The Louis de la Parte Florida Mental Health Institute

Recovery-Oriented Medicaid Services for Adults with Severe Mental Illness

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Recovery-Oriented Medicaid Services for Adults with Severe Mental Illness Contents

Executive Summary

Background

In October 2004, Florida's Medicaid Authority, the Agency for Health Care Administration (AHCA), developed and implemented new Medicaid services intended to promote the recovery and rehabilitation of adults with severe mental illnesses. The implementation of recovery-oriented services is consistent with policy changes taking place at both state and national levels, driven in part by longitudinal research that has demonstrated that recovery is a reality for up to two thirds of individuals with serious mental illnesses (Harding, Zubin, & Strauss, 1987) and (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987).

President Bush's New Freedom Commission issued a report recommending the transformation of the nation's approach to mental health care to ensure that our systems, programs and services actively facilitate the process of recovery (New Freedom Commission on Mental Health, 2003). Many states have responded by developing recovery-oriented systems of care based on an emerging set of recovery principles (NASMHPD/NTAC e-Report on Recovery, 2004; Ralph, 2000; Jacobson & Greenley, 2001). However, models of care that operationalize these principles into objective practices/standards that can be used as a basis for evaluation are only in the early stages of development (Anthony, 2000; Onken, Dumont, Ridgway, Dornan, & Ralph, 2004).

Methods

This study collected administrative data and conducted consumer focus groups and staff interviews to provide information about how service providers are making the transition to delivering rehabilitative, recovery-oriented services. AHCA introduced new administrative service codes to support the transition from traditional day treatment programming containing a focus on consumer monitoring and management to rehabilitative/recovery-oriented services that focus more on consumer self-direction and community functioning. The Community Health Services Coverage and Limitations Handbook (AHCA Handbook) describes these codes and specifies the parameters for service delivery under Florida's Medicaid program.

We analyzed administrative data from all AHCA areas, excluding those with an operational, prepaid mental health plan. We focused on the top ten providers of services for the period January through June 2005 and targeted services delivered under the following codes from the AHCA Handbook:

H – 2012 (MH) Behavioral Health Day Services (Mental Health)

H – 2012 (SA) Behavioral Health Day Services (Substance Abuse)

H – 2017 Psychosocial Rehabilitation Services

H – 2030 Clubhouse Services

To provide a point of comparison, we analyzed administrative data from the top ten providers for the period January through June 2004 and targeted services that have been replaced by the recovery-oriented services listed above:

H – 2012 Mental Health Day Treatment

H – 2014 Basic Living Skills Training

H – 2017 Rehabilitation Day Treatment

In addition, data on administrative service codes from Area 1 were analyzed for periods before and after adopting a prepaid plan and compared to data from the same periods in AHCA Area 4 where only fee-for-service plans have been implemented. The goal was to study how the transition to a prepaid plan affected the delivery of rehabilitative, recovery-oriented services and to provide information that could assist AHCA areas that will be making the transition to prepaid plans in coming years.

Focus groups with recipients of rehabilitative, recovery-oriented services and staff interviews provided information about the type of services being delivered under the psychosocial rehabilitation and clubhouse administrative service codes. Ten programs from throughout the state participated. Each of the consumer focus groups and staff interviews was structured to provide data on five factors that have been found to correspond to recovery-oriented practices in state mental health systems, including life goals, involvement, diversity of treatment options, choice, and individually tailored services (O'Connell, Tonodora, Croog, Evans, & Davidson, 2005). The focus groups and interviews also identified challenges to implementation and successful strategies.

Results/Discussion

Summary of Administrative Data

The comparison of administrative data for the top ten service providers for the pre-period (January to June, 2004) to the post-period (January to June 2005) demonstrated a general increase in cost for the new services. Key findings include:

- There was a 43% increase in the total cost for services under the new rehabilitative, recovery-oriented administrative service codes: $11,816,920 in the post-period vs. $8,258,763 in the pre-period.
- The cost per person increased 57%.
- The cost for Psychosocial Rehabilitation Services in the post-period was 90% higher per person ($3,976) than the cost per person for Basic Living Skills in the post-period ($2,127).
- The units of service for Psychosocial Rehabilitation Services in the post-period were 160% higher than units for Basic Living skills in the pre-period.
- There were no significant differences in demographic or diagnostic profiles for persons receiving services in the pre- and post-period.

The comparison of administrative data for rehabilitative, recovery-oriented services for the pre-period (November 2000 to October 2001) to the post-period (November 2003 to October 2004) for Area 1 and Area 4 demonstrated a significant reduction in the delivery of day treatment services in both areas. Key findings include:

- In Area 1, the service delivery shifted from day treatment in the pre-period (fee-for-service coverage) to drop-in center service in the post-period (prepaid mental health plan - PMHP - coverage). The PMHP in Area 1 provided 4.8 times more drop-in units than day treatment units in the post-period.
- In Area 1, the number of days per person for individuals receiving day treatment services decreased from 83 to 50, a reduction of nearly 40%.
- In Area 4, the number of days per person for individuals receiving day treatment dropped from 75 to 60, a reduction of 21%.
- There were no significant differences in demographic or diagnostic profiles for persons receiving services in the pre- and post- period for both Area 1 and Area 4.

Summary of Consumer Focus Groups and Staff Interviews

Psychosocial Rehabilitative Services

Fifteen staff persons who were responsible for implementing psychosocial rehabilitation services were interviewed at five agencies, including program supervisors and line staff. Fifty-four consumers from five different psychosocial programs responded to questions in five focus groups.

Both the staff interviews and consumer focus groups provide evidence that each of the programs participating in this study provides the kinds of activities described in the AHCA Handbook for Psychosocial Rehabilitation Services. Staff persons described a broad range of beliefs about the potential for recovery for persons with mental illnesses. However, services provided in the programs were generally similar, focusing less on ameliorating symptoms and more on restoring functional capabilities. Programs delivered these services in groups, usually in a classroom setting, with a focus on skills teaching activities.

A summary of key themes and recommendations for program implementation is listed below:

- Treatment Planning

  Staff sometimes described a process for treatment planning that seemed more a fulfillment of bureaucratic requirements than the basis for consumer and staff collaborations. Consumers were not always aware of the connection between their goals and program activities.

  Recommendation: Person-centered treatment planning should be considered as a core component of rehabilitative, recovery-oriented services and be a top priority for future program development (Adams & Grieder, 2005).

- Changes to Recovery-Oriented Language

  Staff described language changes in treatment plans that reflect a person-centered recovery orientation. However, examples of these language changes suggest that a general orientation to the principles and practices of recovery-oriented services is needed.

  Recommendation: Create a manual that provides a baseline orientation to the principles and practices of recovery-oriented services.

- Consumer Skill Development

  The prime focus for rehabilitative, recovery-oriented programming was on skill development in classroom settings, with less emphasis on the application of skills in natural environments.

  Recommendation: Skill development activities should place a greater emphasis on recovering important roles and in supporting consumers with the application of skills in places where they live, learn, work, or socialize (Anthony & Liberman, 1986).

- Staff Buy-In

  Staff perspectives of rehabilitative, recovery-oriented services covered a broad spectrum. Some staff members were well informed and enthusiastically supportive, while others expressed little belief in the potential for recovery and the value of rehabilitative, recovery-oriented services.

  Recommendation: Staff buy-in is essential for the effective implementation of rehabilitative, recovery-oriented services. Practice standards need to be implemented statewide to ensure the consistent application of practices across programs and provide a frame of reference for consensus building, development, and evaluation activities.

- Meaningful Consumer Engagement in Program Activities

  Staff at each of the programs expressed frustration with engaging consumers in program activities, evidenced by a lack of follow-through with treatment plans, poor attendance, and a perceived lack of motivation. Some consumers were not inspired by program activities and described their participation in groups as feeling like "busy work."

  Recommendation: Person-centered planning, opportunities for community integration, and peer interventions can significantly enhance consumer participation and should be integrated into future program development.

- Services for Residents of Assisted Living Facilities (ALFs)

  Communication between staff at mental health agencies and ALFs took place on an informal, as needed basis.

  Recommendation: Program staff and ALF staff should consider establishing more formal mechanisms for communication/care coordination in collaboration with consumers. The focus should extend beyond managing the effects of illness and include issues that are important to the quality of life of consumers.

- Consumer Participation

  Each of the programs in the study has taken steps to include consumers in the planning and delivery of services, including some consumer advisory boards. These activities are all consistent with a recovery orientation, but should be augmented with opportunities for consumers to partner at executive levels such as policymaking, program development, and board meetings.

  Recommendation: Develop formal policies that support not only consumer input, but also partnerships that involve consumers at executive/policy making levels.

- Staff Turnover

  Staff turnover was described as a concern by consumers in each of the programs studied. Program staff also identified lack of staffing as a barrier to effective service delivery.

  Recommendation: Hiring and retaining competent staff is critical to all services in the system of care, but is especially critical to effectively implementing rehabilitative, recovery-oriented services where trusting relationships are the lynchpin to success. In the long term, a system-wide strategy that addresses issues effecting policy, financing, and program management will be required. In the short term, hiring staff who share the principles and values of the recovery approach will help to ensure more enduring connections with consumers receiving services in these programs.

- Technical Assistance

  Most staff did not express a strong need for technical assistance or training. Only one person identified the need to learn about rehabilitative, recovery-oriented services. This lack of interest in training may be indicative of an incomplete awareness about the knowledge and skills required to effectively implement these programs.

  Recommendation: Provide general orientations on the principles and practices of recovery- oriented services, as well as in-depth training in the skills needed for effective practice. Developing a set of standards for these services is also critical to helping programs determine the degree to which current interventions are effective and to developing training/technical assistance plans that target the areas of greatest need.

Clubhouse

Clubhouses have been operating throughout the country for over 30 years, but are only recently attracting broad attention in Florida. The Clubhouses that participated in this study represent programs that are fully committed to implementing services according to the International Center for Clubhouse Development (ICCD) model, as described in the AHCA handbook. All of the programs sought to create an experience of community for persons with mental illnesses where members are treated respectfully. The clubhouses also provided the structure of a work-ordered day to support member participation in the operation of the clubhouse. However, four of the five clubhouses had not yet developed

Transitional Employment Programs, a core component of the model that provides members with the opportunity to work in paying jobs. Only one of the clubhouses participating in this study established the process for billing Medicaid. It was also the only clubhouse in the state actively billing Medicaid for services.

- Medicaid Billing Issues

  The four clubhouses in this study not billing Medicaid explored possibilities for participating but identified the following barriers: lack of billing infrastructure in clubhouses that are not connected to mental health centers, insufficient compensation (especially in comparison to psychosocial rehabilitation rates), procedures for establishing provider numbers and project codes, and documentation requirements that are not compatible with the clubhouse model.

  Recommendations: AHCA should consider meeting with the Florida Clubhouse Coalition to discuss barriers and identify strategies that would support implementation. In addition, gathering information from clubhouses in other states that have successfully billed Medicaid for services may help to inform these discussions.

- ICCD Certification Progress

  Each of the clubhouses participating in this study utilized the ICCD standard for implementing all clubhouse operations. Clubhouse directors could clearly articulate their progress in achieving this standard and identified areas requiring development. However, not all of the front-line staff members have received ICCD training.

  Recommendations: It will be important to implement strategies that will support clubhouses in achieving and maintaining services that meet ICCD certification, including training, technical assistance, and information sharing across programs.

- Staffing

  Staff generally described having high levels of job satisfaction. However, for two of the clubhouses operating within community mental health agencies there were some problems related to having clubhouse staff members who either did not understand or fully accept the clubhouse model. Staff members working in other programs within the agency were at times unsupportive of the clubhouse approach.

  Recommendations: The principles and practices of the clubhouse model provide an important anchor for members and staff, but it is critically important for staff to be oriented, properly trained, and to share the fundamental values of the approach. All of the programs have had some level of ICCD training, but they also describe a need for further training of clubhouse staff and orientation about the clubhouse model for both clinical and administrative staff in the host agency.

- Engaging Members in Clubhouse Activities

  Staff expressed concern and frustration with members who have a more passive orientation to services, evidenced by a lack of meaningful participation in the work-ordered day. Clubhouses represent a significant change for members who have histories with services that focus primarily on managing the effects of illness and on social activities.

  Recommendations: Clubhouses should consider implementing peer-to-peer interventions that have been developed to help consumers with becoming involved in their own care (Clay, 2005).

- Transitional Employment Programs

  Transitional Employment Programs (TEPs) are a vital part of the clubhouse model, providing the primary link between the work-ordered day of the clubhouse and work in the community. Four of the five clubhouses studied are at the initial phase of developing this critical component.

  Recommendations: A plan for providing technical support and other resources to clubhouses for TEP development should be considered to ensure their success.

Conclusions

The administrative service data analyzed in this study demonstrate a significant shift of service activity to the new Psychosocial Rehabilitation Services described in the 2004 AHCA Handbook. However, both consumers and staff express difficulty with the emphasis on greater consumer self-direction that is central to the implementation of recovery-oriented programs. In contrast, clubhouse services had no statewide billing activity for the period of this study. Each of the five programs had explored Medicaid as a funding option, but only one was preparing to bill for services. The Florida Clubhouse Coalition, AHCA, and other interested stakeholders should explore strategies for overcoming current barriers and may benefit from approaches employed in other states.

Funding mechanisms to support rehabilitative, recovery-oriented services such as those introduced by AHCA provides critical financial incentive to service providers. However, program standards are also needed to provide a detailed roadmap for effective program implementation and a foundation for program evaluation. In addition, policy changes taking place at both state and national levels provide an important context for service delivery. Florida, like many states across the nation, has taken the lead from President Bush's New Freedom Commission and initiated state and local level planning. Strategies for developing finance structures to support rehabilitative, recovery-oriented services should be integrated with these policy initiatives.

The shift in some AHCA areas from fee-for-service financing to capitated systems, represented by Prepaid Mental Health Plans (PMHP's) and Health Maintenance Organizations (HMOs), also has important implications for the delivery of rehabilitative, recovery-oriented services. PMHPs and HMOs should be considered critical partners in the state's transformation planning. Consumer

input into the development and implementation of PMHP and HMO contracts will also be critical to supporting recovery-oriented service delivery.

Cultural and community resource issues also significantly impact the implementation of rehabilitative, recovery-oriented services. Services and finance structures are critical to helping people with serious mental illnesses on the road to recovery, but they should be planned and implemented as part of a community-wide response.

Background

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

The implementation of recovery-oriented services is consistent with policy changes taking place at both the state and national levels. These changes are the result of advances in our understanding about the course and treatment of psychiatric disorders. Longitudinal research has demonstrated that recovery is a reality for up to two-thirds of individuals with serious mental illnesses (Harding, Zubin, et al., 1987; Harding, Brooks, et al., 1987). At the state level, the Secretary of the Department of Children and Families (DCF) has identified recovery as a top priority for future mental health planning. DCF recently initiated a state level plan, implemented in districts and localities, for transforming Florida's mental health system based on the principles of recovery and resiliency.

Recovery is also the central focus of federal mental health policy. President Bush's New Freedom Commission concluded that recovery from mental illness is now a "real possibility" and identified recovery as the goal of a transformed system. The report recommends the transformation of the nation's approach to mental health care to ensure that our systems, programs and services actively facilitate the process of recovery (New Freedom Commission on Mental Health, 2003).

Many states have responded by developing recovery-oriented systems of care based on an emerging set of recovery principles (NASMHPD/NTAC e-Report on Recovery, 2004; Ralph, 2000; Jacobson & Greenley, 2001). However, models of care that operationalize these principles into objective practices/standards that can be used as a basis for evaluation are only in the early stages of development (Anthony, 2000; Onken et al., 2004).

The purpose of this study includes the following:

- Determine the effect that changes in administrative service codes have had on delivery of recovery services.
- Determine if the services delivered represent a change to a recovery/rehabilitation orientation, as based on recovery principles and emerging standards in the mental health field.
- Establish a baseline of recovery-based services currently being delivered in the public mental health system, including strengths and barriers to service delivery.
- Examine consumer experiences with services delivered under the new administrative service codes.

The results provide information about how providers are making the transition to delivering services described under the new administrative service codes, whether these services are recovery-oriented, and how services can be improved to be more responsive to the needs of consumers. This information will also be critical for establishing standards for future outcome evaluations and for the development of contracts in prepaid mental health plans.

Methods

This study analyzed administrative data to determine the rate at which recovery-oriented services are provided in differing areas of the state, in addition to financing conditions. We also collected qualitative data to monitor the development of recovery-oriented programming in Florida and identify challenges or barriers that could impede successful implementation.

In 2004, AHCA introduced new administrative service codes to support the transition from traditional day treatment programming containing a focus on consumer monitoring and management to rehabilitative/recovery-oriented services that focus more on consumer self-direction and community functioning. The Community Health Services Coverage and Limitations Handbook (AHCA Handbook) describes these codes and specifies the parameters for service delivery under Florida's Medicaid program. It describes the primary functions of Mental Health Day Treatment as stabilization of symptoms, transitional treatment after an acute episode, and to provide a level of therapeutic intensity not possible in traditional outpatient settings. The primary functions of Rehabilitation Day Treatment are to restore communication and social skills to overcome barriers to independent functioning, use community resources, and conduct activities of daily living.

In contrast, Psychosocial Rehabilitation Services concentrate less on the amelioration of symptoms and more on restoring functional capabilities with a special emphasis on vocational activities. The AHCA Handbook describes services that support the development of the skills needed to function in a work environment and includes work readiness assessments, job development, job matching, on the job training, and job support. Clubhouse Services include a range of social, educational, pre-vocational and transitional employment activities conducted in a structured, community-based setting. The AHCA Handbook specifies that "Clubhouses must be based upon the International Center for Clubhouse Development (ICCD) International Standards for Clubhouse Programs and must be working toward ICCD certification which must be obtained within three years of the first billing date." ICCD standards describe the roles and relationships of consumers and staff persons that define Clubhouse communities (Agency for Health Care Administration, 2004).

To obtain a more comprehensive picture of the delivery of rehabilitative, recovery-oriented services, we collected both administrative and qualitative data. Administrative data are based on claims submitted to AHCA and provide information only about the types of services that are billed. Qualitative data provide information about how services were delivered, but does not illustrate the scope of new practices being implemented.

Administrative Data

We analyzed administrative data from all AHCA areas, excluding those with an operational, prepaid mental health plan. We focused on the top ten providers of services for the period January through June 2005 and on targeted services delivered under the following codes from the Community Behavioral Health

Services Coverage and Limitations Handbook (AHCA Handbook):

H – 2012 (MH) Behavioral Health Day Services (Mental Health)

H – 2012 (SA) Behavioral Health Day Services (Substance Abuse)

H – 2017 Psychosocial Rehabilitation Services

H – 2030 Clubhouse Services

To provide a point of comparison, we analyzed administrative data from the top ten providers for the period January through June 2004 and targeted services that have been replaced by the recovery-oriented services listed above:

H – 2012 Mental Health Day Treatment

H – 2014 Basic Living Skills Training

H – 2017 Rehabilitation Day Treatment

In addition, data on administrative service codes from Area 1, which would later be replaced by the recovery-oriented codes, were analyzed for the periods before and after adopting a prepaid plan and compared to data from the same periods in AHCA Area 4 where only fee-for-service plans have been implemented.

The goal was to study how the transition to a prepaid plan affected the delivery of the same services (mental health day treatment, basic living skills training, and rehabilitation day treatment) to provide information to the AHCA areas making the transition to prepaid plans. Because we analyzed the use of those services before and after the implementation of managed care in Area 1, but before the implementation of the new codes, we were able to gauge the impact of managed care on those services, independent of the creation of new codes.

Qualitative Data

Focus groups, which included recipients of rehabilitative, recovery-oriented services, and residents in Assisted Living Facilities, as well as staff interviews, provided information about the type of services delivered under the psychosocial rehabilitation and clubhouse administrative service codes.

Five programs providing psychosocial rehabilitation services participated in the study:

1. Citrus Health Network, Inc. – Miami (Area 11)
2. Lakeview – Pensacola (Area 1)
3. Boley Centers for Behavioral Health Care, Inc. – St. Petersburg (Area 5)
4. LifeStream Behavioral Center – Bushnell (Area 3)
5. Henderson Mental Health Center – Ft. Lauderdale (Area 10)

Five clubhouses participated in the study:

1. Vincent House – Indian Shores (ICCD Certified – Area 6)
2. Focus House – Miami (Area 11)
3. Palm Club – Sarasota (Area 6)

4. Club Success - Bartow (Peace River Center) (Area 6)
5. Sedona House - Sanford (Seminole Community Mental Health Center) (Area 7)

In addition, focus group participants who were also residents in Assisted Living Facilities (ALF's) participated in a separate survey of their experiences with the service delivery system.

The consumer focus groups and staff interviews were structured to provide data on the five factors that correspond to recovery-oriented practices in state mental health systems (O'Connell et al., 2005):

1. Life Goals: the extent that staff help with the development and pursuit of individually defined goals such as employment and education.
2. Involvement: The extent that persons in recovery are involved in the development and provision of programs/services, staff, training, and advisory board/management meetings.
3. Diversity of Treatment Options: The extent that an agency provides linkages to peer mentors and support, a variety of treatment options, and assistance with becoming involved in non-mental health activities.
4. Choice: The extent that service users have access to their treatment records, staff refrain from using coercive measures to influence choice, and the choices of service users are respected by the staff.
5. Individually Tailored Services: The extent that services are tailored to individual needs, cultures, and interests, and focus on building community connections.

Statewide Administrative Data Analysis

Pre- versus post- (January-June 2004 versus January-June 2005) comparisons for the top ten providers statewide showed that AHCA spent 43% more for services delivered under the new administrative codes than it did for the old. Costs per person increased 57%. Part of the increased costs per person was due to a shift from day treatment, for which AHCA would have paid $12.50 an hour to Psychosocial Rehabilitation and instead paid $36 an hour ($9 a quarter hour). There was a 98% reduction in the number of hours billed to day treatment. For purposes of comparison, we converted the daily units used for day treatment before October 2004 to hours.

A shift of services from basic living skills to psychosocial rehabilitation may also account for increased costs. AHCA paid 89.97% more per person for Psychosocial Rehabilitation during the post-period than for Basic Living Skills during the pre-period ($3,976 versus $2,127). People receiving Basic Living Skills during the pre-period received an average of 90.0 units. Converting the 15-minute units used for Psychosocial Rehabilitation to 30 minutes units used for Basic Living Skills Training shows that people receiving Psychosocial Rehabilitation during the post-period received an average of 234.4 units of service, a 160.4% increase that is far greater than the increase in cost. It is difficult to know whether the increase in the number of units per person reflects an increase in the amount of service they received because a unit of Basic Living Skills Training was a minimum of 30 minutes. In many cases, a single unit of Basic Living Skills Training may have provided more than 30 minutes of service.

An analysis of the billing pattern for Basic Living Skills suggests one explanation for the increased costs per person. There appears to have been a practical if not explicit limit on the numbers of units that could be billed per day per person. The data are not entirely clear, but few if any people appear to have received more than two units a day. The creation of the Psychosocial Rehabilitation code removed this limit.

Billing for Psychosocial Rehabilitation Services during the post-period was $11,758, 161. Clubhouse services had no billing activity during the post-period.

Changes in spending for targeted services from the pre-period to the post-period are outlined in Table 1 below.

Table 1: Statewide Comparisons of Rehabilitative, Recovery-Oriented Services

January-June 2004			January-June 2005		
Service	N	$ per person	Service	N	$ per person
All targeted services	3,389	$2,437	All targeted services	3093	$3,820
MH Day Treatment	537	$1,890	MH Day Services	86	$654
Rehab Day Treatment	323	$2,180	SA Day Services	11	$230
Basic Living	3075	$2,127	Psychosocial	2957	$3,976

Area 1 and 4 Data Analysis

Administrative data from Area 1 for the targeted services for two different time periods were compared to those of Area 4. Period one included services delivered from November 2000 to October 2001 when clients in both Area 1 and 4 received services as part of a Medi-Pass/fee-for-service plan. Period two included services delivered from November 2003 to October 2004 when some Medicaid clients in Area 1 received services as part of a prepaid plan while clients in Area 4 continued to receive services under the fee-for-service plan. Some Medicaid clients, for whom we do not have data, received services through HMOs. Others continued to receive services on a fee-for-service basis.

The results showed that given the option of using Medicaid dollars to provide drop-in services instead of day treatment, a Prepaid Mental Health Plan (PMHP) might prefer the former. The PMHP in Area 1 provided 4.8 times more drop-in units than day treatment units. Fee-for-service providers did not have the option of using Medicaid to pay for drop-in services. Among those receiving day treatment, the number of days per person was lower for those receiving services through the PMHP (32.4) than for fee-for-service clients in Area 1 (54.8). Although this could easily reflect population differences between the two groups, it could also reflect the availability of drop-in services through the PMHP. People receiving drop-in services received an average of 71.1 days of service.

Comparing Areas 1 and 4 presented challenges because we were unable to obtain HMO encounter data for Area 1. For this reason, we focused on units of service per person. The number of days per person for people receiving day treatment services in Area 1 decreased from 83.3 to 50.1, a 39.9% reduction. Some of this reduction may have been due to the shift to drop-in services among PMHP members.

Most of this reduction, however, was probably not due to the implementation of the PMHP. In Area 4, the number of days per person for people receiving day treatment dropped from 74.9 to 59.2, a 21.0% reduction.

Qualitative Data: Summary of Consumer

Focus Groups and Staff Interviews

Psychosocial Rehabilitative Services

We conducted consumer focus groups and staff interviews to examine the implementation of services provided under the psychosocial rehabilitation code H - 2017. While only senior administrative and clinical staff were aware of the changes in the code, all of the consumers and staff participating in the study were aware that the services received focused on psychosocial approaches. The surveys and focus groups were designed to chart the progress programs were making in the transition to delivering rehabilitative, recovery-oriented services. The following questions provided the basis for the focus group discussions:

- Do mental health services promote the achievement of individually-defined goals?

- Do consumers see a day when they won't need as many services?
- Does the system empower consumers to tailor services to their individual needs?
- What do consumers like or dislike about their experience in the system?
- What are some of the barriers to the creation of a recovery-oriented system?
- What are some ways of overcoming these barriers?

In addition, consumers participating in the focus groups who were also residents at Assisted Living Facilities (ALFs) were provided the opportunity to participate in a separate survey about their experiences with services. ALFs represent an important source of housing, especially for persons who receive Social Security Disability as a sole source of income and rely upon Medicaid support for services. The survey focused on issues related to location, access, and quality of services. We also included a question for staff in psychosocial and clubhouse programs about adaptations in services for individuals living in ALFs.

The following summary describes major themes from these consumer/staff discussions.

Staff/Consumer Participants

Fifteen staff persons responsible for implementing psychosocial rehabilitation services were interviewed at each of the five agencies, including program supervisors and line staff. Program supervisors have been in their current positions an average of 6.7 years, ranging from 4.5 to 9.0 years, while line staff averaged 3.5 years. Some staff have been implementing some form of psychosocial services for most of their career, while others are making the transition from providing day treatment services.

Fifty-four consumers from five different psychosocial programs responded to questions in five focus groups. The number of participants from each program ranged from 7 to 13.

Service Delivery

Psychosocial services delivered under the new code most often focused on implementing educational groups. Topics included issues related to mental illness (e.g., symptoms, treatments, triggers, warning signs, relapse prevention, coping skills), normalizing feelings, stigma, self-esteem, activities of daily living (ADLs), life skills, social skills, goals and values, recovery, information about community living (e.g., resources, legal issues), health (e.g., nutrition), and pre-vocational skills.

Supervisory staff reported that the psychosocial rehabilitation service codes gave them the flexibility to cover a more diverse range of topics. They also reported that the 15-minute billing increments allowed them to more closely match services to the needs of each consumer.

Consumers attended the programs providing these services 3 to 5 days a week on average. Some participants missed the social/interpersonal part of day treatment programming and felt that the focus on goals and life skills was restrictive.

Developing Life Goals

Helping consumers identify and achieve life goals that focus on recovering meaningful community roles is a core component of recovery-oriented programs. Staff described a focus on goals in the following three areas:

1. Goals related to managing mental illnesses such as illness awareness, medication management, and staying out of the hospital,
2. Goals related to skill functioning such as activities of daily living (ADLs), social skills, and budgeting, and
3. Goals focusing on areas of personal meaning and reintegration to life in community such as improving relationships, being independent, having a family, dealing with daily stressors, going back to school, and getting a job.

Consumer focus groups described goals similar to those described by staff. However, many consumers spoke in general about exploring goals and values, but did not describe specific goals. One person described his goal of opening a photography shop. One program encouraged consumers to write a daily journal on goals and recovery. One consumer talked about how the program had helped him realize that he was entitled to his values, beliefs, and opinions.

Achieving Life Goals

Some of the consumers described ways that the program helped them reach their goals and were helping them get closer to having the kind of life they wanted. These consumers talked about developing a more positive attitude, learning important skills, and achieving specific outcomes, including:

- Gave confidence.
- Taught how to be responsible.
- Helped with becoming more motivated.
- Taught to trust.
- Helped to develop a better understanding of personal beliefs.
- Helped to understand illness.
- Taught how to manage symptoms.
- Taught about relapse prevention.
- Helped to identify short, realistic steps.
- Helped with learning how to do the things to be more independent.
- Taught how to take care of self.
- Taught how to make friends.
- Taught coping skills to keep from being anxious at school or work.
- Helped with applying for an education grant.

- Helped to develop a resume.
- Taught how to look for work.
- Taught how to do clerical work.
- Taught coping skills.
- Helped with moving closer to goal of independent living.
- Helped with becoming more independent.
- Helped with getting an apartment.
- Helped with getting a job.
- Helped with developing emotionally and socially

A few consumers reported that they had not received the help they wanted. One person reported that he was too frightened to take the bus to access services he was referred to. Another felt that he did not have enough support when he went on job interviews. One person said the program did not have the resources to empower him.

Need for Services in the Future

Most of the consumers who responded to the question about the need for services in the future felt that they would reach a point where they would not need the services or would not need them as often. Some of these consumers felt that it may take years to reach this point. Some of those who felt they would reach that point also wanted the option to return to the program in the future. A few consumers did not know or felt that they would not reach that point. One person said that he had been in the program since he was young and would be afraid to go out on his own.

Treatment Planning: Individually Tailored Services/Consumer Involvement

Recovery-oriented programs provide consumers with the opportunity to tailor services to their individual needs. Treatment planning is the prime mechanism for shaping services to meet the needs of individuals and for defining the roles and relationships of staff and consumers in the treatment process. The staff interviews and consumer focus groups explored processes and procedures for treatment planning, including the process of decision making and level of consumer participation. Staff and consumers mostly agreed that staff use input from consumers and other sources to write treatment plans. Plans are then discussed with the consumer, and any disagreements about goals are negotiated. One staff member said that consumers could write a response if there was a disagreement about the plan. There were no indications that other programs would not give consumers the same opportunity.

Consumer responses to the question about who makes the final decision for treatment plans varied within each program and among all focus groups; some said it was a consumer decision, some said a mutual decision, and others said that staff made the final decision. No consumer reported being unable to put something in the treatment plan that he or she wanted there. Some consumers felt that the treatment plan should be reviewed more often or that the program could create

better treatment plans. One said that more attention should be paid to how long consumers planned to stay in the program.

During the treatment planning process, some staff asked consumers if they wanted anything different from what the program offered. Staff reported giving more emphasis to consumer involvement as a result of the shift to psychosocial programming. Specific changes included encouraging consumers to work collaboratively with their treatment team, having consumers dictate their goals, using more consumer-centered language, and changing the name of the plan from treatment plan to personal recovery and empowerment plan.

Some programs also used consumer surveys and/or community forums to facilitate consumer involvement, but these often focused on recreational activities such as outings. At one program, staff and consumers agreed that the forum gave consumers a role in determining topics for psycho-educational groups. Another program described the steps for ensuring that consumer input was taken seriously, including a requirement for senior management to attend consumer meetings and to respond to consumer concerns. Minutes are kept of these meetings, and consumers receive a written explanation when their requests are not granted.

Consumers were sometimes encouraged to form their own groups. Some consumers were able to decide which groups they wanted to attend and how often they attended the program.

Diversity of Treatment Options

We asked staff persons and consumers about the kinds of options for services that were available both within and outside of the agency and for mental health and non-mental health activities. All of the programs reported helping consumers access services from other agencies and programs. These include housing, employment services, medical care for non-psychiatric illnesses, and spiritual counseling. In some cases the programs helped consumers receive psychiatric and/or counseling services from a different mental health agency. Other options included the opportunity to participate in civic organizations, perform volunteer work, and refer people to support groups in the community.

It is not clear how many options, if any, consumers have for receiving psychosocial rehabilitation services from other agencies. This makes it impossible to judge whether consumers have any real power to shape services to fit their needs by voting with their feet.

Barriers and Solutions

Staff members were asked to describe barriers to implementing rehabilitative, recovery-oriented services and suggest solutions for overcoming these barriers.

Staff identified some consumers as poorly motivated and unable to make good choices and expressed frustration with poor program attendance and lack of medication compliance. Some staff also acknowledged the hopelessness that consumers sometimes feel and articulated the system's role in creating dependency. They also proposed ways to motivate consumers such as taking more time with people to explore their future preferences and establish better plans of action,

being a good listener, giving people time to adjust to the program, and asking people how they want to participate. Other staff noted the problem of working with people with severe behavioral problems. Some talked about the difficulty of working with diverse diagnoses in the same program environment.

One staff member argued that the recovery model underestimates the importance of mental illnesses and sets unreasonably high expectations by assuming that all consumers can live and work independently. As a consequence, individuals with severe disorders were thought to be at risk for frequent symptom exacerbations.

Staff also identified the following barriers to implementing quality services:

- Time required for paperwork
- Insufficient information about documentation requirements
- Insufficient information regarding AHCA guidelines
- Staff turnover
- Inadequate number of staff
- Transportation
- Not enough space for all the people who would like services

Training and Technical Assistance Needs

Staff identified the following areas of need for training and technical assistance:

- Specific documentation requirements for First Health and AHCA
- Assistance with implementing services within AHCA guidelines
- Group work with individuals who present with different levels of functioning
- Causes and symptoms of mental illness
- Role recovery
- Medications

Recommendations

Staff and consumers were both asked to make recommendations for how services could be improved and provided the following responses:

Staff Responses

- Pay more attention to helping people apply the skills they learn in community environments.
- Provide drop-in centers for individuals who do not recover as quickly and who need a place to connect with others.
- Increase funding.
- Allow larger groups for psychosocial rehabilitation.
- Realize that there can be too much emphasis on empowerment.
- Make more units for behavioral health available.

Both consumers and staff felt that it was important for consumers to have a place to go if they left the program and then relapsed.

Consumer Responses

- Split up consumers into different groups based on length of stay to prevent repetition of old material for long-term participants
- Treat people as adults (e.g., allow them to smoke)
- Reduce staff turnover
- Increase the number of staff
- Provide sensitivity training for staff
- Provide more individually tailored classes
- Provide more group therapy
- Lower the student-teacher ratio
- Provide more groups
- Bring in speakers from the community
- Provide more outings
- Increase length of time in the program

Satisfaction/Dissatisfaction

When asked to describe the program on a scale of 1 to 10, with 10 representing most satisfied, most consumers gave the programs high marks with an average of 8.7. For many consumers, the programs provided a comfortable place to be during the day and an opportunity to socialize. Some individuals came to the program on off days for the social connection. Consumers talked about having a place to go when they got bored, the accepting atmosphere, and the opportunity to attend every day and try their hardest. They also talked about how they enjoyed being around the staff and other consumers. A few talked about the voluntary nature of the program and the importance of structure.

Discussions of the things consumers liked the least provided the following responses:

- Consumers who don't do their share of the work
- Rude, tactless, or burned out staff
- Staff turnover
- Classes that are too big
- Poor food
- Too many "baby sitting services" (i.e., recreational activities) instead of clinical services
- Instructors who take the easy way out (e.g., show a film rather than teach computer skills)

Clubhouse Services

Focus Group Results

Fifty-three consumers who are clubhouse members participated in focus groups conducted at five Florida clubhouses. Each group lasted ninety minutes to two hours. Fifteen staff persons, three at each clubhouse, were interviewed. Staff included program directors and line staff at each clubhouse.

Staff Roles

Staff members in clubhouses were expected to be generalists. All staff members, including directors, were expected to attend to all of the tasks in the clubhouse such as food preparation, cleaning, office management, reception, etc. However, there are some important distinctions between directors and general staff. Directors are responsible for duties that include program start-up, program development, fund raising, staff supervision/evaluation, participation on the board, ICCD certification, development/supervision of Transition Employment Programs (TEP), community education, and advocacy. Directors also regularly conduct basic tasks such as kitchen and clerical work. Other staff members are generalists but hold titles such as clubhouse advocate and clubhouse specialist.

Key tasks for all of the clubhouses included creating the experience of community among members, supervising the work-ordered day, developing employment opportunities, and managing house operations. The length of time employed at the clubhouse ranged from one to three years, but all programs were new or in a start-up phase.

Directors in clubhouses that operate within community mental health centers described challenges integrating clubhouse principles and practices into administrative structures/cultures. In addition, they had administrative responsibilities in the agency that took them away from clubhouse duties.

Clubhouse Member Participation

Members attended the clubhouse an average of three to five days per week, five hours per day. All of the members participated in the work-ordered day with common activities including kitchen tasks, administrative/clerical duties, preparing newsletter, shopping/laundry, computer operations, snack bar duties, outreach to members who were not attending, and social activities.

When members were asked what they would be doing if they were not at the clubhouse, most indicated that they would be at home watching television, sleeping, or engaging in some other leisure activity.

Clubhouse Services

Only one of the clubhouses was billing Medicaid for services at the time of our interviews, but all of the programs used ICCD certification as the standard for implementation. The activities within each of the clubhouses was structured around the work-ordered day where members and staff work side-by-side in the running the clubhouse. The clubhouses are organized into work units such

as kitchen, clerical, administrative, and member outreach. The work activities provided structure for the community and were intended to help members regain a sense of self worth and to develop confidence in abilities.

It is important to note that in-house activities support the functions of the community and are not considered part of job training. However, providing members with the opportunity to return to paid work is a core feature of the Clubhouse Model. Only the ICCD certified clubhouse had a functional Transitional Employment Program (TEP). The other four clubhouses were all in the process of establishing TEPs as part of their ICCD plan to achieve certification.

Service Implementation

- Life Goals

  Each of the programs engaged members in identifying life goals that are entered into activity plans. Clubhouses do not develop "treatment" plans and do not focus on mental illnesses, although members are supported in receiving care for psychiatric disorders through other treatment providers. Members at the three clubhouses operating within community mental health agencies typically received psychiatric care from treatment programs within the agency.

  The goals most commonly identified across all five clubhouses included employment, housing, GED diploma, interpersonal/social, and education. Progress toward goal achievement was monitored every six months, but informal support and monitoring by staff and members is an integral part of the work-ordered day.

  Each of the five clubhouses helps members with identifying life goals shortly after engaging with the program. Members describe holding regular conversations with staff about goals but needed prompting in the focus groups to identify goals. Common goals included finding a place to live, jobs within the clubhouse as part of the Transitional Employment Program, and goals related to establishing social relationships. Some members indicated that staff were instrumental in helping them build the confidence needed to achieve goals and appreciated respectful treatment such as "being treated like an adult." When asked if there might be a time in the future when services will not be needed as much as in the present, members presented mixed points of view and responded that they might do better in the future but feel that the connection to the clubhouse is something they may revisit. Many acknowledged the importance of being a "member for life."

- Involvement

  Staff in each of the clubhouses describe full member involvement in the daily activities of the clubhouse, including planning, scheduling, and management of the work-ordered day. Each clubhouse has weekly meetings, but the focus is most often on daily activities rather than policy/program development or administration. Decisions are made by consensus. In some cases members sit on the board of directors/advisory board.

The members in each of the clubhouses described participation in weekly house meetings as the forum for making suggestions and especially for shaping the schedule of activities that make up the work-ordered day. Decisions are made at meetings through a consensus process. Members also felt comfortable with speaking to staff at any time about issues of concern.

- Diversity of Treatment Options

  The most common referrals for services described by staff included transportation, eyeglasses, and vocational rehabilitation. All clubhouses also provided members with assistance in finding suitable housing. Psychiatric treatment and case management services are provided by community mental health agencies. Each of the clubhouses work in collaboration with these and other service providers to provide support for the care of members.

  Treatment for psychiatric disorders is not part of the clubhouse model. However, members received support accessing mental health services as well as entitlement (Medicare/social security), housing, and educational programs. Most members had relationships with mental health treatment providers and case managers. The clubhouse experience provided contacts with peers/mentors and a range of non-mental health activities.

- Choice

  All staff identified member choice concerning attendance and participation as fundamental components of clubhouse operation. Members are encouraged to engage in activities as part of the work-ordered day, but participation is voluntary. Members are members for life with no time limits. Members participate in writing activity notes and have access to them at any time, per request. However, clubhouses within mental health agencies keep treatment records at a separate location. The process for accessing these records varies according to agency policy.

  Members in each of the focus groups described participation in all clubhouse activities as entirely voluntary. There were no indications of coercion by staff or other members to participate in activities. Members participate in writing notes in activity records and have regular access. Some members described treatment records at the community mental health center as "confidential."

- Individually Tailored Services

  The work-ordered day provides the context for member activities, although staff provide support/service to each member based on individual preference. Staff described the need to function as generalists and to "do whatever needs to be done" to support the clubhouse community and the needs of individual members. Some members have goals to gain competitive employment, while others may choose to focus on the social and emotional benefits of being part of the community.

  Members in each of the focus groups responded to the question about how the program responds to individual needs by describing positive experiences of being part of a community. The importance of having a place where they felt safe and secure and had the freedom to participate in meaningful activities was a major theme. Members usually described individual activities as they relate to interactions with staff and other members in the community and the structure of the work-ordered day.

Barriers to Implementation

Staff members were asked to describe barriers to implementing clubhouse services, strategies for overcoming these barriers, and service strategies that have been most successful.

The following are common barriers identified by staff:

- Procedures for Medicaid Billing

  Only one of the clubhouses completed the process for Medicaid billing, and it is the only clubhouse in the state currently billing Medicaid for services. The other four clubhouses were in the process of determining if Medicaid billing was feasible. The barriers to establishing Medicaid support for member services was primarily related to billing requirements based on medically modeled service delivery. Clubhouses do not provide psychiatric treatment and have difficulty meeting requirements related to staffing, providing psychiatric treatment, and documentation. In addition, clubhouses that are not associated with community mental health agencies do not have an infrastructure to support the billing process.

  Directors for each of the clubhouses also identified the reimbursement rate as inadequate to support clubhouse services. They noted that psychosocial rehabilitation services receive a rate nearly double that of clubhouses, though the service codes are very similar. They also expressed frustration about procedures for establishing provider numbers and project codes and the requirement to have a licensed person on the premises. The directors each indicated that they would rather seek alternative sources for funding than compromise fundamental clubhouse principles.

- Barriers Identified by Clubhouses Operating within Mental Health Agencies

  Clubhouse directors indicated that administrative and clinical staff within mental health agencies sometimes lack an understanding of the clubhouse model and consequently may not be supportive. For example, some agency staff are not comfortable with person-centered approaches in which members determine the focus of care. Clubhouse directors also have administrative responsibilities for the agency that are not specifically related to clubhouse operations. In addition, regulations related to liability, insurance, and safety can pose problems (e.g., members using sharp knives in the kitchen).

- Family Member Concerns

  Staff reported that some family members did not fully understand the model and were concerned that clubhouses lacked sufficient structure for safety. This stands in contrast to members who describe the safe and secure environments of clubhouse as a positive feature.

- Stigma

  Clubhouse staff described a pervasive belief among the general public that people with mental illnesses can not make decisions or be productive. In addition, they described a lack of understanding about recovery among the general public and mental heath professionals who view “chronic” mental illnesses as conditions with little or no hope for improvement.

- Transportation

  Each of the clubhouses tried to locate in areas close to public transportation and accessible to people with mental illnesses in the community. However, access is still a challenge for some members. The clubhouses provide some assistance with transportation, but it is limited by staff availability and funding. Some Assisted Living Facilities provide transportation for their residents.

- Acquiring Start-Up Funds

  Four of the five clubhouses are in a phase of start up. Directors from each clubhouse indicated that acquiring funds during this phase was an ongoing challenge. Potential sources of support included private donations from individuals and businesses, in addition to foundations.

- Engaging Members

  Many of the staff identified the challenge of engaging individuals with mental illnesses who have long histories of receiving services that required them to comply with treatment regimes prepared by the care giver. Traditional day treatment or drop-in programs typically require little active involvement. In contrast, the clubhouse focus on choice, self-direction, active participation in the work-ordered day, and developing strengths represents a significant change for many members. Staff described the critical importance of helping members make the transition to an environment where staff and members shared equal status and where the mental illness is not the primary focus.

- Lack of Affordable Housing

  Staff in each of the clubhouses identified a lack of affordable housing as a significant problem for many of their members. People with mental illness on fixed disability incomes are especially vulnerable. Each of the clubhouses provides support to members who seek to change/improve their housing.

- Need for More Staff

  Each of the clubhouses identified the need for more staff to support and develop services, especially those focusing on employment. They identified difficulties with maintaining competent staff because of inadequate salaries.

Overcoming Barriers

Each of the clubhouses has a plan for development based on ICCD certification requirements and has trained staff at an ICCD site. These plans have provided an important template for addressing barriers to clubhouse development and implementation. Approaches to responding to the barriers listed above have involved community outreach and education. Specific strategies include:

- Designate a staff person with an understanding of Medicaid and financing to work with AHCA on addressing bureaucratic procedures and issues related to compatibility with the clubhouse model.

- Explore alternate sources of funding from the state, foundations, and private sources.
- Provide community education about mental illnesses and the clubhouse model to community stakeholders such as, families, vocational rehabilitation providers, schools, hospitals, and the YMCA.
- Educate mental health agency and clubhouse staff about the clubhouse model.
- Invite community stakeholders to the clubhouse to provide orientation to the model and to promote good relationships in the community.
- Participate in meeting with community service providers, planning councils, and other stakeholders.

Successful Strategies

Staff members were asked to identify strategies that have been instrumental to implementing successful clubhouses. The following were identified:

- Use Transitional Employment Programs (TEPs) that are keys to successful clubhouses. With the exception of Vincent House, which is already operating a TEP, the clubhouses are all in the process of trying to establish relationships with community employers. TEP development represents a high priority and is a requirement for ICCD certification.
- Provide meaningful structure, opportunities to build confidence, competence, and a sense of community through a work-ordered day.
- Create community where members help members.
- Provide a service for individuals who are not served by the current system such as persons not yet ready for supported employment but who find traditional day treatment activities to be demeaning.
- Create a policy where members are members for life to establish a sense of enduring community.
- Maintain a wellness focus with a person-first rather than illness focus.
- Be a good neighbor in the community.
- Provide advocacy activities for people with mental illnesses.
- Outreach to members who have not been attending.

Members were asked how the clubhouse helped them become closer to having the kind of life they wanted to have. The main themes included:

- Assistance with practical issues such as bus passes, social security applications, and having a place to discuss the frustrations associated with daily living.
- Participating in a community where "members help members" was described as vitally important.

Member Satisfaction

The level of satisfaction of members in each of the clubhouses was uniformly high with an average rating of 9.1 on a scale of 1 to 10 (10 indicating most satisfied).

Members in each clubhouse were able to identify numerous things that they liked about the program. The major themes included feelings of safety/security, opportunities for social connections and being part of a community, and the opportunity to learn new skills. Members also expressed satisfaction with the level of respect received by staff and other members in the clubhouse. One member noted, “You’re treated more like an adult and less like a child.”

The discussion about things liked least in the clubhouse produced the most varied responses across clubhouses. In some clubhouses, there was frustration among some members with the distribution of labor and concern that some members were not helping with daily work tasks. There was also some concern about the need to repair buildings/appliances. Staff turnover was the primary concern at a clubhouse that was connected to a community mental health agency. This quote from a member captures the tone of the discussion: “It is really hard to adjust to new staff, because like you said, you get comfortable with one staff and you can go to that staff and you have confidence in them and sometimes just trying to get with a new staff is hard, like with me, I tend to isolate back up because you are really scared.” Members at this clubhouse also noted that the staff seemed tired and overworked.

Plans for Certification

The AHCA administrative service codes require clubhouses to obtain ICCD certification within three years. One of the programs in this study is already ICCD certified and the other four were working on a plan coordinated with the ICCD for achieving certification. The primary area needing development for certification was the development of Transitional Employment Programs (TEPs). Certification requires establishing relationships with community employers who will provide work opportunities for clubhouse members. All of the clubhouses identified the need for more staff to assist with the development of TEPs.

Technical Assistance Needs

Staff identified the following areas of need for training and technical assistance: Sending all staff to ICCD training, opportunities for sharing information with other clubhouses, training and support with computer software, and grant writing.

Recommendations

Staff and members were asked to make recommendations for how clubhouse service could be improved and provided the following responses:

Staff

- The need to hire more staff, attain better staff retention, and provide higher salaries was identified at each clubhouse.
- Developing more TEP placement options was a high priority for each clubhouse.
- The Medicaid billing rate for clubhouses should be equal with psychosocial services.

- There is a need to address member and family fears about losing disability benefits because of employment income.
- All staff expressed a passionate belief in the clubhouse model as a way to assist people with serious mental illnesses and expressed high levels of job satisfaction with working in this model.
- Vincent House was interested in taking a lead role in supporting clubhouses statewide.
- All programs identified the need to educate the general public, members, family members, and staff about the clubhouse models and about the myths surrounding mental illness.

Members

Member recommendations focused on expanding existing services, specifically employment programs, clubhouse staffing, and improved facilities.

Adaptations for Persons Living in Assisted Living Facilities (ALFs)

Both the psychosocial rehabilitation and clubhouse programs serve individuals living in ALFs. Many of these residents receive Social Security disability as a sole source of income and are supported by Medicaid for all of their mental health services. As part of the study survey, staff at psychosocial rehabilitation programs and clubhouses were asked about adaptations that are made to serve individuals living in ALFs. In addition, participants in the focus groups who were ALF residents were given the opportunity to participate in a separate survey about their experiences with receiving mental health services. Fourteen consumers participated in this additional survey, 9 from psychosocial rehabilitation programs and 5 from Clubhouses.

Psychosocial Rehabilitation Programs

Each of the psychosocial rehabilitation programs served individuals living in ALFs. The programs did not adapt the type of programming provided, but two of the agencies conducted groups on site at the ALF for individuals who could not participate in services at the program site. Program staff maintain regular communication with ALF staff about how consumers are functioning. ALF staff contact the programs if there is concern about particular residents. However, there are no formal arrangements to support staff meetings or the coordination of services. Two of the programs provided van transportation. One staff member said that lunch was provided by the agency, although the cost for meals, once covered as part traditional day treatment, is no longer covered by psychosocial rehabilitation services. During the focus group, some consumers described dissatisfaction with living in group settings and expressed the desire to live independently.

Clubhouse

Each of the clubhouses served members residing in ALFs but none of them adapted services for this group. Transportation to and from the clubhouse was the area of greatest concern among clubhouse staff. Some clubhouses were located in

neighborhoods that were accessible to ALFs and provided van service for those who needed it. Some ALFs provided transportation to the clubhouses, although in at least one case this service was discontinued because of cost. Most ALF residents received psychiatric care through a community mental health center. Clubhouse staff communicate with ALF operators and community mental health centers, but there are no formal mechanisms for sharing information or coordinating services.

Survey of Consumers Living in ALFs

The 14 individuals interviewed participate in mental health programs an average of 3 to 5 days per week, with 7 using public transportation and 7 using a van service provided by the mental health agency. When asked about services received at the ALF, most of the consumers mentioned medication management, meals, and laundry. One person indicated receiving some assistance with receiving food stamps. One person received a monthly visit from a case manager, but no one was receiving mental health services on-site at the ALF. Most of the consumers indicated a high level of satisfaction with their mental health services and with their experience in the ALF, although one person was uncomfortable with the lack of privacy and would prefer living in her own residence.

When asked about how their experience could be improved, they provided the following responses:

- Expanded meal menu
- Better food
- Funds for transportation
- Activities groups on-site
- Contact with a counselor
- Improved facilities

Issues Impacting Implementation: Impressions and Recommendations

The staff interviews and consumer focus groups conducted at the psychosocial rehabilitation programs and clubhouses participating in this study describe services that reflect service descriptions in the AHCA handbook. However, the discussions also clearly describe a period of transition for programs where consumers and staff are in a process of defining new roles and responsibilities in the delivery of these services. In replacing day treatment services with psychosocial rehabilitation services, AHCA provided a clear incentive reflected in the high levels of service activity after the new administrative service codes went into effect in October 2004. Clubhouse services were supported by AHCA for the first time and not offered to replace another service. However, only one clubhouse was billing AHCA for services, while others have sought alternative sources of funding.

It is important to note that the implementation of psychosocial rehabilitation services was guided only by the description in the AHCA handbook, which includes a general description of program activities. There were no practice standards or implementation guidelines specifying the process for conducting interventions. In contrast, clubhouses in this study followed the International Center for Clubhouse Development (ICCD) standards.

The Challenge of Implementing Rehabilitative, Recovery-Oriented Services

There are challenges inherent to implementing rehabilitative, recovery-oriented services in state mental health systems (NASMHPD/NTAC e-Report on Recovery, 2004). Though consensus has emerged on a common set of principles (Substance Abuse and Mental Health Services Administration, 2006), establishing common definitions and practice standards are still in the early stages of development (Anthony, 2000; Onken et al., 2004). The challenge is defined in large part by the nature of the recovery process. Recovery from mental illnesses refers to the person's experience of the illness as expressed not only in signs and symptoms, but also in the ability to cope, find meaning, and function in meaningful roles in the community. In addition, the person's progress may not follow a linear course and may be different for individuals. The person's subjective experience is the focal point and is as important as objective measures of progress. Though we know that up to two-thirds of people with mental illnesses will experience significant improvement over a lifetime, we do not currently have the capacity to predict which individuals will be more likely to recover (Harding, Zubin, et al., 1987). In summary, the recovery process is multidimensional, fluid, non-sequential, and complex (Onken et al., 2004).

In contrast, traditional programs and finance structures usually focus on a single dimension related to impairment or functioning rather than the whole person, face challenges in individualizing care for large numbers of consumers, and track progress in discrete, sequential units. State-level transformation initiatives throughout the country have faced a formidable challenge in developing systems and programs that are compatible with the experience of recovery. The shift to rehabilitative, recovery-oriented programs is an evolutionary process that will ultimately require a partnership of government, funding agencies, service providers, consumers, family members, and other community stakeholders.

The findings from this study describe the progress of 10 Florida programs in addressing the challenges of supporting persons with mental illnesses on the road to recovery. The following discussion examines the implementation of psychosocial rehabilitation programs and clubhouses and provides recommendations for developing polices and practices consistent with a recovery orientation.

Psychosocial Rehabilitation

Both the staff interviews and consumer focus groups provide evidence that each of the programs participating in this study provide the kinds of activities described in the AHCA Handbook for Psychosocial Rehabilitation Services. Staff persons described a broad range of beliefs about the potential for recovery for persons with mental illnesses. However, the services provided in the programs were generally similar, focusing less upon the amelioration of symptoms and more upon restoring functional capabilities. Programs delivered these services in groups, usually in a classroom setting, with a focus on skills teaching activities.

The following discussion identifies areas that are significant for effectively implementing rehabilitative, recovery-oriented programs with recommendations for implementation.

Treatment Planning

Staff sometimes described a process for treatment planning that seemed more a fulfillment of bureaucratic requirements than the basis for consumer and staff collaborations. Treatment plans identified the person's goals and the programs provided a menu of topics in a group/classroom setting to assist with achieving these goals. However, consumers were usually assigned to groups, or in some cases they selected groups, from a program menu. Most consumers showed no awareness of the connection between their goals and the program activities. For consumers who were involved with programs for many years, the activities were sometimes repetitive and aimless. Consumers who are involved in treatment planning are more likely to know and value the goals described on their treatment plans. This involvement also supports more meaningful participation in services designed to help them with achieving these goals.

Recommendations: Treatment planning is the most critical component for implementing recovery-oriented services (Adams & Grieder, 2005). Treatment planning should be a process through which consumers and staff work as partners to chart a course for recovery, and where consumers can identify a clear link between goals and program activities. It should also be a person-centered activity where consumers drive the process. Staff persons who implement person-centered treatment planning establish partnerships with consumers in helping them achieve personally important goals rather than prescribing regimens. Person-centered treatment planning should be considered as a core component of rehabilitative, recovery-oriented services and be a top priority for future program development. In addition, psychosocial rehabilitation groups should be used to both model and teach consumer-service provider collaboration.

Changes to Recovery-Oriented Language

Staff described language changes in treatment plans that reflect a person-centered recovery orientation. However, examples of these language changes suggest misunderstandings about recovery principles and practices. One staff person provided the example of a consumer's goal: "I would like to be more medication compliant." It was written in person-first language, but references to compliance reflect a service provider perspective and do not reflect a partnership to develop goals that reflect the wishes of the person.

Recommendation: Create a manual that provides an orientation to the basic principles and practices of recovery-oriented services.

Consumer Skill Development

The prime focus for most of the psychosocial programming was on skill development in classroom settings. However, the greatest area of need for most consumers, especially those living in non-institutional settings, is not to acquire new skills but to learn how to apply skills in real world settings. Classroom learning can be an important component, but without a process for supporting functional capabilities in real life environments/situations, skills may not be applied and will not support people with regaining meaningful roles in the community (Anthony & Liberman, 1986).

Recommendations: Skill development activities should place a greater focus on recovering important roles and in supporting consumers with the application of skills in the places where they live, work, go to school, or socialize. This transition would require a greater shift of some services from the agency site to real life community settings. In addition, it would require some one-on-one coaching/supports, in addition to the group activities. Enhanced reimbursements for individual services should be considered as an incentive.

Staff Buy-In

Staff perspectives about rehabilitative, recovery-oriented services covered a broad spectrum. Some staff were well informed and enthusiastically supportive, while others expressed little belief in the potential for recovery and the value of rehabilitative, recovery-oriented services. Some staff were also frustrated by what they see as a lack of consumer motivation and did not believe that persons with serious mental illnesses have the ability to make competent decisions and/or hold the potential for recovery. In addition, some staff viewed the implementation of recovery-oriented services as neglecting the signs and symptoms related to mental illnesses, and consequently, as a cause for increased symptom exacerbation. Successful implementation is not possible unless staff fully buy-in to recovery-based principles and practices.

Recommendations: Staff buy-in is essential for the effective implementation of rehabilitative, recovery-oriented services. Practice standards need to be implemented statewide to ensure the consistent application of practices across programs and to provide a frame of reference for consensus building, development, and evaluation activities (O'Connell et al., 2005; Onken et al., 2004).

Meaningful Consumer Engagement in Program Activities

Staff at each of the programs expressed frustration with engaging some consumers in program activities, evidenced by a lack of follow-through with treatment plans, poor attendance, and a perceived lack of motivation. Some consumers were not inspired by program activities and described their participation in groups as feeling like "busy work." Consumers should experience program activities as relevant (i.e., a means to achieving life goals). Services that are not person-centered, that emphasize compliance, and that are unappealing can undermine motivation and will not meaningfully engage consumers. In addition, consumers need to believe that progress on the road to recovery is a real possibility. Belief in the possibility of a better future is necessary for both consumers and staff to realize the benefits of recovery-oriented activities.

Recommendations: Person-Centered Treatment Planning is one of the most critical components for ensuring meaningful consumer participation (Adams & Grieder, 2005). Consumers need to experience the connection between personal goals and program activities. Consumers also respond more enthusiastically when options for housing, employment, education, and developing friendships are made available by the program and are perceived as attainable. Peer interventions that

focus on leaning about the process of recovery should also be considered. Peer services provide concrete evidence about the possibilities for recovery and can help consumers develop a more hopeful attitude about the future (Clay, 2005).

Services for Residents of Assisted Living Facilities (ALFs)

Program staff and ALF staff communicate informally, on an as-needed basis, about issues related to medication management and general functioning. With the exception of a few group activities and case manager visits, most of the services received by residents of ALFs were delivered at the programs sites of the mental health agencies. Transportation is critical to ensuring access to program sites from the ALFs. However, for many residents the trip to the program represents not only the opportunity to participate in services, but also to socialize with others. For many consumers, including those living in ALFs, opportunities to socialize were a prime motivation for attending the program. Many of these consumers are on limited/fixed incomes that restrict opportunities for participation in community activities. Recovery-oriented services should identify strategies to assist consumers with establishing meaningful connections with other community resources.

Recommendations: Program staff and ALF staff should consider establishing more formal mechanisms of communication/care coordination in collaboration with consumers. The focus should extend beyond managing the effects of mental illness and include issues that are important to the quality of life of consumers. Staff should coordinate activities with drop-in centers, clubhouses, and other community resources.

Consumer Participation

Each of the programs in the study has taken steps to include consumers in the planning and delivery of services. Programs currently accept input on treatment plans, but there is room for progress in establishing a more equal partnership where consumers play the central role in directing their own plans. Programs have also instituted community advisory groups and conducted consumer program meetings to solicit input about satisfaction with programming. Some programs also used consumer surveys to solicit information. These activities are all consistent with a recovery orientation but should be augmented with opportunities for consumers to partner at executive levels such as in policy making, program development, and board meetings.

Recommendations: Develop formal policies that support not only consumer input but also partnerships that involve consumers at executive/policy making levels. Each program should consider creating a position staffed by consumers that deals directly with consumer affairs. In addition, psycho-educational programs that focus on teaching consumers and staff methods for effective collaboration, at levels of policy and practice, should be implemented.

Staff Turnover

Staff turnover was described as a concern by consumers in each of the programs studied. High levels of staff turnover have the effect of disrupting trusting relationships that are central to developing consumer-staff partnerships.

Consumers identified a lack of funding as a primary cause of problems with staff turnover and expressed anxiety about how services will be affected in the future. Program staff also identified a lack of staffing as a barrier to effective service delivery.

Recommendations: Hiring and retaining competent staff is critical to all services in the system of care, but is especially critical to effectively implementing recovery-oriented services where trusting relationships are the lynchpin to success. In the long term, a system-wide strategy that addresses issues effecting policy, financing, and program management will be required. In the short term, hiring staff who share the principles and values of the recovery approach will help to ensure more enduring connections with consumers receiving services in these programs.

Administration of Services

Staff indicated that the dividing units of service into 15 minute increments for psychosocial services provided more flexibility in shaping services to meet the needs of individual consumers. However, services are provided mostly in the group settings. Individual support is important to helping consumers with applying the skills to community settings.

Recommendations: Create incentives to augment more group psychosocial rehabilitative services with individual services that focus on the application of skills in community settings.

Training and Technical Assistance

Most staff did not express a strong need for technical assistance or training. Areas of interest included AHCA guidelines and issues related to mental illnesses. Only one person identified the need to learn about rehabilitative, recovery-oriented services. Staff did describe challenges that require specific skills to overcome. This lack of interest in training may be indicative of an incomplete awareness of the knowledge and skills required to effectively implement rehabilitative, recovery-oriented programs.

Recommendations: Provide general orientations on the principles and practices of rehabilitative, recovery-oriented services, as well as in-depth training in the skills needed for effective practice. Developing a set of standards for these services is also critical to helping programs determine the degree to which current interventions are effective and to developing training/technical assistance plans that target the areas of greatest need (Onken et al., 2004).

Clubhouse

Clubhouses have been operating throughout the country for over 30 years, but are only recently attracting broad attention in Florida. The Clubhouses that participated in this study represent programs that are fully committed to implementing services according to the ICCD model, as described in the AHCA handbook. All of the programs sought to create an experience of community for persons with mental illnesses where they are treated respectfully. The clubhouses

also provided the structure of a work-ordered day to support member participation in the operation of the clubhouse. However, four of the five clubhouses had not yet developed Transitional Employment Programs, a core component of the model that provides members with the opportunity to work in paying jobs. Only one of the clubhouses participating in this study established the process for billing Medicaid. It was also the only clubhouse in the state billing Medicaid for services.

The following are key issues effecting implementation that emerged in our discussion with members and staff, with recommendations.

Medicaid Billing Issues

Only one clubhouse in Florida has completed the process for billing Medicaid for services. The four clubhouses in this study not billing Medicaid explored possibilities for participating but identified the following barriers: lack of a billing infrastructure in clubhouses that are not connected to mental health centers, insufficient compensation (especially in comparison to psychosocial rehabilitation rates), procedures for establishing provider numbers and project codes, and documentation requirements that are not compatible with the clubhouse model.

Recommendations: The four clubhouses not billing Medicaid for services expressed interest in doing so in the future. AHCA should consider meeting with the Florida Clubhouse Coalition to discuss barriers and to identify strategies that would support implementation. In addition, gathering information from clubhouses in other states that have successfully billed Medicaid for services may help to inform these discussions.

Progress toward ICCD Certification

Unlike psychosocial rehabilitative programs that are operating without a common definition of recovery or a structured model for implementation, each of the clubhouses participating in this study utilized the ICCD standard for implementing all clubhouse operations. Clubhouse directors could clearly articulate their progress in achieving this standard and identified areas requiring development. However, not all of the front-line staff have received ICCD training.

Recommendations: The AHCA administrative code specifies that clubhouses work toward achieving ICCD certification within the next three years. This requirement supports the use of the ICCD standard and provides a critical structure for identifying strengths and weaknesses, guiding service implementation, identifying priorities for future development, and evaluating the progress of clubhouses statewide. It will be important to consider strategies that will support clubhouses in achieving and maintaining services that meet this standard, including training, technical assistance, and information sharing across programs.

Staffing

Most of the staff that were interviewed described a passionate commitment to working with people with mental illnesses and to the clubhouse model as an effective method for restoring dignity and hope among members. Staff generally

described having high levels of job satisfaction. However, for two of the clubhouses operating within community mental health agencies there were some problems related to having clubhouse staff who either did not understand or fully accept the clubhouse model. Staff working in other programs within the agency were at times unsupportive of the clubhouse approach.

Recommendations: The principles and practices of the clubhouse model provide an important anchor for members and staff, but it is critically important for staff to be oriented, properly trained, and to share the fundamental values of the approach. All of the programs have had some level of ICCD training, but they also describe a need for further training of clubhouse staff and orientation about the clubhouse model for both clinical and administrative staff in the host agency.

Engaging Members in Clubhouse Activities

Most of the members describe experiences of feeling respected and empowered by the clubhouse. Members in each of the clubhouses expressed a bond to the program, an experience that is fundamental to implementing recovery-oriented services. However, staff expressed concern and frustration with members who have a more passive orientation to services, evidenced by a lack of meaningful participation in the work-ordered day. Clubhouses represent a significant change for members who have histories with services that focused primarily on managing the effects of illness and on social activities.

Recommendations: Part of the challenge faced by clubhouses is helping members recognize their potential for meaningful participation in both the clubhouse and in other community activities. Clubhouses should consider implementing peer-to-peer interventions that have been developed to help consumers with becoming involved in their own care (Clay, 2005).

Transitional Employment Programs

The availability of alternatives for having meaningful roles in the community (e.g., housing, employment, education) is a critical part of engaging individuals in their own process of recovery. Transitional Employment Programs (TEPs) are a vital part of the clubhouse model, providing the primary link between the work-ordered day of the clubhouse and work in the community. Four of the five clubhouses studied are at the initial phase of developing this critical component. Because of the time and resources required, the development of viable TEPs stand as the most difficult barrier to achieving ICCD certification.

Recommendations: A plan for providing technical support and other resources to clubhouses for TEP development should be considered to ensure their success.

Conclusions

The administrative service data analyzed in this study demonstrate a significant shift of service activity to the new Psychosocial Rehabilitation Services described in the 2004 AHCA Handbook. The focus groups and interviews describe a period of transition for both consumers and staff in implementing these services. Per descriptions in the AHCA handbook, programs were focusing less on the amelioration of symptoms and more upon restoring functional capabilities, as evidenced by skill development activities in each of the programs. However, both consumers and staff express struggles with the emphasis on greater consumer self-direction that is central to the implementation of recovery-oriented programs.

In contrast, clubhouse services had no statewide billing activity for the period of this study. Each of the five programs had explored Medicaid as a funding option, but only one was preparing to bill for services. Key issues include a lack of billing infrastructure, concern about the level of compensation, and documentation requirements that are not compatible with the clubhouse model. However, each of the programs followed International Center for Clubhouse Development (ICCD) standards, and are part of a growing statewide coalition. Staff and consumer members were almost universal in their passionate support for the clubhouse model. Despite issues related to compatibility with traditional finance structures, clubhouses in other states have successfully created a process for billing Medicaid. The Florida Clubhouse Coalition, AHCA, and other interested stakeholders should explore strategies for overcoming current barriers and may benefit from approaches employed in other states.

Funding mechanisms to support rehabilitative, recovery-oriented services such as those introduced by AHCA provides critical financial incentive to service providers. However, service descriptions such as those provided in the AHCA handbook can only provide general parameters for guiding service delivery. Program standards are needed to provide a detailed roadmap for effective program implementation and a foundation for program evaluation. Standards to support rehabilitative, recovery-oriented services are emerging in the field (Onken et al., 2004). Program standards should be considered as an important next step in supporting effective service delivery.

Policy changes taking place at both state and national levels provide an important context for service delivery. Florida, like many states across the nation, has taken the lead from President Bush's New Freedom Commission and identified recovery as the goal for transforming our mental health system. Partnerships of consumers, family members, policy makers, service providers, and representatives from a broad range of government agencies who serve individuals with mental illnesses have formed at the state and community level. Strategies for developing finance structures to support rehabilitative, recovery-oriented services should be integrated with these policy initiatives.

The shift in some AHCA areas from fee-for-service financing to capitated systems, represented by Prepaid Mental Health Plans (PMHP's) and Health Maintenance Organizations (HMOs), also has important implications for the

delivery of rehabilitative, recovery-oriented services. In fee-for-service financing, there is a focus on discrete units of care defined by medical necessity. Capitated financing can provide more flexibility and can be more compatible with the holistic approaches of recovery-oriented services. For example, the analysis of Area 1 data demonstrated a shift from day treatment services to drop-in centers after the implementation of the PMHP. These consumer driven programs could not have been implemented under the fee-for-service system. PMHPs and HMOs should be considered critical partners in the state's transformation planning. Consumer input into the development and implementation of PMHP and HMO contracts will also be critical to supporting recovery-oriented service delivery.

Cultural and community resource issues also significantly impact the implementation of rehabilitative, recovery-oriented services. The prevalence of stigma connected to mental illness continues not only among the general population, but also within the mental health system. Limited financial resources strain the workforce and contribute to high levels of staff turnover, representing a major area of concern for the consumers who participated in this study. The lack of affordable housing and employment opportunities creates a significant barrier to achieving full community integration. Services and finance structures are critical to helping people with serious mental illnesses on the road to recovery, but they should be planned and implemented as part of a community-wide response.

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