and recovery practices.

Despite the availability of information about how to implement evidence-based practices, these 12 states varied in the degree to which they appeared to make use of it. Some states used their grants to implement one or more components of a clearly articulated, broad systems transformation strategy, whereas others implemented what seemed to be stand-alone initiatives. Still others had education initiatives that a cursory review of the research literature would have revealed as inadequate for achieving their goals.

Before planning systems change initiatives generally, and the implementation of evidence-based practices specifically, state staff need to review the relevant literature and to take advantage of available technical expertise to become more knowledgeable about implementation challenges and methods to address them. Understanding what other states have tried and the challenges they faced and resolved—or not—will also help staff to develop successful approaches.

Several Grantees mentioned federal Medicaid rules as a major impediment to the adoption of a recovery orientation, because the rules preclude coverage of many recovery-oriented

practices. Many Grantees also said that lack of Medicaid reimbursement for all components of evidence-based practices made it difficult to implement the practices with high fidelity. However, Medicaid pays for services—not practices. Medicaid principally pays for medical services (including psychiatrist and some psychologist services), and the majority of mental health services are covered through optional benefit categories, such as rehabilitation and clinic services.

Because evidence-based practices include some components that Medicaid does not cover, states need to break down the practices into services to determine what Medicaid can cover under the State Plan and to identify other sources of funding for the components not covered. For example, North Carolina uses state funds for recovery-oriented services and Medicaid funds for services that meet State Plan requirements to seamlessly integrate evidence-based practices with recovery-oriented services such as housing, employment, social, and peer supports.

Although it is understandable that states with limited budgets look to Medicaid to fund recovery-oriented services, including peer support and all components of evidence-based practices, it is important for state staff and policy makers to recognize that the basic provisions of Medicaid law determine parameters for Medicaid services, which may not encompass all of the services and supports that beneficiaries with serious mental illnesses need to live successfully in the community.

Employing Medicaid to underwrite mental health services entails finding the fit between Medicaid program coverage and the services and supports that a state has identified as critical to meeting the needs of individuals with serious mental illnesses. Several states have done so successfully. Eight states support peer specialists through various Medicaid financing strategies, primarily by qualifying individuals with mental illness as providers under the Medicaid rehabilitation option. Georgia and South Carolina have also developed a distinct peer support service under the rehabilitation option. Michigan, Colorado, and New Mexico use §1915(b) waivers to cover peer support services.

States should consider investigating other Medicaid authorities for covering these services. For example, Michigan and Oregon use the §1915(b)(3) waiver authority to use savings obtained through managed care arrangements to cover additional services, including recovery-oriented services. Nevada and Iowa are using the new §1915(i) home and community-based services (HCBS) authority to provide services for individuals with mental illness. A major advantage of this authority is that it does not tie the provision of HCBS to a requirement that an individual need an institutional level of care.

Finally, states need to establish measurable goals to guide the transformation to an evidence-based, recovery-oriented mental health system and to identify desired individual,

provider, and systems-level outcomes to measure progress toward those goals. However, fidelity assessments and other systems evaluation measures are very costly to implement, and states need to provide technical assistance and funding to providers to conduct fidelity reviews and measure progress.

### **Next Steps**

The MHST grants provided much-needed funds for 12 states to implement initiatives to increase the use of evidence-based and recovery-oriented practices in their mental health systems. However, additional funding is needed to continue their efforts and sustain quality over time.

Given the very high cost of efforts to change clinicians' practice patterns, states should consider giving greater attention to working with professional licensing boards, colleges, and universities to ensure that students preparing for work in the mental health system—at all levels—receive training based on current evidence-based psychosocial intervention research and obtain clinical experience in the use of evidence-based practices. A SAMHSA-led national-level effort in this area could help to jump-start state-level initiatives as well as focus much-needed attention on the need to prepare mental health practitioners and clinicians at all levels to provide evidence-based and recovery-oriented services.

The proposed changes to services under Medicaid's rehabilitation and targeted case management options—and uncertainty about how, when, and whether the changes will be finalized—have led many states to put mental health systems improvement initiatives on hold. Many Grantees said that their states will be unable to move forward with their plans to increase the availability of evidence-based and recovery-oriented practices in their mental health systems until CMS releases final rules. However, CMS cannot act until the congressional moratorium ends, and Congress may extend it until the new administration decides how to handle the proposed changes.

## Section 1: Introduction<sup>1</sup>

Mental illness is the leading cause of disability in the United States, and serious mental illnesses such as schizophrenia, bipolar disorder, and severe depressive disorders, can be especially disabling if undiagnosed or untreated. Individuals with serious mental illnesses experience substantial limitations in major life activities, at home, at work, and in the community. Each year, approximately 6 percent of the U.S. population experiences a serious mental illness.<sup>2</sup>

Public funds account for almost \$3 of every \$5 spent on mental health services in the United States. The organization and management of public mental health systems is a state responsibility, and states and localities underwrite a substantial share of national mental health expenditures. Historically, public mental health systems revolved around the operation of large public institutions. Today these systems focus on assisting individuals in the community. Federal funding for mental health services comes from the Medicaid program and grants to states from the Substance Abuse and Mental Health Services Administration (SAMHSA).

The joint federal-state Medicaid program is the single largest source of funding for public mental health services. On average, over a 10-year period from 1991–2001, Medicaid accounted for 44 percent of public mental health spending.<sup>3</sup> Approximately 11 percent of Medicaid beneficiaries use mental health and/or substance abuse services.<sup>4</sup> Most state Medicaid programs cover mental health services that are frequently unavailable through private health insurance or Medicare.<sup>5</sup>

No single source of public funding—including Medicaid—is sufficient in its amount or purpose to fully support effective community mental health services. States must use multiple funding sources to support individuals. However, Medicaid can play a pivotal role in underwriting vital services and supports for low-income individuals with serious mental illnesses.

The delivery of publicly funded mental health services has evolved over the past decades from a system that consisted of large state-run mental institutions, funded solely with state funds, to a community support system (CSS) that strongly emphasizes support for individuals in the community rather than confining services to fixed-site clinics and offices. The CSS philosophy recognizes that individuals with serious mental illnesses frequently need supports beyond treatment and clinical services to help them live successfully in community settings. It also underscores the critical role that peers, families, friends, and other sources of community support outside the formal service delivery system can play in supporting individuals in community settings.

The CSS framework also includes traditional mental health services, which have been enhanced by the development of a wider array of effective medications to treat mental disorders, improvements in medication management, and the identification of “evidence-based practices” that have demonstrated efficacy and cost-effectiveness in securing positive outcomes for individuals with serious mental illnesses. The President’s New Freedom Commission on Mental Health stressed the importance of increased use of evidence-based practices.<sup>6</sup> (See Box 1 below.)

**Box 1. Evidence-Based Mental Health Practices<sup>7</sup>**

An evidence-based practice (EBP) is a method to address a condition, which meets scientific and stakeholder criteria for safety, effectiveness, and cost-effectiveness.<sup>8</sup> EBPs translate research findings into practice. The deployment of EBPs is widely regarded as central to improving health care quality. They have been developed and are being researched across a broad spectrum of health services.<sup>9</sup> There are now six recognized adult mental health EBPs:<sup>10</sup>

- **Assertive Community Treatment (ACT)** (ACT; also known as Program for Assertive Community Treatment [PACT]) targets individuals with serious mental illnesses (a) for whom traditional or less intensive services have been ineffective; (b) who experience the most difficulty in independent community living; and (c) who are frequent users of inpatient hospital and crisis services. These individuals frequently experience homelessness, criminal justice system involvement, and/or use of illegal substances. ACT was pioneered in Wisconsin in the late 1970s; most states now have ACT teams. ACT is furnished by interdisciplinary teams of 10 to 12 professionals, including case managers, a psychiatrist, nurses, and social workers, and vocational, substance abuse treatment, and peer specialists. Each team serves approximately 100 individuals.

Individualized services are available on a 24-hour basis and continue as long as necessary. Treatment, support, and rehabilitation services are furnished in community settings rather than offices and clinics. Studies have shown that individuals who receive ACT experience reduced hospitalization rates, a better quality of life, and higher employment rates. Studies also have shown that the costs of ACT (about \$9,000 to \$12,000 per year per person) are offset by reduced hospitalization costs.<sup>11</sup>

- **Family Psychoeducation.** It is estimated that between one-quarter and one-third of adults with serious mental illnesses reside with their family, usually a parent. Thus, families play a critical role in supporting these individuals. Family psychoeducation is a method of working in partnership with families to help them develop increasingly sophisticated and beneficial coping skills for handling problems posed by mental illness in the family and skills for supporting the recovery of the family member with a mental illness.

Family psychoeducation identifies strategies for handling difficult situations, educates family members to better understand the person’s mental illness, and links families to other families who have similar experiences. Family psychoeducation has been demonstrated to improve the quality of the family’s and individual’s life as well as to markedly reduce costs through reduced hospital admissions, shorter hospital stays, and reduced crisis intervention.

(continued)

**Box 1. Evidence-Based Mental Health Practices (continued)**

- ***Integrated Dual Disorders Treatment.*** The percentage of adults with serious mental illnesses who also have a co-occurring substance abuse disorder (abuse or dependence related to alcohol or other drugs) is estimated to run as high as 50 percent. However, only a small percentage receives treatment for both disorders. People with co-occurring disorders are at high risk of negative outcomes, including hospitalization, violence, legal problems, and homelessness. They are the heaviest users of costly services and have poor clinical outcomes. The bifurcation of the mental health and substance abuse services delivery systems can pose problems in effectively serving these individuals. Integrated Dual Disorders Treatment combines mental health and substance abuse treatments within the same system of care. It features a comprehensive range of integrated services, including counseling, case management, medications, housing, vocational rehabilitation, social skills training, and family intervention that are modified to include both diagnoses. This practice promotes positive outcomes, including improved quality of life, reduced hospitalization, and lower costs.
- ***Illness Management and Recovery Program (Wellness Self-Management<sup>12</sup>)*** is “based on research which has shown that by learning more about managing mental illness, people who have experienced psychiatric symptoms can take important steps toward recovery.” This program has been shown to decrease relapses and hospitalization, reduce symptom distress, and result in more consistent medication use. Practitioners work with people to develop personalized strategies for managing mental illness and achieving personal goals. This 3- to 6-month program is designed for people who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression.
- ***Medication Management Approaches in Psychiatry (MedMAP).*** Medications are a part of the recovery for most people diagnosed with serious mental illnesses. MedMAP promotes the systematic selection of medications, measures outcomes, uses the results to modify medications, and enhances the individual’s adherence to medication regimens. MedMAP also stresses shared decision making by the individual and practitioner in the selection of medications. MedMAP aims to eliminate ineffective practices in prescribing medications and to improve the results achieved from their use.
- ***Supported Employment.*** Individuals with serious mental illnesses have an estimated unemployment rate of 80 to 90 percent.<sup>13</sup> Most individuals want to work, and, with support, a majority of them can succeed in the workplace. Supported employment programs aid individuals to secure regular jobs in the community. These programs do not screen individuals for “work readiness” or employ intermediate settings like “pre-vocational” units or sheltered workshops. Employment specialists work with individuals in locating and acquiring a community job and furnish ongoing supports to individuals, usually outside of the workplace. Supported employment has demonstrated effectiveness in promoting community integration and securing meaningful work for individuals.

Several of these evidence-based practices have a strong recovery component. Recovery is a compelling paradigm for supporting individuals with serious mental illnesses (see Box 2). Recovery has its roots in the fundamental principles of the community support system concept and stresses how crucial it is for people with mental illnesses to assume responsibility for and control of their lives by making decisions about their services. Recovery shares many of the same philosophical underpinnings as those of the broader self-

direction movement among people with disabilities of all types who are asserting greater authority over service provision and assuming personal responsibility for improving the quality of their lives.<sup>14</sup>

**Box 2. Recovery-Oriented Services and Peer Support<sup>15</sup>**

Several models of recovery-oriented services have been developed, and each integrates services provided by professionals, consumers, and both in collaboration. Professional services include medication and therapy, and their recovery orientation is determined by the attitudes and approaches of the professionals who provide them (i.e., that professionals believe recovery is possible and that the goal of treatment and support is the promotion of hope, healing, empowerment, and connection).

Peer support is social and emotional support—frequently coupled with help to perform daily living tasks—that is mutually offered or provided by persons having a mental health condition to others with a similar or different condition, to bring about a desired social or personal change.<sup>16</sup>

Peer support can be furnished on a paid or volunteer basis and includes a wide range of activities, including self-help groups, peer-delivered mental health services, and services provided by consumer-/peer-operated programs. The latter are services planned, implemented, and provided by consumers for consumers. Examples include advocacy, peer support programs, hotlines or “warm lines,” and programming that provides opportunities for role modeling and mentoring.

Collaborative services are provided by consumers and professionals as well as family members and friends, and emphasize their diverse but complementary strengths. Examples include recovery education and training, clubhouse organizations, crisis planning, the development of recovery and treatment plans, community integration, and consumer rights education.

In addition, peer support can be provided as part of specific recovery-oriented practices, such as Wellness Recovery Action Planning. (See Box 3.)

Over the past decade, prompted by advocates, the emerging research literature, and concurrent demands to improve the effectiveness of public mental health services, several states have introduced the recovery concept into their mental health systems. In many states, this introduction coincided with a shift toward a managed care approach to financing services and system accountability.<sup>17</sup> Peer support is an essential component of a recovery-oriented service system. (See Box 2.)

The terminology used to describe the many types of peer support—and its components—varies in the research, policy, and mental health literature, as well as in states’ mental health systems. The term is used both to designate a broad concept and specific services. Some states may not even use the term “peer” in the title of a service provided by peers (e.g., recovery specialist). To eliminate confusion, *this report uses the generic term “peer support” as the umbrella term for all peer-provided supports and services, whether on a volunteer or paid basis, and whether provided in the traditional mental health system or*

through consumer-/peer-operated programs or activities. Other terms will be used only when needed to make distinctions between different types of peer support.

### Box 3. Examples of Recovery-Oriented Peer Support Practices

**Wellness Recovery Action Planning (WRAP)** was developed by a mental health recovery advocate to teach persons with serious mental illness recovery and self-management skills and strategies for dealing with psychiatric symptoms in order to promote higher levels of wellness, stability, and quality of life; decrease the need for costly, invasive therapies; decrease the incidence of severe symptoms; decrease traumatic life events caused by severe symptoms; encourage them to actively work toward wellness; and increase their sense of personal responsibility and empowerment.

A recent study found preliminary support for the use of WRAP to change consumers' and mental health professionals' knowledge and attitudes about recovery.<sup>18</sup> The National Institute on Disability and Rehabilitation Research is currently funding a study on WRAP<sup>19</sup> (<http://www.mentalhealthrecovery.com/aboutwrap.php>).

**Pathways to Recovery** is a self-help approach that helps persons with mental illness to set life goals. The approach uses a workbook, *Strengths Recovery Self-Help Workbook*, published by the Office of Mental Health, Research & Training, at the University of Kansas School of Social Welfare (<http://www.socwel.ku.edu/projects/SEG/pathways.html>).

**Peer Bridgers** is a program to help individuals being discharged from psychiatric hospitals to successfully transition to community life and to significantly decrease their need for readmission. Consumers working as peer bridgers provide support and advocacy, and help individuals to connect with community resources ([http://www.nyaprs.org/pages/View\\_Content\\_A.cfm?ContentID=47](http://www.nyaprs.org/pages/View_Content_A.cfm?ContentID=47)).

Although the level of evidence for the efficacy of peer support practices is not strong, individuals with mental illness report that these practices help them to achieve the recovery goals in their person-centered plans.<sup>20</sup> Rigorous research on peer support practices is under way to begin to identify the potential effects of some of these practices on various measures, including personal outcomes important to consumers and systems outcomes such as hospitalization rates and use of community-based services.<sup>21</sup> Until research demonstrates their efficacy, recovery-oriented peer support practices may be viewed as promising practices or emerging best practices.<sup>22</sup>

The principles of recovery and the emergence of evidence-based practices are exerting a strong influence on the provision of publicly funded community mental health services. Beginning in 2000, SAMHSA and the Robert Wood Johnson Foundation co-led a nationwide effort to promote the application of evidence-based practices. Many states have launched initiatives to introduce and expand the use of evidence-based practices in their community mental health systems. Several states, including Georgia and Michigan, have made progress in redesigning their coverage of Medicaid mental health services to incorporate the essential principles of recovery.

## **Challenges Faced When Implementing Evidence-Based Practices**

Despite states' interest in incorporating evidence-based practices into their mental health systems, they face many challenges in their efforts to do so. First, many mental health practitioners lack knowledge about evidence-based practices because their education and training did not cover them. Information about evidence-based practices has only recently begun to be widely disseminated, so this challenge still exists.<sup>23</sup>

Second, mental health practice varies widely, and professionals do not always agree on which practices lead to the best outcomes. Thus, many practitioners are reluctant or resistant to change their practice modalities, particularly if they have been using them for many years or even decades. Even when they are convinced of a practice's efficacy, change is very difficult without extensive education and training and consistent reinforcement. Reinforcement is needed from the research and clinical fields, but practitioners also need support from the mental health infrastructure that supports their work.

Third, evidence-based practices may not be supported by key stakeholders in a state's mental health system. A state's organizational culture, a lack of leadership and teamwork, statutory and regulatory policies, and reimbursement policies can all impede the adoption of both evidence-based practices and of a recovery orientation.<sup>24</sup> For example, Medicaid does not cover all the components of some evidence-based practices, and states face numerous challenges in developing effective strategies for combining federal, state, and local funding to cover them.

Fourth, individuals with mental illness and their families may also not know about these practices or be convinced of their utility. Consumers and their advocates may be more interested in encouraging the adoption of a recovery orientation and specific recovery-oriented practices, both within the traditional mental health system and through an alternative or parallel system, than they are in supporting adoption of evidence-based practices. Some view these practices as more medically oriented than recovery oriented; however, this view may be based solely on their names (e.g., "Illness Management" rather than "Maintaining Wellness").

Fifth, implementing evidence-based practices is a costly undertaking. States and provider agencies often lack the necessary funds to change the existing infrastructure to support widespread implementation of evidence-based practices.

## **Challenges Faced When Adopting a Recovery Orientation<sup>25</sup>**

Consumers and professionals who view recovery as synonymous with cure may dismiss it as an unrealistic expectation, particularly for persons with very serious illnesses such as schizophrenia and those experiencing psychotic symptoms. Thus, a major challenge for a

state seeking to incorporate a recovery orientation into its mental health system is the need for extensive education and training about the recovery concept. Recovery is more aptly conceived of as a healing process with two main components: (1) defining a self apart from the illness, and (2) finding ways to relieve the symptoms of the illness or reduce the social and psychological effects of stress.

For providers to incorporate a recovery orientation into their practice, they must make a fundamental shift from being “in charge” to sharing both power and responsibility. Such a change in roles and relationships can be very challenging because it requires that providers change their fundamental concepts about the course of mental illness and the way they practice, focusing on individuals’ strength and goals rather than solely on their illness. They must also abandon the hierarchical relationships they are comfortable with and develop collaborative relationships with the individuals they serve. Collaboration allows individuals with mental illness to work with providers to plan, negotiate, and make decisions about the services and activities they will use to support their recovery. To make all these changes, providers need extensive education, training, and ongoing supervision, as well as a mental health system infrastructure that not only supports these changes but also encourages them.

Efforts to encourage and support the employment of individuals with mental illness in the traditional mental health system face two specific sets of challenges. The first set arises from the stigma associated with mental illness and negative views about the capabilities of persons with mental illness. The second arises from mental health providers’ ethical and professional concerns about dual relationships (i.e., interacting with a client in both a client and a co-worker role) and about confidentiality. These are valid concerns that states need to address.

Peer support staff can also experience difficulty in redefining their roles and boundaries as employees, particularly if they are hired by the agency where they are also a client. Clients may also have difficulty accepting a friend and/or peer in a paid provider role.<sup>26</sup> States need to address these and other human resources issues before peer support staff can be successfully integrated into the mental health services delivery system.

Finally, finding funding for peer services can be a challenge if they are not defined in a manner consistent with Medicaid reimbursement requirements.

## **Mental Health Systems Transformation Grants**

Given the challenges and barriers enumerated above, in September 2004 CMS provided \$3.6 million to fund Mental Health Systems Transformation (MHST) grants to encourage states to develop the infrastructure to implement and sustain evidence-based and recovery-oriented practices. Grants were awarded to 12 states under the Systems Change grants

program: Delaware, Maine, Massachusetts, Michigan, Minnesota, New Hampshire, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, and Virginia.

Seven Grantees finished their grants in September 2007, and four finished in September 2008. Because Michigan did not receive its grant until May 2005, the time frame for its completion was extended to April 2009. Detailed information about each Grantee's initiative can be found in the individual state summaries in Appendix A.

The primary purpose of the grants was to help states increase their capacity to deliver evidence-based practices and to adopt a recovery orientation in order to better serve individuals with mental illness receiving Medicaid-funded services. Another purpose was to help states to better align their Medicaid and mental health systems to collaborate with one another and with other stakeholders. States were permitted to use grant funding flexibly to achieve their goals.

This report describes the 12 MHST Grantees' projects, with a focus on implementation issues and challenges and how they were addressed.

## **Study Methods**

To gather initial information about the Grantees' initiatives, we reviewed summaries of their goals and activities and their annual reports submitted to CMS. We also sought input from the CMS project officer and other staff. We prepared discussion guides tailored to grant activities and conducted in-depth telephone interviews during fall 2008 with all the grant project directors and associated staff, such as grant contractors. Based on these discussions and other source materials, including grant-funded reports, we prepared written summaries of grant activities and sent them to each project director for review to confirm their accuracy. We obtained clarification and additional information through follow-up calls and e-mail. These summaries were the primary source of information for the main report and are included in Appendix A. To ensure accuracy, we also sent Section 2—Overview of Grantees' Initiatives—to all of the project directors for their final review.

## **Limitations**

The descriptions of the initiatives in this report are not intended to be comprehensive or exhaustive but to provide sufficient context for understanding the discussion of policy and implementation issues.

## **Organization of This Report**

Section 2 presents an overview of the Grantees' initiatives. Section 3 discusses Grantees' initiatives with a focus on their challenges and how they addressed them. Section 4 presents our conclusions.

Appendix A provides a summary of each of the 12 Grantees' goals and initiatives and the policy-related issues and challenges they faced. Appendix B contains the August 15, 2007, State Medicaid Director's Letter pertaining to CMS policy regarding peer support services.



## **Section 2: Overview of Grantees' Initiatives**

This section highlights the major features of the 12 Grantees' initiatives. Table 2-1 provides an overview of the Grantees' overall goals and their primary approach for achieving them. Two Grantees had initiatives that focused on both evidence-based and recovery-oriented practices (Virginia, Oklahoma). Four Grantees had initiatives that focused solely on evidence-based practices (Delaware, Minnesota, New Hampshire, and North Carolina). Although Delaware's overall goal was to provide a stronger recovery orientation in the mental health system, its primary approach was to develop and pilot family psychoeducation: an evidence-based practice.

Six Grantees focused on recovery practices only (Maine, Massachusetts, Michigan, Ohio, Oregon, and Pennsylvania). All of the eight Grantees whose primary goal was to promote recovery had at least one initiative to develop, expand, or sustain peer support services or programs; all but one of these Grantees had peer support initiatives as their main focus. In addition to developing new and expanding existing peer-operated programs and services, a major goal for Oregon was to promote these services as evidence-based practices.

Most of the Grantees had several different initiatives to help them achieve their goals, which are described in the individual descriptions of each grant in Appendix A.

### **Target Populations**

Grantees targeted improvements in their mental health systems to benefit specific populations.

- Maine, Michigan, North Carolina, Ohio, Oregon, and Virginia targeted adults with mental illness.
- Oklahoma targeted adults with mental illness and/or substance abuse disorders.
- New Hampshire and Pennsylvania targeted adults with mental illness and children with serious emotional disturbance.
- Massachusetts targeted adults with mental illness and children with serious emotional disturbance, including those with co-occurring substance abuse disorders; it also targeted young adults transitioning out of the children's mental health system.
- Delaware targeted children with behavioral health problems and their families.
- Minnesota targeted children with serious emotional disturbance and their families.

**Table 2-1. Overview of MHST Grantees' Initiatives**

<b>Lead Agency</b>	<b>Overall Goal</b>	<b>Primary Approach</b>
<b>Delaware</b> Department of Services for Children, Youth and Their Families	Enhance the mental health services delivery system by providing a stronger orientation toward recovery, with families as key agents for support during relapse and in the recovery process.	Develop and pilot a family psychoeducation program to educate parents/caregivers, providers, school psychologists, and guidance counselors on social, emotional, and behavioral health problems in children and youth.
<b>Maine</b> Department of Health and Human Services	Increase the State's ability to offer recovery-oriented services to Medicaid-eligible individuals with mental illness.	Design and implement a peer support specialist training and certification program.
<b>Massachusetts</b> University of Massachusetts Medical School	Promote a recovery orientation throughout the State's mental health system with a particular focus on strengthening the role of peer specialists.	Design and implement a peer support specialist training and certification program, and establish a state-level, consumer-operated Recovery Center of Excellence.
<b>Michigan</b> Department of Community Health	Establish recovery-oriented practices as the foundation of Michigan's adult mental health system.	Develop infrastructure to support recovery-oriented mental health services, including peer supports and a consumer-operated Recovery Center of Excellence.
<b>Minnesota</b> Department of Human Services	Improve the quality of children's mental health services and their treatment outcomes, and reduce out-of-home placements.	Develop an EBP database, educational materials, and training for clinicians and families to enable the provision of effective treatment strategies based on scientific research.
<b>New Hampshire</b> Bureau of Behavioral Health	Implement illness management and recovery (IMR) as an evidence-based practice in behavioral health services for individuals with severe mental illness.	Develop an organizational structure supporting IMR clinicians in each community mental health center region, and revise reimbursement regulations to cover IMR services.
<b>North Carolina</b> Division of Mental Health, Developmental Disabilities, & Substance Abuse Services	Achieve greater incorporation of evidence-based practices into the local mental health system.	Develop infrastructure to support EBPs in four pilot areas, and disseminate EBP tool kits statewide to help other local areas replicate the infrastructure-building process.
<b>Ohio</b> Department of Mental Health	Ensure that peer support specialists are included as part of Assertive Community Treatment (ACT) services offered by community mental health centers throughout the State.	Develop a curriculum to train individuals as peer support specialists in order to serve on ACT teams, and provide training, consultation, and technical assistance to traditional mental health providers.
<b>Oklahoma</b> Department of Mental Health & Substance Abuse Services	Provide quality mental health and substance abuse services focused on recovery, and involve consumers in treatment decisions.	Develop a policy and program framework for evidence-based practices, and a network of recovery support specialists.
<b>Oregon</b> Addictions and Mental Health Division	Develop new—and expand existing—peer-operated programs and services, and promote their acceptance statewide as evidence-based practices.	Improve peer-operated program structure and services by identifying collaboration strategies, funding mechanisms, and policy changes needed to sustain peer-operated programs.

(continued)

**Table 2-1. Overview of MHST Grantees' Initiatives (continued)**

Lead Agency	Overall Goal	Primary Approach
<b>Pennsylvania</b> Department of Public Welfare, Office of Mental Health & Substance Abuse Services	Integrate recovery-oriented practices in the State's mental health services delivery system.	Train and certify peer support staff and develop a Medicaid reimbursement methodology for their services; provide training and technical assistance to counties to meet the requirements for the new peer support service.
<b>Virginia</b> Department of Mental Health, Mental Retardation, and Substance Abuse Services	Introduce and sustain the provision of recovery-oriented evidence-based practices and peer support services to adults with serious mental illness.	Develop infrastructure to align Medicaid Mental Health Rehabilitation option services with three EBPs: ACT, IMR, and Supported Employment; and train and certify consumers as peer specialists.

### Specific Practices Selected by Grantees

As shown in Table 2-2, six Grantees chose to develop the infrastructure for or implement one SAMHSA-recognized evidence-based practice. Minnesota developed a database of evidence-based practices for children with serious emotional disturbance (SED). Four of the Grantees selected the evidence-based practice of Illness Management and Recovery. North Carolina selected four practices, and Virginia selected three. Eight Grantees chose to work on recovery-oriented practices, with peer supports selected by eight.

**Table 2-2. Evidence-Based and Recovery-Oriented Practices Selected by Grantees**

	DE	MA	ME	MI	MN	NC	NH	OH	OK	OR	PA	VA	Total
<b>Evidence-Based Practices</b>													
Illness Management and Recovery						•	•		•			•	4
Assertive Community Treatment												•	1
Family Psychoeducation	•					•							2
Supported Employment						•						•	2
Integrated Mental Health and Substance Abuse Treatment						•							1
Practices for Children with SED					•								1
<b>Recovery-Oriented Practices</b>													
Peer Support		•	•	•				•	•	•	•	•	8
Consumer-Operated Services and Supports		•						•		•			3
Wellness Recovery Action Planning				•				•					2
Peer Bridgers								•		•			2



## **Section 3: Implementation of Grant Initiatives**

This section of the report focuses on the challenges Grantees faced during implementation of the initiatives and how they addressed them. The first part looks at initiatives to incorporate a recovery orientation in the mental health services systems—primarily through the provision of peer support. The second part focuses on initiatives to develop the necessary infrastructure for or to implement evidence-based practices.

### **Implementing Recovery-Oriented Initiatives**

Because peer support is an essential component of a recovery-oriented service system, all of the eight Grantees with recovery initiatives focused their efforts on developing, implementing, sustaining, and/or expanding various methods for providing peer support.

#### ***Training Individuals with Mental Illness to Provide Peer Support in Traditional Mental Health Settings***

As noted in Section 1, this report uses the generic term *peer support* as the umbrella term for all peer-provided supports and services, whether on a volunteer or paid basis, and whether provided in the traditional mental health system or through consumer-/peer-operated programs or activities. When referring to individuals with mental illness who provide paid services, we use the general term peer support staff unless referring to the specific terms the states use.

Several Grantees developed curricula and trained individuals with mental illness to be employed in specific recovery-focused roles in the mental health system. States use different names for these roles (e.g., recovery support specialist in Oklahoma; certified intentional peer support specialist in Maine).

For example, Maine developed a peer support specialist certification process, which required completion of two courses; quarterly co-supervision with staff in the Office of Adult Mental Health Services, Office of Consumer Affairs; two continuing education classes per year; and 75 hours of work per year on a paid or volunteer basis. Certification is issued upon completion of all requirements, which must be met within 1 year of completing the training program. To maintain certification, the requirements for continuing education, co-supervision, and 75 hours of peer support work must be met annually.

Michigan developed continuing education courses to help peer support specialists keep their newly learned skills current by working with community colleges to develop a curriculum offering three elective credit hours; this course can also be used to complete requirements for certification.

States confronted a few operational issues related to training. For example, in some states, individuals who were interested in receiving newly available training were already working in a peer support capacity, and their employers were reluctant to grant them time away from their jobs to participate because of the lost revenue. To address this concern, Ohio revised its peer support specialist training to be provided in half-day rather than full-day segments.

In Maine, the State lacks trained peer facilitators needed to provide Wellness Recovery Action Planning (WRAP). One of Maine's grant goals was to increase the number of consumers who could be WRAP facilitators by having them attend a train-the-trainer curriculum offered by an advocacy organization that provides WRAP technical assistance. However, the organization increased its participation requirements, and very few interested individuals were able to meet them.

With the exception of such operational issues, Grantees did not report any major challenges in conducting training. However, in some states, individuals who received training could not find employment. (These states did not require applicants to either have a current peer support position or a commitment from an employer to hire them once training was completed.)

### ***Provider-Related Challenges and How They Were Addressed***

Grantees identified several major provider-related challenges that impeded the overall adoption of a recovery orientation and the incorporation of peer support services, specifically, in the mental health services system. Challenges related to mental health services providers included the following:

- a lack of knowledge about recovery concepts, practices, and skills, and/or a lack of interest in obtaining such knowledge and skills;
- skepticism about the recovery concept, particularly for individuals with serious illnesses such as bipolar disorder and schizophrenia, individuals who experience psychotic symptoms, and persons whose providers have been unable to find effective medications;
- resistance to recovery practices that entail giving up control and working collaboratively with individuals they perceive as "clients";
- negative views about individuals with mental illness, particularly in regard to their ability to reliably provide valuable and useful services; and
- reluctance to hire individuals with mental illness based on valid concerns about professional ethics and boundary issues, maintaining confidentiality, and various human resources issues.

Many of these challenges are interrelated, and all of them must be addressed if states want providers in their mental health systems to promote recovery.

The extent to which Grantees grappled with these challenges varied, but all did so to some degree. Oklahoma's experience provides an example of provider resistance to hiring peer support staff. Oklahoma mandates that ACT providers have a Recovery Support Specialist (a peer provider) on their team in order to be certified. To circumvent this requirement, some Oklahoma ACT teams have hired professionals who have experienced mental illness in the past, calling them Recovery Support Specialists in addition to their professional title, even though they do not function as Recovery Support Specialists.

Other Oklahoma ACT providers have "borrowed" a Recovery Support Specialist from another section of their treatment facility (e.g., the outpatient division) when undergoing recertification. Once recertified, the Recovery Support Specialist returns to the original position. Oklahoma grant staff noted that some ACT teams do not want to hire Recovery Support Specialists because they are unconvinced that individuals with mental illness have the ability to fully recover and provide effective services (despite the practice, noted above, of hiring some professionals who have a mental health history). They also noted that some providers are less inclined to hire individuals who are receiving SSI or SSDI, preferring those with current work experience.

Grantees developed and conducted a wide range of education and training initiatives to address provider-related challenges. For example, the Ohio Coordinating Center for ACT now includes a 1-day training on peer support specialists as part of its technical assistance and training package for individual ACT teams. The Center also provides training about supervising and supporting peer support specialists as part of an ethics course for traditional providers, many of whom attend the course to meet professional licensure requirements.

Michigan grant staff and members of its Recovery Council—established by grant staff to direct and support grant activities—found it very challenging to work with large numbers of providers with multiple clinical perspectives. Grant staff reported that differences in perspectives regarding recovery-oriented principles and practices required much discussion and interaction to develop a shared perspective and to make decisions. At the same time, such discussion strengthened the Council's capacity to provide direction and oversight of the State's recovery activities.

As noted above, many providers voiced valid concerns about confidentiality, human resources issues, professional ethics, and boundary issues when peer support staff are hired (e.g., concerns about dual relationships and the potential for violating professional boundaries required in psychotherapy). A dual relationship is created when a person receiving services from a provider is also employed by that provider.

To protect clients, the professional ethics codes for nurses, social workers, psychiatrists, and psychologists discourage dual relationships because of the power imbalance between provider and client, which raises questions for providers about how to deal with issues that arise when employees/co-workers are also clients.

Ohio grant staff and partners addressed concerns about dual relationships by clarifying hiring and supervision practices for peer support specialists designed to avoid dual relationships (e.g., by requiring that supervisors not be involved in peer support specialists' clinical care).<sup>27</sup> Grant staff also had positive discussions with licensing boards, which helped to reduce concerns about dual relationships. Other Grantees provided training for supervisors of peer support staff to address similar concerns.

To ensure that providers understand consumers' perspectives on recovery, Michigan tries to ensure that consumers constitute a large proportion of those attending mental health trainings (i.e., more than the usual 51 percent representation requirement). Michigan's grant staff pointed out that consumers need to have a "critical mass" to get their point across. The presence of such a large group creates a different learning dynamic and gives consumers confidence that their views on what helps and hinders recovery will be heard. To encourage large numbers of consumers to attend training sessions, the State invites them to attend at no charge; it also tries to place consumers on training teams in order to improve clinicians' views about recovery. Peer support specialists also attend psychiatrists' training sessions, and their presence and contributions help inform psychiatrists' recovery perspective. (See Box 4.)

In addition to education and training on recovery-oriented practices, providers often need technical assistance to support the development of peer support and peer-operated services. To meet this need, Massachusetts developed a peer-operated training and technical assistance center (the Transformation Center) to support, improve, and expand recovery-oriented and peer-operated programs. The Center not only provides technical assistance to other peer-operated organizations and a training program for certified peer specialists, it also conducts training about recovery practices for providers.

### ***Challenges for Peer Support Staff and How They Were Addressed***

Ohio's grant staff reported that peer support staff face challenges when working for traditional providers who have never encountered clients as staff members. These challenges can include the expression of negative attitudes and disrespectful comments by non-peer staff about peer support staff and clients.

**Box 4. Promoting Recovery Throughout the Mental Health System**

Michigan's mental health system employs about 550 certified peer support specialists who provide services through 46 county-based community mental health services programs. They work in a variety of areas, including housing, jail diversion, psychosocial rehabilitation, ACT, crisis settings, employment, and consumer-run organizations. Their services are reimbursed by Medicaid under the State's §1915(b)(3) waiver authority.

Because peer provision of recovery-oriented services is an established service in Michigan, the State used its grant for a much broader purpose than did the other Grantees: to make recovery-oriented practices the foundation of Michigan's adult mental health system. To achieve this goal, Michigan's grant staff and consumer leaders developed a statewide Recovery Council comprising state staff and a majority of consumer members. The Council oversees state, regional, and local recovery-oriented initiatives and works with educational institutions to promote systems change. To support the transition to recovery-oriented practices, the Recovery Council developed a strategic plan to develop needed infrastructure and bring about systems change.

Such challenges can create discomfort and workplace conflicts. To help peer support specialists cope with these challenges and learn advocacy skills to increase their ability to get what they need from their work environment, Ohio Advocates provides mentoring for peer support specialists who are employed by community mental health centers. Mentoring can also be provided by other peer support staff or by professionals who also use mental health services.

Another method to help peer support staff deal with workplace challenges is the development of a peer support staff network. One of Pennsylvania's grant goals was to support and expand the activities of certified peer specialists (CPS) by establishing a self-help network for CPS graduates. To achieve this, grant staff conducted two conferences as networking opportunities for CPS staff, which 70 people attended. Attendees recommended that the State develop a consumer-run statewide peer support association and continuing education opportunities. The Peer Support Association was subsequently formed and was scheduled to conduct its first meeting in January 2009. Continuing education programs have been developed, including one focused on working with older adults and individuals involved in the justice system.

Not all individuals who receive training to provide peer support find employment. Many of Ohio's peer support specialists had expected to find a job in the mental health system when they completed their training and were disappointed when they did not. One year after training, only 56 percent were working in the mental health system in some capacity, with just 26 percent employed as peer support specialists (including four individuals who had worked as peer support specialists prior to the training).

The failure to find employment raises questions about the advisability of using scarce resources to train individuals for positions in which employment is not ensured. To address

this problem, the Project Director and Ohio Advocates staff recommended to the Ohio Department of Mental Health that individuals not be accepted for training until after they have been hired to provide peer support services or until an employer has committed to hiring them once trained.

It is also important to recognize that in states that do not have a Medicaid buy-in program, the risk of losing Medicaid benefits because of increased income is a potential work disincentive.

### ***Reimbursement Issues for Peer Support and Other Recovery-Oriented Services***

CMS issued guidance on how to secure Medicaid reimbursement for peer support services in a letter to State Medicaid Directors on August 15, 2007. (See Box 5 for a summary of Medicaid reimbursement criteria for peer support services.)

#### **Box 5. Medicaid Provisions for Reimbursement of Peer Support Services**

For providers to bill for services, states must identify the Medicaid authority—State Plan or waiver—to be used for coverage and payment; describe the service, the service providers, and their qualifications; and describe the utilization review and reimbursement methodologies. To qualify for reimbursement, peer support providers should be self-identified consumers, and the state must meet minimum requirements for supervision, care coordination, and training.

Reimbursement must be based on an identified unit of service and be provided by one peer support provider, based on an approved plan of care. States must have mechanisms in place to prevent over-billing for services, such as prior authorization and other utilization management methods. CMS reimburses peer support either when offered as a distinct rehabilitative service or when delivered with other covered rehabilitative services.<sup>28</sup> (The complete text of the letter is in Appendix B.)

Several Grantees worked to develop reimbursement policies for peer support services, but not all Grantees succeeded in securing Medicaid reimbursement for these services. In 2005, Pennsylvania developed and submitted an application for a State Plan amendment to include peer support services as a component of rehabilitation services, and at the same time developed the coding and billing mechanisms for reimbursement. After CMS approved the amendment in 2007, grant staff developed a 17-point checklist to help providers meet requirements for furnishing the new service. They also provided technical assistance and training to all of the State's 67 counties to ensure implementation of Medicaid-funded peer support services.

Oregon's grant staff developed a compendium of research on peer-delivered services (*Peer-Run/Peer-Driven Programs, Services, and Organizations: A Review of the Evidence*) to help mental health organizations and consumer/survivor organizations identify evidence-based and promising peer-delivered services used elsewhere in the United States. Oregon's

established EBP hierarchy has six evidence categories, with Category 1 denoting practices with the highest level of evidence. The Oregon Addictions and Mental Health Division designated the socialization aspect of peer-operated drop-in centers as a Category 3 practice and also approved a service description and associated Medicaid billing code for peer-operated drop-in centers to provide this service.

However, to be able to bill for this service, a peer-operated organization in Oregon must be either a certified mental health provider agency able to offer all mental health services, or must subcontract to another certified mental health provider agency to provide drop-in center and other peer-operated services. Because very few consumer-operated organizations can meet the certification requirements or enter into subcontracts to furnish these services, only one peer-operated organization in the State is currently billing for the newly approved service.

Because New Hampshire has a peer support service system that is separate from and complementary to its community mental health center services system, the State has chosen to forego Medicaid reimbursement for peer support services in order to ensure the system's flexibility and stability. Instead, the State uses federal block grant funds to reimburse these services supplemented by state funds.

Several Grantees mentioned inadequate funding—and a lack of Medicaid reimbursement in particular—as the reason their state could not offer or expand recovery services, particularly peer support. In particular, they noted that the change in CMS policy to no longer allow bundled billing for ACT services had hampered their ability to employ peer support staff on ACT teams. For example, in Ohio, ACT teams can hire mental health service users to provide Community Psychiatric Supportive Treatment services—which are Medicaid reimbursable; however, WRAP training and support and other peer support services are not Medicaid reimbursable. Grant staff said that having separate billing procedures for Medicaid and non-Medicaid services impedes the continuity of care provided by peer support specialists.

Ohio grant staff also noted that non-Medicaid funding for peer support is limited by severe constraints on the State's budget. In addition, many of Ohio's county mental health boards are running out of funds to provide the local required match for federal financial participation (FFP; i.e., the federal portion of Medicaid reimbursement). Currently, the Ohio Department of Mental Health is working with the Ohio Department of Job and Family Services (the state Medicaid agency) and CMS to change the match method so that the State, rather than county boards, will be responsible for the entire required FFP match.

Several Grantees said that their respective state's plans to submit State Plan amendments (SPA) to obtain Medicaid funding for peer support services have been put on hold until

issues related to Medicaid coverage of services under the rehabilitation and targeted case management options are resolved. These issues were raised in a proposed rule for changes in the rehabilitation option (Federal Register notice dated August 13, 2007) and targeted case management (Federal Register notice dated August 13, 2007). Because of widespread opposition to the proposed regulation by states, service providers, and advocacy groups, Congress placed a moratorium on the implementation of the targeted case management regulation until July 2009 and does not want the Department of Health and Human Services to finalize the rehabilitation regulation until the new administration obtains more information and decides how to proceed.

Many of the Grantees said that their states were reluctant to make any changes in their Medicaid State Plans until policy regarding service coverage under the two regulations is finalized. Some said their states were reluctant to submit a State Plan amendment because during the review, CMS looks at all services and language on the submitted pages, which may lead to questions about services in the State Plan that may not currently be reimbursable.

### ***Determining the Extent of Organizations' Recovery Orientation***

To determine whether an organization is improving its recovery orientation, baseline and follow-up measures are needed. Recovery-oriented measures assess the basic content of services, how they are provided, and the views of individuals who receive the services. Assessing the extent of an organization's recovery orientation on various measures can identify areas for improvement.

Several types of tools are available for determining the degree of any organization's recovery orientation, including the Recovery Enhancing Environment (REE) tool, the Recovery Oriented System Indicators (ROSI) tool, and the Fidelity Assessment Common Ingredient Tool (FACIT). (See Box 6.) Several Grantees used one of these tools to help various entities in the mental health services system assess their recovery orientation and identify areas for improvement.

Virginia's Department of Mental Health, Mental Retardation, and Substance Abuse Services encouraged Community Service Boards to use the ROSI scale to help determine the extent to which their services were recovery oriented. Although the ROSI survey tool includes a consumer assessment and an organization assessment, grant funds were sufficient only to conduct a consumer assessment.

### Box 6. Tools for Assessing Recovery Orientation or the Quality of Recovery Services

**The Recovery Enhancing Environment (REE) Tool**<sup>29</sup> was designed for consumers to rate personal markers of recovery in their lives; it can also be used to rate the recovery orientation of the agency from which they receive services. The tool can be used in strategic planning to promote change in provider organizations. The REE collects information on personal recovery, organizational climate factors that support resilience, and services and programs that influence recovery. The REE has a total of 166 items organized into eight domains: Demographics, Stage of Recovery, Importance Ratings on Elements of Recovery, Program Performance Indicators, Special Needs, Organizational Climate, Recovery Markers, and Consumer Feedback<sup>30</sup> (see <http://psychservices.psychiatryonline.org/cgi/content/full/55/12/1461> for detailed information).

**The Recovery Oriented System Indicators (ROSI)**<sup>31</sup> was designed to assess the recovery orientation of community mental health systems. It has two components: (1) a consumer self-report measure with 42 personal assessment items, and (2) 23 items measuring administrative characteristics of provider agencies.<sup>32</sup> The consumer domains include person-centered decision making and choice, self-care and awareness, meaningful activities and roles, peer advocacy, staff treatment knowledge, and access. The administrative domains include peer support, choice, staffing ratios, system culture and orientation, consumer inclusion in governance, and coercion.<sup>33</sup>

**The Fidelity Assessment Common Ingredient Tool (FACIT)**<sup>34</sup> is a fidelity assessment protocol developed during SAMHSA's Consumer Operated Services Program Multisite Research Initiative in the late 1990s. It was developed to assess the extent to which consumer-operated services shared a set of common elements identified by programs participating in the Consumer-Operated Services Program Multi-site Research Initiative. The tool measures elements of a consumer-run organization's structure, advocacy, education, environment, and peer support.<sup>35</sup>

Virginia's grant staff and contractors surveyed consumers in 2005 using the ROSI tool at 43 sites in 11 local Community Service Board areas. Grant funds were used to train and pay mental health peers to conduct the survey. The peer surveyors interviewed 600 consumers and also disseminated 400 *Roadmap to Recovery* pamphlets at mental health centers across Virginia. The Department has encouraged Community Service Boards to continue to use the instrument, and, in 2008, 496 consumers were surveyed with the ROSI tool in one of the State's seven planning regions.

The Michigan Department of Community Health and its Recovery Council adopted the REE tool as a quality improvement measure for recovery-oriented practices. Grant staff began data collection with grant funds in November 2008, and the Department plans to use SAMHSA Mental Health Block Grant funds to support long-term REE data collection statewide.

Oregon's grant staff modified an existing fidelity assessment protocol used in the peer-operated services field—the FACIT—and shared it with eight peer-operated organizations. All of the organizations implemented the protocol and used the findings to identify areas of peer-operated services in need of improvement.

### ***Remaining Recovery-Orientation Challenges & Recommendations to Address Them***

Several Grantees noted that both states and the federal government need to revise existing policies to facilitate and promote infrastructure development and bring about systems change to support a recovery orientation in the public mental health system. States can make some changes without federal approval, but others require action by CMS and SAMHSA.

Grantees' recommendations for expanding the provision of recovery-oriented services include the following:

- Federal and state policy regarding Medicaid provider requirements should be modified to permit consumer-operated programs to become providers of reimbursable recovery-oriented peer services.
- SAMHSA should combine the block grants for mental health and substance abuse. For youth, the co-morbidity rate for these disorders is high, and requiring a diagnosis for only one of these conditions to receive services discourages the development and adoption of integrated mental health and substance abuse treatment interventions.
- The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate is the foundation for many of a state's mental health services for children and their families, and it needs to be retained to ensure that these services continue to be provided.
- CMS should consider funding another grant initiative to help states implement and sustain major mental health systems improvements.
- The proposed changes in the definition of rehabilitation services and targeted case management will create many serious problems for states' mental health systems if implemented. Many of these proposed changes need to be dropped. The final rules need to be published as soon as is practically feasible because States cannot move forward with their plans to increase the recovery orientation of their mental health systems until they know whether funding for current services is ensured.
- The Federal External Quality Review requirements for managed care providers of mental health services should be amended to include a strong focus on recovery-oriented practices.

### **Implementing Evidence-Based Practices**

Several SAMHSA-recognized evidence-based practices have demonstrated efficacy and cost-effectiveness in securing positive outcomes for individuals with serious mental illnesses. Yet the practices validated by research are not widely offered in mental health practice

settings.<sup>36</sup> One possible explanation for this gap between knowledge and practice is that states need a robust infrastructure to support delivery of these practices, but developing this infrastructure is costly and challenging. Essential elements of infrastructure development include

- active involvement from state staff, providers, consumers, and families;
- sustained provider training and follow-up clinical supervision;
- adequate initial funding for start-up and sufficient reimbursement for implementation;
- practical methods and funding to monitor implementation to improve quality; and
- alignment of federal, state, and provider policies and structures to support practice implementation.

The more elements of a service system that can be employed to support change and reduce resistance, the more likely that practice improvements will occur.<sup>37</sup>

Six of the MHST Grantees had initiatives to implement evidence-based practices in their states' mental health systems, focused primarily on provider training and supervision; developing reimbursement methods; and developing monitoring methods to ensure that evidence-based services are being provided with high fidelity (i.e., in accordance with implementation instructions).

### ***Provider Training and Supervision***

Changing how clinicians practice is a major undertaking. The challenges include (1) a lack of provider knowledge of and/or interest in evidence-based practices; (2) a lack of professional consensus about which practices lead to the best outcomes; (3) provider reluctance or resistance to changing long-standing practice modalities; (4) the high cost of education, training, follow-up consultation, and consistent reinforcement over the long term; (5) a lack of support and leadership within the mental health system; and (6) the cost of developing the mental health infrastructure to support clinicians.

Research has shown that education alone does not strongly influence the practice behaviors of health care providers and that additional efforts are needed, including providing clinicians with supervision and feedback on practices.<sup>38</sup> Resources spent on education and training will be wasted in the absence of ongoing clinical supervision on how to implement evidence-based practices (see Box 7). Such supervision is important to reinforce learning from an initial training course and to provide information to help clinicians grapple with various issues that may arise when implementing a new practice.

**Box 7. Aligning Policy and System Infrastructure to Support Practice Implementation**

As noted, the research literature on evidence-based practices shows that the willingness, knowledge, and skills of individual service providers alone will not result in broad-based implementation of evidence-based practices.<sup>39</sup> States and provider agencies need to align their policies and organizational structures to support practice implementation, identify leadership to provide oversight of practice implementation, and develop and implement a plan with firm action steps and a realistic implementation timeline.

To align policy and practice, New Hampshire grant staff rewrote the administrative rule that governs the provision of mental health services to include illness management and recovery (IMR), and helped gain its approval by a legislative committee. They also revised reimbursement regulations to ensure coverage of IMR services, and implemented the new regulations after passage by a legislative committee.

A central goal of New Hampshire's grant was to develop an organizational structure supporting IMR clinicians in each community mental health center (CMHC) region. To achieve this, community mental health centers developed IMR implementation teams and designated IMR coordinators to oversee the implementation of the IMR practice. Each center also established an IMR implementation committee comprising various stakeholders, including service users, who work with the IMR coordinator to implement and sustain the IMR practice. Grant staff provided consultation to the IMR teams regarding CMHC policies and procedures that support illness management and recovery, as well as Medicaid reimbursement of IMR services.

When introducing North Carolina's new evidence-based practices, grant staff suggested to service providers that they designate staff "champions" to ensure that their practitioners receive training and feedback about implementing EBPs. North Carolina also addressed the need for ongoing supervision by setting reimbursement rates high enough to cover its cost. The State also often pays for additional supervision and coaching through grants and contracts.

In Minnesota, after an orientation to a new Family Psychoeducation EBP database failed to change clinicians' clinical practice, the Grantee developed a new curriculum requiring in-person attendance for 5 days, followed by weekly phone consultation with clinical EBP experts over a 6- to 9-month period. During these calls, the clinical EBP experts train the clinician to use a specially designed form—called a clinical dashboard—to monitor treatment patterns and measure client outcomes on a weekly basis, as well as client progress over time.

The dashboards provide a graphic representation of the treatment strategies that have been used during each session with the client and the client's progress toward treatment goals. This training approach allows clinicians time to use the new practice with one or two clients at a time and provides assistance from clinical experts. After 6 to 9 months of training and consultation, each supervisor was expected to be part of a team to train a new cohort of

clinicians, because teaching others both reinforces the training and strengthens an agency's clinical infrastructure by improving the skills of a greater number of staff.

Delaware developed a manual to facilitate the adoption of family psychoeducation by providing a visible reminder for therapists to use the evidence-based practice. The manual has proved to be a useful tool, providing everyone who serves children in the mental health system with a common framework for discussing treatment goals and approaches. Therapists noted that family psychoeducation provides a common philosophical basis for treatment among different entities; for example, school staff and mental health providers.

As with training for peer support staff, providers were reluctant to have their clinicians participate in training because time off for training meant lost revenue. To offset this loss, New Hampshire gave its 10 provider agencies a total of \$375,000 over a 2-year period. In 2007, Minnesota's legislative appropriation included a new funding category to cover the cost of clinicians' participating in the 5-day training course as well as the 6 to 9 months of ongoing consultation and follow-up.

New Hampshire is in the early stages of developing credentialing procedures and standards for IMR providers to facilitate long-term Medicaid reimbursement. To minimize the administrative burden on community mental health centers, the State's Illness Management and Recovery Steering Committee decided to develop a mechanism to credential agencies rather than individual practitioners, and chose five measures for credentialing: (1) overall IMR fidelity score, (2) the proportion of workers completing annual training, (3) the proportion of workers receiving regular supervision on IMR practice, (4) the proportion of eligible consumers receiving IMR services, and (5) the number of consumers who complete all 10 modules of the IMR treatment program.

Another challenge some Grantees had to address was high staff turnover in community mental health centers, on average 20 percent across the provider system (one agency had a 60 percent turnover rate on its adult treatment team). High staff turnover substantially increases training costs, as evidenced in New Hampshire. To help ensure that high staff turnover would not impede IMR implementation efforts, the New Hampshire Bureau of Behavioral Health committed to providing IMR training for new CMHC hires, which includes weekly supervision for a period of 4 months by a trainer from the Dartmouth Psychiatric Research Center.

### ***Ensuring Reimbursement for Evidence-Based Practices***

To facilitate the adoption of new practices—and to track their delivery—some states developed separate billing codes for specific practices. For example, Delaware established a separate billing code for Family Psychoeducation, which is billed in 1-hour increments. However, rather than use this code, providers have been incorporating Family

Psychoeducation in their Individual and Family Mental Health Intervention sessions (e.g., counseling) and using the billing code for this service. As a result, the State cannot accurately assess the extent to which the new practice is being provided.

During the grant period, North Carolina was in the midst of a major effort to reform its mental health care system, which included revisions to the service definitions used for determining Medicaid reimbursement. The State also implemented initiatives to educate administrators, providers, and consumers about how the new evidence-based practices fit within the revised service definitions.

### ***Medicaid Reimbursement Issues***

Implementing evidence-based practices with high fidelity to achieve the best client outcomes is dependent on implementing SAMHSA's EBP tool kits, which are sets of detailed instructions guiding practice implementation. Fidelity is the term used for the degree to which a practice is implemented according to these instructions. Virtually all of the Grantees implementing evidence-based practices said that the toolkits for some practices include recovery-oriented components that frequently are not billable to Medicaid.

Several grant staff noted that Medicaid's inability to reimburse for *all* EBP components makes it difficult for providers to furnish the practices with high fidelity. However, several States recognize the need to find other funding sources to cover services that Medicaid will not reimburse. For example, Ohio providers can bill portions of the evidence-based practices of Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Multi-Systemic Therapy, Illness Management and Recovery, and Supported Employment using existing Medicaid codes for Community Psychiatric Supportive Treatment, behavioral health counseling, and other Medicaid-billable services. The components of these practices that do not meet Medicaid criteria for inclusion in the State Plan, particularly supported employment, are covered by a combination of state general revenue funds, levies, client fees, and a few foundation grants.

North Carolina developed multiple reimbursement codes to ensure that providers are able to bill for all services components of the Integrated Dual Diagnosis Treatment tool kit. Using multiple codes results in a complex billing structure, but it ensures coverage for all of the components of the practice.

### ***Ensuring the Quality of Evidence-Based Practices***

Research indicates that when mental health programs attempt to implement evidence-based practices, the quality of the implementation strongly influences outcomes (i.e., programs that have higher fidelity to the defined practice tend to produce superior clinical results). This finding suggests that efforts to promote evidence-based practice must include fidelity

measures and self-correcting feedback mechanisms.<sup>40</sup> Researchers have developed several measures and instruments to assess the fidelity of the implementation process. (See Box 8.)

### **Box 8. Fidelity Measures**

Each SAMHSA EBP tool kit includes a fidelity assessment instrument for use by organizations (state staff, providers, outside reviewers). Fidelity is the term used for the degree to which an evidence-based practice is being implemented according to the specifications contained in the tool kit. Fidelity scales have been developed for each of the six EBPs included in the Implementing EBP Project (assertive community treatment, supported employment, integrated treatment for dual disorders, illness management, family psychoeducation, and medication guidelines). Each scale assesses approximately 15 to 30 critical ingredients of the EBP, based on its underlying principles and methods.

“The scale items provide concrete indications that the practice is being implemented as intended. For example, one item on the Supported Employment Fidelity Scale concerns “rapid job search.” This item is rated as fully implemented if the consumers in a program average one month or less between admission to the supported employment program and their first job interview. A reviewer uses the instrument to rank various aspects of the implementation process. After rankings are completed, the scores on the various measures are combined within and across assessment categories to develop an overall fidelity score.”<sup>41</sup>

A companion assessment tool to EBP fidelity scales is the General Organizational Index (GOI). The GOI measures a set of general operating characteristics of an organization that are hypothesized to be related to its overall capacity to implement and sustain any EBP. The higher the score, the greater the likelihood of success implementing evidence-based practices with fidelity and sustainability. The GOI can be used by outside reviewers or program managers to conduct self-ratings. Routine use of such indices provides an objective, structured way to give feedback about program development.<sup>42</sup>

States recognize the need to ensure regular monitoring of provider practices. However, fidelity assessments are expensive, and providers cannot afford to conduct them on an ongoing basis. To address this issue, North Carolina analyzed the cost of fidelity monitoring conducted under the grant to determine the amount of additional state funds to add to the payment rate for Local Management Entities (LMEs) to support the State’s new monitoring requirement.

Some Grantees developed structured processes to support fidelity measurement. For example, New Hampshire’s IMR Steering Committee developed a quality assurance process that includes consumer outcome measures, SAMHSA IMR fidelity measures, and General Organizational Index measures. Fidelity assessment teams—consisting of Bureau staff, a consumer, a CMHC quality improvement staff member, and occasionally a family member conducted fidelity reviews of all community mental health centers in the State. The State reviewed fidelity scores to identify areas needing technical assistance as well as the IMR

implementation process to identify areas for improvement. The State mandated the annual fidelity review process and will continue to fund it.

New Hampshire also decided to have its IMR implementation process evaluated by expert external evaluators using an objective methodology—the State Health Authority Yardstick (SHAY), which was developed by SAMHSA and Dartmouth Medical School to measure how a state authority is implementing and supporting evidence-based practices. Overall, the New Hampshire CMHC scores were similar to those in the National Evidence-Based Practices Implementation Project, on both the aggregate CMHC fidelity score and by the individual measures.

North Carolina began developing procedures and instruments for ensuring the quality of evidence-based practices by adopting the fidelity assessment instruments in the SAMHSA EBP tool kits. Local Management Entities or external evaluators will conduct the fidelity assessments. Two of the four LMEs conducted fidelity assessments during the grant period. Ohio's data collection effort demonstrated that the State's 37 ACT teams serving 1,560 service users were meeting Dartmouth Assertive Community Treatment fidelity criteria, recognized by SAMHSA.

Although attention to process outcomes through fidelity monitoring is an important component of quality assurance, consumer outcomes are the most important quality measure; but only New Hampshire grant staff mentioned the need to evaluate these outcomes.

### ***Remaining EBP Challenges and Recommendations to Address Them***

Most of the challenges mentioned throughout this section remain. One of the Grantees noted that the MHST grant was very helpful in establishing illness management and recovery as a service but that significant state funding was needed to implement the practice: about triple the amount of the grant. Obtaining continued funding for training and ongoing fidelity reviews is always a challenge, and given the states' current budget situation, future funding is uncertain.

Recommendations from Grantees on how CMS might address continuing challenges are as follows:

- Facilitate the provision of evidence-based practices by providing a specific Medicaid reimbursement code for each SAMHSA-approved evidence-based practice, and reimburse all of the component services of each practice.
- Consider funding more systems change grants to help states continue developing the infrastructure needed to implement evidence-based practices and to sustain their use.

## **Section 4: Conclusions**

Although SAMHSA has approved six evidence-based practices and encouraged their adoption, science remains far ahead of practice. Some states have taken the lead and made progress in the delivery of both evidence-based and recovery practices, but others are still in the very early stages of implementation. The 12 states that received MHST grants have unique service delivery systems and are at different stages in the systems transformation process, yet they faced similar challenges. Despite these challenges, all of them made significant progress in developing the infrastructure to support evidence-based and recovery practices.

### **Using Research to Help Ensure Successful Initiatives**

Despite the availability of information about how to implement evidence-based practices, the 12 states that received MHST grants varied in the degree to which they appeared to make use of it. When introducing new evidence-based practices, ideally, initiatives will be part of a broad and integrated approach to develop the infrastructure to support the new practice. Some states used their grants to implement one or more components of a clearly articulated, broad systems transformation strategy, and others implemented what seemed to be stand-alone initiatives.

Similarly, it has been well known for decades that providing information does not change behavior and that training without regular ongoing consultation and continuing education will not lead to changes in clinicians' practice. Yet one state used its grant initially to implement a stand-alone education initiative about evidence-based practices. When grant staff found that the initiative did not lead to changes in clinicians' behavior, they conducted interviews and focus groups to discover what a cursory review of the research literature would have told them: clinicians need both training to learn how to implement practices and ongoing supervision to ensure their consistent use.

Before planning systems change initiatives generally, and the implementation of evidence-based practices specifically, state staff need to review the relevant literature and make use of available technical expertise to become more knowledgeable about implementation challenges and how to address them. Understanding what other states have tried and the challenges they faced and resolved—or not—will also help staff to develop successful approaches.

### **Understanding Medicaid's Reimbursement Options and Limits**

Many Grantees noted that lack of reimbursement of all components of evidence-based practices made it difficult to implement the practices with high fidelity. However, Medicaid pays for services—not practices. Medicaid principally pays for medical services (including

psychiatrist and some psychologist services), and the majority of mental health services are covered through the optional benefit categories, such as rehabilitation and clinic services.

Because evidence-based practices include some components that Medicaid does not cover, states need to break down the practices into services to determine what Medicaid can cover under the State Plan and to identify other sources of funding for the components not covered. For example, North Carolina uses state funds for recovery-oriented services and Medicaid funds for services coverable under the State Plan to seamlessly integrate evidence-based practices with recovery-oriented services such as housing, employment, social, and peer supports.

Although it is understandable that states with limited budgets look to Medicaid to fund recovery-oriented services, including peer support and all components of evidence-based practices, it is important for state staff and policy makers to recognize that the basic provisions of Medicaid law determine parameters for Medicaid services, which may not encompass all of the services and supports that beneficiaries with serious mental illnesses need to live successfully in the community.

Employing Medicaid to underwrite mental health services involves “finding the fit” between Medicaid program coverage and the services and supports that a state has identified as critical to meeting the needs of individuals with serious mental illnesses.<sup>43</sup> Several states have done so successfully; for example, eight states support peer specialists through various Medicaid financing strategies, primarily by qualifying individuals with mental illness as providers under the Medicaid rehabilitation option. Georgia and South Carolina have also developed a distinct peer support service under the rehabilitation option.<sup>44</sup> Michigan, Colorado, and New Mexico use §1915(b) waivers to cover peer support services.

States should consider investigating other Medicaid authorities for covering these services. For example, Michigan and Oregon use the §1915(b)(3) waiver authority to use savings obtained through managed care arrangements to cover additional services, including recovery-oriented services. Michigan’s grant staff noted that its §1915(b) waiver has enabled them to fund a wide range of recovery-oriented services, including peer support specialists and peer-operated programs such as drop-in centers. They believe that the reason other states have been unable to fund peer support services under Medicaid is that they have not made use of available Medicaid authorities.

Another option for providing services to individuals with mental illness is the new §1915(i) authority.<sup>45</sup> The §1915(i) authority gives states the ability to provide home and community-based services to adults with disabilities without requiring an HCBS waiver or demonstrating cost neutrality (i.e., services do not have to cost less than institutional alternatives). States

are limited to offering services to participants whose income does not exceed 150 percent of the federal poverty level.<sup>46</sup>

Unlike the HCBS waiver authority, the §1915(i) authority does not tie the provision of HCBS to a requirement that an individual need an institutional level of care. This is an important difference between the two authorities that may prove especially beneficial for states that want to provide services to individuals with mental illnesses who currently cannot qualify for HCBS waiver services because they do not meet institutional level-of-care criteria.<sup>47</sup> Only two states to date—Nevada and Iowa—have made use of this option to offer services for individuals with mental illness.

### **Measuring Progress**

States need to establish measurable goals to guide the transformation to an evidence-based, recovery-oriented system and identify desired individual, service, and systems-level outcomes to measure progress toward those goals. Fortunately, the states and provider agencies use a small number of common measures: SAMHSA's fidelity instruments to assess EBP implementation and a few different instruments to determine the recovery orientation of provider agencies.

Although widespread use of common instruments will help to promote their broad acceptance and enable comparisons to be made within and among states, fidelity assessments and other systems evaluation measures are very costly to implement. Procedures for using these instruments recommend outside assessors, which can help to ensure acceptance of results and uniformity of reviewing procedures across provider agencies, but which also increase costs.

To ensure that systems transformation efforts lead to improved outcomes for persons with mental illness, states need to provide technical assistance and funding to providers so they will be able to conduct fidelity reviews and measure progress.

### **Next Steps**

The MHST grants provided much-needed funds for 12 states to implement initiatives to increase the use of evidence-based and recovery-oriented practices in their mental health systems. However, additional funding is needed to continue their efforts and sustain quality over time.

One Grantee recommended that CMS provide free technical assistance to states for implementing recovery practices in both State Plan and waiver services as it does for improving quality in HCBS waiver programs. In fact, CMS already provides free technical

assistance when requested by states and also has a contractor who can provide technical assistance regarding quality assurance and improvement.

The proposed changes to services under Medicaid’s rehabilitation and targeted case management options—and the uncertainty about how, when, and whether the changes will be finalized—has caused many states to put mental health systems improvement initiatives on hold. Many Grantees said that their states will be unable to proceed with their plans to increase the availability of evidence-based and recovery-oriented practices in their mental health systems until CMS releases final rules. However, CMS cannot act until the congressional moratorium ends, and Congress may extend it until the new administration decides how to handle the proposed changes.

Only one Grantee noted the need to determine how to work with professional licensing boards, colleges, and universities to ensure that students preparing for work in the mental health system—at all levels—receive training based on current evidence-based psychosocial intervention research and obtain clinical experience in the use of evidence-based practices. Given the very high cost of efforts to change clinicians’ practice patterns, states should consider devoting greater attention to working with these entities.

A SAMHSA-led national-level effort in this area could help to jump-start state-level initiatives as well as focus much-needed attention on the need to prepare mental health practitioners and clinicians at all levels to provide evidence-based and recovery-oriented services.

## Endnotes

- <sup>1</sup> Unless otherwise cited, the information in the first four pages of the Introduction is condensed from the discussion in Smith, G., Kennedy, C., Knipper, S., and O'Brien, J. (January 2005). *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*. Office of Disability, Aging, and Long-Term Care Policy. Available at <http://aspe.hhs.gov/daltcp/reports/handbook.pdf>.
- <sup>2</sup> National Institute of Mental Health. Available at <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america.shtml>. Accessed on January 2, 2008.
- <sup>3</sup> U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2005). *National Expenditures for Mental Health Services and Substance Abuse Treatment 1991–2001*. DHHS Publication Number SMA 05-3999.
- <sup>4</sup> Buck, J., Teich, J. L., and Miller, K. (2003). Use of Mental Health and Substance Abuse Services Among High-Cost Medicaid Enrollees. *Administration and Policy in Mental Health*, 31(1).
- <sup>5</sup> The Kaiser Commission on Medicaid and the Uninsured. (March 2007). *Medicaid: A Primer*. Key Information on the Health Program for Low-Income Americans. Available at <http://www.kff.org/medicaid/upload/Medicaid-A-Primer-pdf.pdf>.
- <sup>6</sup> President's New Freedom Commission on Mental Health. (2003). *Final Report of the New Freedom Commission on Mental Health*. Rockville, MD. Available at <http://www.mentalhealthcommission.gov/reports/reports.htm>.
- <sup>7</sup> Smith, G., et al., op. cit., note 1.
- <sup>8</sup> Evidence-based practices are identified by reviewing research findings on treatment interventions to determine how well they improve mental health conditions. Practices evaluated through several randomized controlled trials or other well-designed experiments showing positive outcomes with no harmful effects are ranked the most evidence based.  
  
The evidence base decreases accordingly as the number or quality of well-designed studies decreases. Practices for which the evidence shows harmful effects or a lack of research are ranked as the least evidence based. Once identified, policy makers promote the adoption of practices having the highest level of evidence by supporting training and technical assistance for mental health providers.
- <sup>9</sup> The fundamental precepts of EBP in health emerged roughly a decade ago. In the United States, the Institute of Medicine has been a central force in promoting the development and implementation of EBPs (see, especially, Committee on Quality of Health Care in America [2002]. *Crossing the Quality Chasm*. Institute of Medicine). The Agency for Health Care Policy and Research at the U.S. Department of Health and Human Services has lead responsibility for promoting evidence-based practice in health care.
- <sup>10</sup> Unless otherwise specified, all the descriptions of evidence-based practices summarize materials included in the following: the 2002 draft resource kits, materials disseminated by the New York State Office of Mental Health via its website, and the 1999 Surgeon General's Report on Mental Health.

These practices were identified by a consensus panel sponsored by the Robert Wood

Johnson Foundation (RWJF). This panel was composed of researchers, families, individuals with mental illnesses, and mental health administrators. Funding from RWJF, SAMHSA, and other sources is underwriting the preparation of materials by the New Hampshire-Dartmouth Psychiatric Research Center in collaboration with several other organizations to facilitate and accelerate the implementation of EBPs by agencies and mental health systems. Implementation resource kits have been prepared for each practice for use by administrators, program directors, practitioners, individuals with mental illnesses, and families. These “tool kits” are designed to promote interest in the use of these practices, facilitate their adoption, and provide tools (fidelity measures) to assess whether the practice is being used consistently. These kits are located at <http://www.mentalhealth.org/cmhs/communitysupport/toolkits>.

- <sup>11</sup> Extensive materials concerning ACT are available from the National Alliance for the Mentally Ill (NAMI), which has been a leading advocate for the expanded availability of ACT nationwide. NAMI employs the acronym PACT (Program for Assertive Community Treatment). NAMI also has exercised leadership in the development of standards for ACT. For more information, go to <http://www.nami.org/about/pact.htm>.
- <sup>12</sup> This term is occasionally used in practice by provider organizations.
- <sup>13</sup> *NAMI Issue Spotlight: Employment and Income*  
[http://www.nami.org/Template.cfm?Section=Issue\\_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=13158](http://www.nami.org/Template.cfm?Section=Issue_Spotlights&template=/ContentManagement/ContentDisplay.cfm&ContentID=13158).
- <sup>14</sup> This description of recovery is from Smith, G., et al., note 1.
- <sup>15</sup> Text condensed from Jacobson, N., and Greenley, D. (April 2001). What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services*, 52, 482-485. © 2001 American Psychiatric Association. Adapted with permission.
- <sup>16</sup> Solomon, P. (2004). Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Rehabilitation Journal*, 27(4), 392-401.
- <sup>17</sup> Jacobson, N. (2000). Recovery as Policy in Mental Health Services: Strategies Emerging from the States. *Psychiatric Rehabilitation Journal*, 23(4), 333-341. The author notes that in the managed care framework, recovery is envisioned as a set of guiding principles whose application can result in cost-effective behavioral health care and which suggest measurable treatment outcomes.
- <sup>18</sup> Doughty, C., Tse, S., Duncan, N., and McIntyre, L. (2008). The Wellness Recovery Plan (WRAP): Workshop Evaluation. *Australasian Psychiatry*, 16(6), 450-456.
- <sup>19</sup> The study is being conducted by Judith Cook at the National Research and Training Center on Psychiatric Disability at the University of Illinois–Chicago.
- <sup>20</sup> A review of research on peer-delivered services compared with other services (case management, supported employment, supported housing, skills training, and integrated dual diagnosis treatment for mental illness and addiction) found that the evidence base for peer-delivered services was the weakest among all of the services. Solomon, P. (2004). *Ibid*.
- <sup>21</sup> A few randomized controlled trials and research efforts using quasi-experimental designs have been conducted, and more research projects using randomized controlled trials and quasi-experimental research projects are currently under way. Cook, J. A. (2005). *“Patient-Centered” and “Consumer-Directed” Mental Health Services*. Prepared for the Institute of Medicine, Committee on Crossing the Quality Chasm—Adaptation to Mental

- Health and Addictive Disorders. Available at <http://www.cmhsrp.uic.edu/download/IOMreport.pdf>.
- <sup>22</sup> Stotland, N. L., Mattson, M. G., and Bergeson, S. (2008). The Recovery Concept: Clinician and Consumer Perspectives. *Journal of Psychiatric Practice*, 14(Supplement 2), 45-54.
- <sup>23</sup> Additionally, many academic and research centers tend to focus on theory and not on preparing clinicians to work in actual practice settings. Stuart, G. W., Burland, J., Ganju, V., Levounis, P., and Kiosk, S. (January 2002). *Educational Best Practices*. Working paper developed under grant number HS10965 from the Agency for Healthcare Research and Quality. Available through <http://commerce.metapress.com/content/t0475161q9232685/>.
- <sup>24</sup> Corrigan, P. W., Steiner, L., McCracken, S. G., Blaser, B., and Barr, M. (2001). Strategies for Disseminating Evidence-Based Practices to Staff Who Treat People with Serious Mental Illness. *Psychiatric Services*, 52, 1598-1606; Rosenheck, R. A., Organizational Process: A Missing Link Between Research and Practice, 1607-1612; Goldman, H. H., Ganju, V., Drake, R., Gorman, P., Hogan, M., Hyde, P., and Morgan, O., Policy Implications for Implementing Evidence-Based Practices, 1591-1597; Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Rush, A. J., Clark, R. E., and Klatzker, D., Implementing Evidence-based Practices for Persons with Severe Mental Illnesses, 45-50. © 2001 American Psychiatric Association. Adapted with permission.
- <sup>25</sup> Unless otherwise cited, this section is condensed from the discussion in Jacobson, N., and Greenley, D. (April 2001). What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services*, 52, 482-485. © 2001 American Psychiatric Association. Adapted with permission.
- <sup>26</sup> O'Brien, J., White Tiegreen, W., and Campbell, J. (July 2008). *Policy Issue #2: Introducing and Supporting Peer Providers in Traditional Mental Health Provider Networks*. Second in a series of three policy briefs on peer supports in mental health delivery systems. Independent Living Research Utilization in collaboration with the Human Services Research Institute.
- <sup>27</sup> In urban areas, dual relationships can often be circumvented because there are several settings in which peer support specialists can work, reducing the likelihood that they will receive their services from the same agency that employs them. But this is not always possible in rural or other areas with few providers.
- <sup>28</sup> Smith, G., Kennedy, C., Knipper, S., and O'Brien, J. (January 2005). *Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook*. Office of Disability, Aging, and Long-Term Care Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.
- <sup>29</sup> The REE was developed by Priscilla Ridgway with the Yale University Program for Recovery and Community Health in 1999.
- <sup>30</sup> Ridgway, P., and Press, A. (2004). *Assessing the Recovery-orientation of Your Mental Health Program: A User's Guide for the Recovery-Enhancing Environment Scale (REE)*. Version 1. Lawrence, Kansas: University of Kansas, School of Social Welfare, Office of Mental Health Training and Research.
- <sup>31</sup> The ROSI was developed in part by Steve Onken, Ph.D., and Jeanne Dumont, Ph.D.
- <sup>32</sup> Questionnaire can be found at <http://www.power2u.org/downloads/ROSI-Recovery%20Oriented%20Systems%20Indicators.pdf>.

- <sup>33</sup> Taken from Campbell-Orde, T., Chamberlin, J., Carpenter, J., and Leff, H. S. (Eds.). *Measuring the Promise: A Compendium of Recovery Measures*. Cambridge, MA: The Evaluation Center @ Human Services Research Institute.
- <sup>34</sup> The FACIT was developed by Jean Campbell, Ph.D.
- <sup>35</sup> Detailed information on implementing the FACIT can be found at <http://www.cstprogram.org/consumer%20op/Multi-Site%20Activities/FACIT%20Protocol/FACIT%20Protocol.pdf>.
- <sup>36</sup> Torrey, W. C., Drake, R. E., Dixon, L., Burns, B. J., Rush, A. J., Clark, R. E., and Klatzker, D. (2001). Implementing Evidence-based Practices for Persons with Severe Mental Illnesses. *Psychiatric Services*, 52, 45-50.
- <sup>37</sup> Ibid.
- <sup>38</sup> Ibid.
- <sup>39</sup> Stuart, G. W., Burland, J., Ganju, V., Levounis, P., and Kiosk, S. (January 2002). *Educational Best Practices*. Working paper developed under grant number HS10965 from the Agency for Healthcare Research and Quality. Available through <http://commerce.metapress.com/content/t0475161q9232685/>.
- <sup>40</sup> Torrey, W. C., et al., op cit.
- <sup>41</sup> SAMHSA Health Information Network. [http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/IMR\\_FidelityScale3.asp](http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/IMR_FidelityScale3.asp).
- <sup>42</sup> The items on the GOI were derived from clinical experience, although the research literature also supports the importance of many of these factors. It contains broad principles regarding elements such as program philosophy, training, supervision, and program monitoring. The GOI contains simple-to-understand face-valid items that are rated on a 5-point response format, ranging from 1 equals no implementation to 5 equals full implementation, with intermediate numbers representing progressively greater degrees of implementation. Typical sources of information include interviews with staff, observation of team meetings, review of charts, and observation of interventions. See [http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/14.SE\\_GOI.pdf](http://download.ncadi.samhsa.gov/ken/pdf/toolkits/employment/14.SE_GOI.pdf) for detailed information about the index.
- <sup>43</sup> This discussion of Medicaid reimbursement is based on the discussion in Smith, G., et al., op cit., note 28.
- <sup>44</sup> Campbell, J., and Eiken, S. (August 2005). *Promising Practices in Using Medicaid for Peer-Delivered Mental Health Services*. Prepared for the U.S. Department of Health and Human Services.
- <sup>45</sup> The §1915(i) authority was established under Section 6086 of the Deficit Reduction Act of 2005, effective January 2007, now P.L. 109-171.
- <sup>46</sup> Under the HCBS waiver authority, a state may offer waiver services to persons with incomes up to approximately 225 percent of the federal poverty level (by covering individuals with incomes up to 300 percent of the Federal Benefit Rate for SSI payments.) Although §1915(i) permits states to cover persons with incomes up to 150 percent of the federal poverty level, a state may offer HCBS only to persons who are financially eligible for Medicaid in eligibility groups that the state already has included in its Medicaid State Plan.
- <sup>47</sup> Federal law does not permit states to claim federal financial participation in the costs of services furnished to adults between the ages of 22 and 64 with mental illnesses in an

“Institution for Mental Disease” (IMD). An IMD is a hospital, nursing facility, or other institution of more than 16 beds that primarily engages in the diagnosis and treatment of mental disease. The “IMD exclusion” has proven to be a barrier to states in operating HCBS waivers for these adults. Because adult IMD services are not Medicaid reimbursable, an HCBS waiver cannot operate to furnish alternatives to such services. Three states (CO, MT, and WI) operate HCBS waivers that specifically target adults with serious mental illnesses. These waivers are structured to furnish HCBS as alternatives to a nursing facility rather than IMD services. Many other states operate HCBS waivers for people with disabilities that accommodate adults with serious mental illnesses. More information about this topic is contained in Smith et al., op. cit, note 28 (available at <http://aspe.hhs.gov/daltcp/reports/handbook.htm>).