



## **King County**

### **Recovery Plan for Mental Health Services Phase II Progress on Implementation**

**August 2008**

#### **Introduction**

On November 15, 2005, the Metropolitan King County Council passed Ordinance 15327, a revised Mental Health Recovery Ordinance. The Recovery Ordinance adopted the recovery model as the policy framework for developing and operating the mental health services for which King County is responsible, and adopted a five-year work plan for implementing changes in the system that would result in a recovery orientation and recovery outcomes.

The Council has requested periodic reports regarding the implementation of the five-year work plan. A report on Phase I of the work plan was submitted to the Council in February, 2006. A report on Phase II Implementation was submitted in June, 2007. The following report will summarize the work of Phase I and the progress of Phase II implementation.

#### **Background**

The idea of recovery and mental illness has evolved over many years. The initial goal of treatment, in the 1960's, was that people who have a mental illness should live in the community, not in big institutions like hospitals, and should receive services where they live. In 1963, the Community Mental Health Centers Act was passed by the U.S. Congress.

Progress was steady, if slow, in the evolution of the system in the last decades. This was due to the growing understanding of what kinds of community based services help coupled with uneven funding of services over time. The concept of Recovery from mental illness first appeared in the rehabilitation literature in 1991 and began to be adopted as a philosophy and treatment.

#### **The First Mental Health Recovery Ordinance**

On October 16, 2000, the Metropolitan King County Council passed Ordinance #13974, the first Mental Health Recovery Ordinance. Ordinance #13974 was championed by the late Councilmember Kent Pullen, who wanted to assure that the publicly-funded mental health system provided the appropriate types of supports to enable people with mental illnesses to move towards greater independence and less reliance on the public service delivery system. The ordinance directed the Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) of the Department of Community and Human Service (DCHS) to ensure that the publicly funded mental health system in King County became grounded in mental health recovery principles, and to report to the Council on system progress.

Ordinance #13974 was written with the idea that persons with severe mental illness should

become “recovered” and spoke of clients becoming less dependent as a measure of recovery. Reporting requirements focused on adults only, and only those with certain diagnoses.

At that time, new information began to emerge in the literature that spoke to recovery for all persons with mental illness, whatever their age and whatever their level of disability. Research was published from longitudinal studies of people who had been very ill at one time with mental illnesses, many of whom were found to eventually become well. Nine studies in the U.S. and other developed countries have been published now that show up to 60% of persons who had a severe mental illness and were in state hospitals were able, over time, to recover to the extent that they were no longer on medications, lived in the community, worked successfully, and were indistinguishable from their neighbors.

Additionally, in the time since Ordinance #13974 had passed, three developments occurred that suggested that it might be time to revisit the ordinance.

1. MHCADSD began to implement services that started to move the publicly funded mental health system into a recovery-oriented system. For example, MHCADSD developed Regional Employment Centers, vocational programs available to clients anywhere in King County, when their own mental health agency did not have its own employment program. MHCADSD also began to shift residential resources away from large facilities to services that support publicly funded mental health clients to live safely in the community.

Finally, MHCADSD began conducting an annual evaluation of the extent to which mental health services provided in the publicly funded system are recovery based. The results indicated much more focus on ways to support mental health recovery was needed. Adding employment services and supportive housing were insufficient in themselves to trigger the fundamental changes in attitude, skills, and values needed to shift to a system that supports the mental health recovery for participants in the mental health system.

2. The concept of recovery continued to evolve nationally. Clinical practices that foster recovery are increasingly based on research findings and established best practices, and accountability measures are becoming more clearly identified. Both of these developments meant that how to implement recovery and how to measure it was more clearly articulated than they were in 2000. In 2003, the President’s New Freedom Commission on Mental Health report was released. The commission states:

"Recovery refers to the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery."

Consumers reported that while some might experience recovery as an outcome or end point, others experienced recovery as a process. To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with

six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004. The conference explicitly included all ages in consideration.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. The following consensus statement was derived from expert panelist deliberations on the findings.

“Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.”

The panelists also identified the Ten Fundamental Components of Recovery:

Self-Direction	Strengths-Based
Individualized and Person-Centered	Peer Support
Empowerment	Respect
Holistic	Responsibility
Non-Linear	Hope

3. The King County publicly funded mental health system faced significant challenges. The challenges included decreased funding, increased federal regulatory requirements, and reduced inpatient resources. The impact of these challenges was to create an environment of resource scarcity. This in turn restricted the ease with which system transformation could occur.

In April 2005, the Metropolitan King County Council approved MHCADSD's request to suspend Ordinance #13974 and replace it with one that more fully reflected the evolving understanding of recovery.

### **Recovery Ordinance 15327**

In addition to the revised Recovery Ordinance, the council passed Budget Ordinance 15333 with a proviso to support the plan for changing the system from one based on maintenance of persons with mental illness to one promoting recovery of functioning in community life. In response to the requirements of the budget proviso, the Department of Community and Human Services' Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) submitted to the council on March 1, 2006 a Phase I Recovery Implementation Plan.

### **Phase I – Creating a Shared Vision of Recovery**

The work of Phase I built a powerful guiding coalition of stakeholders invested in building and/or strengthening programs that support recovery; constructed a clear, compelling vision of the advantages of practicing from a recovery orientation; began to build structures for much greater engagement of mental health consumers and their families in the design and evaluation of

recovery services; identified barriers to system change and the means to dismantle them; and began to spread a sense of greater hope, more optimism, and higher expectations for mental health consumers.

The Phase I plan was a detailed work program that specified the scope of work, tasks, schedule, milestones, and specific plans for the use of expert consultants. The work plan also included plans for a system change oversight group and implementation planning work groups.

### **Phase I Work Plan Activities**

During Phase I, MHCADSD staff sought out and worked with a variety of expert consultants, established planning groups, and worked to gather input from key partners in a concerted effort to inform its recovery transformation activities.

#### **A. Work with Expert Consultants**

1. MHCADSD hired an expert on recovery to a part-time temporary position to provide leadership to staff, agencies, and consumers for the transformation activities.
2. MHCADSD contracted with Technical Assistance Collaborative, Inc. to develop strategies for aligning financial incentives with recovery practices.
3. A Request for Proposal (RFP) to select a training consultant was developed based upon input from the various activities of Phase I.

#### **B. Established Implementation Planning Groups**

1. Recovery Implementation Group (RIG). This stakeholder work group focused on what the new recovery oriented system should look like and how to implement new recovery policies. Members include representatives from the major stakeholder groups, including consumers, family advocates, providers, and county staff.
2. Youth and Older Adult Provider Work Groups. Because recovery literature is primarily concentrated on adult services and outcomes, these work groups were formed to discuss and define how recovery is experienced by children, youth and families and by older adults. An early recommendation from the Youth Work Group was that the term “resiliency” be included as important to recovery for that population. This group meets on an ad-hoc basis.
3. Consumer directed group-Voices of Recovery (VOR). This group of consumers of mental health services was formed, and meets regularly, to provide input into all of the county’s recovery transformation activities. This is the first time that a freestanding group consisting of and led by mental health consumers has been involved in a sustained analysis of recovery policies and practices in King County.
4. Financial Realignment Group. This planned group proved not to be necessary.

MHCADSD staff accomplished a considerable amount of developmental work with the help of expert financial consultants. Analysis of the current payment structure was completed as well as a thorough review of other fiscal models across the country that successfully implemented a recovery transformation.

C. Input from providers, consumers, and family advocates

1. Chief Executive Officer (CEO) Retreats. MHCADSD held three recovery retreats with community mental health agency CEOs, senior managers, and consumers.
  - The first retreat focused on arriving at a shared vision of recovery, system transformation challenges, desirable recovery outcomes, and training needs.
  - At the second retreat, agency CEOs provided updates about recovery practices that were already being implemented, or were planned for implementation. Members of Voices of Recovery shared their views about needed system changes. Providers gave input about potential changes in the financial model to support recovery practices.
  - At the third retreat, a consumer panel described their experiences in the system and spoke about the services that helped, and those that did not help, in their recovery journeys.
2. Roundtable Dialogues. MHCADSD staff conducted a series of 17 roundtable dialogues at provider sites with the participation of middle managers, line staff, and consumers. These dialogues were held to elicit staff and consumer views about recovery. Several recurrent themes emerged from those discussions that helped to guide planning and development of the training RFP, among them:
  - There was a pervasive concern that caseload size and workload associated with documentation requirements represented a huge barrier to thinking about, much less implementing a recovery model of care.
  - There was considerable interest in learning about recovery-engendering practices and how they differ from traditional approaches. As a result, the timeline for providing agency training was accelerated.
3. Recovery Initiatives Committee (RIC). The Recovery Initiatives Committee was a committee of the King County Mental Health Advisory Board. Their role was to review and comment on plans and documents related to recovery and make recommendations. The Board and its committees are comprised of consumers, advocates, and provider representatives.

## **Phase II – Initiating Change**

The Recovery Ordinance specified the steps in bringing about the implementation of the recovery model, stating that:

*“...the department of community and human services, or its successor, shall complete a detailed recovery system implementation plan. The department shall submit, by June 2007, an ordinance to the council for approval of the plan. The plan shall result from completion of work described in Phase I of the Recovery Plan for Mental Health Services.”*

As directed by the council, the detailed Phase II Implementation plan developed by MHCADSD (published in June 2007) was based on activities that occurred since the development of the Phase I Work Plan (published in March 2006) and described the next steps in the process of transforming the public mental health system in King County to one with a recovery orientation.

While the past year has certainly seen the initiation of change consonant with the title of Phase II, as described in the King County Recovery Plan (adopted by ordinance by the King County Council), some of the planned changes are still in the implementation stage.

In the Phase II Implementation Plan as published, MHCADSD planned to realign fiscal resources, continue to increase awareness of and engagement in recovery-oriented quality improvement activities, to engage in intensive staff development for both county and provider staff, and increase consumer voice and empowerment. Much of that is coming to fruition, while some initiatives have required retooling and a different approach.

### **Phase II – “Initiating Change” – Progress toward implementation**

Progress on elements of the implementation plan requested in Ordinance 15327 to date in Phase II are addressed in A through F of this section, as follows:

#### **A. Progress Report on developing a shared vision of recovery**

In Phase I and II, MHCADSD staff, consumers, family advocates, and providers developed a vision that includes the following elements.

- There will be clearly defined, measurable recovery oriented outcomes.
- The fiscal system will reward the attainment of the recovery outcomes.
- The system will be consumer-focused and consumer-directed.
- Consumers will be less dependent on the public mental health system, and will rely more on themselves, peers, and their communities.

- The system will be hopeful about recovery for every consumer, and will expect consumer growth and change.
- There will be higher expectations that some consumers will no longer need ongoing services from the public mental health system.
- More people will work and live in integrated settings in the community.
- The system will work to eradicate the stigma associated with mental illness.

A full time Recovery Specialist was hired in early 2008 to provide leadership on many of the recovery initiatives. (The previous part-time, temporary Recovery Specialist completed his work at the end of 2007.)

As Phase II evolved, the stakeholder advisory groups also changed and evolved. Each of the advisory groups and the ad-hoc workgroups offered opportunities to develop a shared vision of recovery and to practice recovery principles: of partnership; identifying and building upon strengths; articulating needs individualized to the population; and, to emphasize the hope and belief that the system will transform and will provide services to participants who are supported in their mental health recovery as they define it.

#### The Executive Oversight Committee

As required by the King County Council, the Executive Oversight Committee has been convened comprised of leaders from county departments who have an interest in mental health issues: the Department of Community and Human Services, Department of Adult and Juvenile Detention, and District and Superior Court. Consumer representation, council staff and MHCADSD staff are also included in this committee.

#### The RIG and the RIC

The Recovery Implementation Group (RIG) and the Recovery Initiatives Committee (RIC), both begun in Phase I, worked in the initial stages of Phase II to identify recovery process and outcome measures to be used to transform current activities to those that promote recovery. The groups also identified barriers to recovery implementation and potential strategies to surmount those barriers. These committees completed their work and the groups disbanded at the close of 2007.

#### Voices of Recovery

Much of the membership of the Voices of Recovery (VOR) group has turned over recently and the group is in a process of reorientation. A training plan is being developed for members of the VOR to enable them to become trainers of consumers county-wide who are interested in moving into positions of leadership within agencies and on boards and other advisory panels. Their recommendations to date include:

- Having staff readily accessible at each agency site to help consumers learn how they can resume employment without losing their disability benefits.

- Providing services as soon as possible after consumers are released from jails and hospitals, in order to increase stability in the community and reduce future hospitalizations and incarcerations.
- Increasing the number of peer counselors working at mental health agencies.
- Increasing recovery training for agency staff.
- Addressing housing issues for all homeless consumers.
- Provide recovery training and orientation to consumers to help them understand that they are the experts in their own experience and what is helpful to recovery.

#### The Recovery Advisory Committee (RAC)

The RAC began meeting in the spring of 2008. This active coalition of consumers, families, and professionals was created to advise and guide all aspects of the implementation and evaluation of the Recovery Plan. The RAC provides direct consumer, family, and provider input into MHCADSD and provider recovery transformation activities and outcomes.

The purposes of the RAC are to:

- Provide regular feedback about community and provider perceptions of how the recovery implementation process is going.
- Identify barriers to recovery implementation, unintended consequences, and recommended ways to reduce or eliminate barriers/unintended consequences.
- Provide recommendations on strategies for promoting consumer and family member leadership at all levels of the system.
- Provide recommendations for improving recovery implementation at provider agencies.
- Provide recommendations on how to improve performance on key recovery outcomes.
- Provide feedback about recovery-related legislation being proposed to the King County Council.
- Provide feedback regarding required reports about recovery transformation to the King County Council.
- At least annually evaluate RAC performance in relation to its charter statement.

#### Incentives Implementation Workgroup

In the initiation of change in Phase II, MHCADSD staff consulted with expert financial consultants about fiscal considerations in system change. Recommendations from the consultants included the following:

- There is no need to fundamentally change the payment structure; financial incentives can be built into the current system.
- The incentive system should be implemented incrementally, with an initial focus on structure and process measures.
- Providers should develop a plan for moving toward recovery and resiliency service approaches, and implementing best practices.
- Providers and King County should work together to develop baseline measures for performance and outcome indicators.
- The first year incentive payments should be linked to provider development of an acceptable recovery plan and assurance of timely and accurate data submission.
- In years two and three, the financial incentives should be based primarily on attainment of performance targets related to specified structure and process measures.
- In year four, the system would shift toward a greater emphasis on consumer outcome measures.

Major financial restructuring was thought not to be required to implement these recommendations. Incentives can be funded from currently available funds. Because a significant number of specific implementation strategies needed to be developed in partnership with the mental health agency provider network, the Incentives Implementation Workgroup was created.

This workgroup of providers and county staff met for many months to define how the incentives should be weighted, measured, and prioritized. The Incentives Implementation Workgroup completed their work in May of 2008.

Two ad-hoc workgroups were created to create definitions and clarity regarding structures and processes to be incentivized. The Guidelines for Peer Support Workgroup met for a short time to refine and finalize the Standards for Peer Support Services. This document describes the value of Peer Support Services, the training of Peer Support Specialists, what Peer Support Services might include and the organizational support necessary for the success of Peer Support Services (Attachment A). The Coding Work Group met for a short time to determine how service codes and other data might be utilized as measures for structure and processes to be incentivized.

#### Recovery Training Workgroup

The most explicit approach to ensuring a shared vision of recovery is the training of staff.

The planned intensive training for the workforce in recovery proved to require retooling and redirection. (See Section D. Strategy II. below for more detail.) For this reason, a Recovery Training Workgroup was created. This stakeholder group is developing a training plan that will serve to educate the workforce in a shared vision of recovery and will build the values and skills necessary to implement that vision.

#### Other initiatives

As the system progresses in the transformation toward a recovery orientation, continuing to build momentum and engaging the entire community in the recovery initiatives is critical. A number of new initiatives are currently being rolled out.

A website devoted to recovery has been developed and will go “live” very soon. Feedback on the website will be sought from stakeholders and revisions will be made as the shared vision of recovery evolves. The website will include information about recovery in general, the recovery initiatives in King County, and will provide information and resources people may find useful on their recovery journey. A key feature of the Recovery Webpage will be short vignettes or “first person narratives” Many people in recovery report that such stories provide the spark that begins their belief that recovery is possible.

A periodic journal updating the community on the progress of the recovery initiatives, “The Recovery Roundup”, began distribution in May of 2008 (Attachment B). This journal includes space for updates on recovery efforts that are entirely consumer driven as well as those underway at the mental health agencies within the publicly funded mental health network in King County. The Recovery Roundup is available on the current MHCADSD website and will be available on the Recovery webpage.

A plan is in development to better engage psychiatrists and other prescribers within the network in the efforts to create a shared vision of recovery. While the prescribers will be included in overall recovery training for the workforce, strategies individualized to their work and expertise will be identified. These professionals often contribute a great deal to the general attitudes of the staff in an agency and can be leaders in the transformation process.

#### **B. Identification and analysis of best practices**

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) identifies six primary evidence-based practices for adult consumers of mental health services. Evidence-based practices are “interventions for which there is consistent scientific evidence showing that they improve client outcomes.”

Implementation of evidence-based and promising practices is encouraged in multiple ways. This includes contracting for specialized programs, financial and logistical support for education and trainings, contract monitoring activities, policies and procedures and incentives, among others. Planning for workforce training includes training in evidence-based and promising practices.

The SAMHSA evidence-based practices are listed below with a report of progress or

implementation of that practice within the publicly funded mental health system in King County.

1. Program of Assertive Community Treatment (PACT). This refers to a mobile multi-disciplinary team that carries a small caseload size and is continuously available to help consumers who are at high risk for homelessness, incarceration, or hospitalization develop the skills and supports needed to successfully live in community settings. Services are provided where people live. Housing is provided and supported. A substantial body of literature dating back 30 years demonstrates that PACT model case management programs increase engagement and community tenure, and reduce hospitalizations.

MHCADSD awarded contracts in 2007 for two high fidelity PACT teams in King County as well as a high fidelity Forensic Assertive Community Treatment team, which is a very similar model individualized to the needs of persons who are also identified as high utilizers of the criminal justice system. Oversight committees, that include consumers, will continue to participate in monitoring implementation and evaluation.

2. Integrated treatment of co-occurring disorders (mental illness and substance use). Simultaneous provision of mental health and substance abuse treatment services in a sustained, integrated fashion is an approach that creates better outcomes than other approaches that attempt to treat mental illness and substance abuse separately.

King County recognized that mental illness and substance abuse often occur together so in 1999, the combined division of the Mental Health, Chemical Abuse and Dependency Services Division was created. King County has long had integrated co-occurring disorder treatment formally available at two agencies, Sound Mental Health and Community Psychiatric Clinic. Multiple other agencies within the network are dually licensed to provide chemical dependency and mental health treatment and work hard to integrate the services as much as possible.

3. Illness management and recovery. Consumers learn skills and take responsibility for self-management of their psychiatric symptoms and their progress toward recovery.

A number of King County mental health agencies report providing variations on this evidence-based practice. Some indicated an interest in developing a high fidelity Illness Management and Recovery program and are seeking funding in order to do so.

4. Medication management approaches in psychiatry. Considerable research supports the efficacy of particular medications for specific conditions that have been shown to reduce or eliminate psychiatric symptoms.

MHCADSD developed Diagnostic Guidelines a number of years ago that include requirements for certain medications that have been identified as efficacious for particular diagnoses. If a prescriber chooses not to follow that guideline, reasons must be documented and a rationale for a different practice provided. In 2007, the annual contract compliance site

visit included a focus on implementation of the Diagnostic Guidelines. Findings suggest in general, the guidelines have been implemented in King County.

5. Family Psycho-education. Families develop knowledge and skills to better support family members in managing their mental illnesses.

A number of King County mental health agencies report providing variations on this evidence-based practice. Some indicated an interest in developing a high fidelity Family Psycho-education program and are seeking funding in order to do so.

6. Supported employment. Placement of consumers into integrated community jobs that correspond with consumers' strengths and interests have been shown to lead to improved clinical outcomes. Eleven solid research studies of supported employment demonstrate that it produces large improvements in competitive employment rates when compared to traditional rehabilitation approaches.

MHCADSD contracted with eight mental health agencies in mid-2008 to provide high fidelity Supported Employment. Each agency is required to have a contract with the Division of Vocational Rehabilitation (DVR). Contracted funds will pay for supported employment before and after DVR provides funding or for full services if the person is not eligible for DVR services. Each agency is required to provide supported employment to any client participating in publicly funded mental health services in King County. The Oversight Committee for Supported Employment will begin meeting soon and throughout Phase III and beyond. Training in the principles of supported employment will be provided system-wide for the workforce.

7. Supported housing. Supported housing is another promising practice that promotes integration into the community and enhances a person's quality of life. Consumers move from institutions into community housing supported by rent subsidies and case management services.

King County continues to seek ways to provide supported housing. Contracts for specialized supportive housing were developed early in Phase II and are closely monitored for fidelity. Finding housing in King County is the greatest challenge. Policies and procedures for all agencies require that a goal for housing be on the individual service plan of all individuals who are homeless or have a history of homelessness. Training in the principles of supported housing will be provided system-wide for the workforce.

In addition to identified evidence-based practices, a number of promising practices support recovery, including the following:

1. Peer support. Peer support is a promising practice strongly endorsed by local and national mental health consumers and family advocates. Peers who have experienced severe mental illness and entered recovery can act as powerful role models for others. They offer unique empathy and rapport with other consumers by virtue of having experienced mental illness themselves. The evidence is growing that well trained peer

specialists can provide a valuable array of behavioral health services, which can augment professional practice. Peer support also has an emerging research base, suggesting that consumer-delivered case management can be as effective as those delivered by non-consumers, particularly with regard to engagement, promoting community tenure (time in the community outside of hospital or jail) and serves to undo the unconscious stigma within the mental health professional community, reported by consumers to be among the most painful stigma they encounter.

The Centers for Medicare and Medicaid Services added Peer Support as a Medicaid service modality several years ago. The Washington State Mental Health Division (MHD) developed a Peer Counselor Training for state certification, which allows the peer to sit for the certification test. Certified Peer Counselors are then eligible to provide the service of Peer Support. The training offered by the MHD is available to any consumer state-wide and competition for the training is intense. King County has a vested interest in increasing the number of certified Peer Counselors in King County. For this reason, MHCADSD has sponsored the state approved Peer Counselor Training twice, in October, 2007 and June, 2008. Training is scheduled for October, 2008 and is already full based on those on the waitlist from the June training. To date, forty consumers have completed the training within King County. Trainings will continue to be offered within King County for King County residents for the foreseeable future.

For the first time, in July of 2008, a “Test Prep” session was offered to people eligible to take the test. Provided by the MHCADSD Recovery Specialist and the members of the Quality Review Team, the session provides test taking tips, role plays, study suggestions, and techniques to cope with the anxiety provoked by the test process itself. The test scores for that class were very high and had one of the highest pass rates of any class.

The “Standards for Peer Support Services” referenced earlier recognize the value and work of peers who may not be able to become certified due to speaking a language other than English, (the training is only available in English,) high test anxiety, or having a legal history. These standards provide guidance to all peer specialists, certified and not, and to mental health agencies about the value, training, services and organizational support appropriate to a peer support program.

In 2007, King County provided mental health agency managers with a training regarding Peer Support and working with peer specialists. A second training was provided to agency management in August of 2008 to address lingering questions about working with peer specialists, such as finding the funds to hire a peer specialist, the impact of the Americans with Disabilities Act, liability concerns, and supervision, among others. Training in the value and work of peer specialists will be provided system-wide for the workforce.

The MHCADSD Recovery Specialist and the Medical Director specializing in services to children and youth will be consulting with the state MHD regarding proposed changes to the curriculum for future trainings statewide.

2. Wraparound approach for high-risk youth. An approach to providing services and

supports, wraparound begins with facilitation of a needs-driven and strengths-based planning process. The child, youth and family are supported by a team of people that include natural/community supports and professionals, eventually evolving to a team of community supports. Wraparound has been shown to improve community tenure, reduce hospitalization, and improve academic performance.

King County has successfully implemented wraparound programs and has demonstrated significant positive outcomes within the three Interagency Staffing Team programs for many years. Funding from the Mental Illness and Drug Dependency Action Plan in King County will allow for more high fidelity wraparound programs in King County. Training in the principles of wraparound is planned for workforce training.

3. Criminal justice alternative services. Mental health and chemical dependency service systems provide treatment rather than incarceration for mentally ill and chemically dependent offenders.

The MHCADSD Criminal Justice Initiative (CJI) focuses on treatment and supportive services for individuals being released from jail, including integrated treatment for co-occurring disorders and supported housing approaches modeled after evidence-based practices. These CJI programs have shown reductions in re-incarceration.

4. Clubhouse-model programs. Employment services are central to these consumer-directed day programs in which members experience a sense of belonging and participating in the business of the clubhouse, leading to recovery. Certified clubhouse model programs have standards requiring integrated community employment that exceeds our current overall system employment rate by 53 percent.

Beginning in Phase I and continuing, MHCADSD provides financial support for two clubhouses certified by the International Center for Clubhouse Development. Both of the clubhouses are available to any consumer who self-identifies as having mental health challenges.

5. Wellness Recovery Action Plans (WRAP). WRAP is a program developed by Mary Ellen Copeland in which participants identify internal and external resources for facilitating recovery, and then use these tools to create their own, individualized plan for successful living (Copeland 1997).

King County provided financial support for a WRAP Facilitators training in early 2008. Two MHCADSD staff completed the training to become certified WRAP Facilitators. These staff members are on the Quality Review Team (QRT) for King County and are self-identified mental health consumers.

Evidence-based and promising practices are identified for replication, in part based upon scientific research supporting their efficacy. Consumer and family member preferences are essential considerations as our system evaluates which best practices to replicate. Consumers and family members strongly prefer services that promote recovery by producing better

outcomes in employment, housing, and stabilization/ integration in the community, while also producing a better quality of life.

C. Assessment of existing services, resources, reimbursement models, and resource realignment

In late 2007, mental health agencies in the King County provider network were required to complete a Self-Audit regarding their services and the degree to which they have implemented recovery oriented services and incorporate recovery principles in their practice.

According to the Self-Audits, the array of services believed to be strongly supportive of mental health recovery within King County is growing. Some agencies have made significant progress and can be called early-adopters, while others are in the beginning stages of the process.

1. Hiring and training peer specialists. A number of agencies already have peer specialists on staff. Some are offering internship positions. One early adopter, Navos (formerly Highline West Seattle Mental Health) created an in-house training program for peer specialists modeled on the Meta program from Arizona, recognized as a leader in recovery. Sound Mental Health, employs a number of peer specialists, some within the criminal justice community reintegration programs. Harborview Mental Health Services, likewise, has long had peer providers. Community House has developed a program, Peer Bridgers” in which paid Peer Support Specialists will serve as a sort of welcoming committee to new clients, orienting them to the programs, making introductions and accompanying them to appointment if desired. All agencies have indicated an intent to increase the amount of peer support services available to consumers.
2. Consumers are moving into leadership positions on quality improvement and strategic planning committees, in addition to involvement with other administrative functions. A number of agencies have consumer advisory councils, some of which have not had them before.
3. Supported employment services are in place in several agencies. With the initiation of Specialized Supported Employment contracts with eight mental health agencies in 2008, high fidelity supported employment services are now available for any consumer participating in publicly funded mental health services in King County.
4. Two new PACT programs began accepting clients in July 2007.
5. Treatment plans are being redesigned as Recovery Plans or Goal Plans. These newly designed service plans better incorporate consumer choices. One agency reported a 50% increase in the number of consumers interested in and willing to sign their plan as the result of adopting a process that solicits consumer input.
6. Wellness Recovery Action Plan (WRAP) is a self-help strategy experiencing burgeoning popularity with consumers. A WRAP plan is based on consumer preferences in managing their illnesses and maintaining their progress towards recovery. A number of agencies

hired and support WRAP facilitators to provide WRAP training to consumers.

7. Two clubhouses received certification by the International Center for Clubhouse Development.

At the time the agencies completed their self-assessments, the agencies were also required to create an Agency Recovery Plan. (Both were required in order to receive the recovery incentive payments for 2008.) MHCADSD provided feedback to each agency and suggestions where indicated. The Agency Recovery Plan provided an opportunity for agencies to indicate a desire for technical assistance related to the required recovery elements.

Recovery elements inventoried and for which a plan for improvement was sought included:

- The role of consumers/families in development of the agency recovery plan
- The desired future role of consumers and families in agency governance, planning, program assessment, and quality management
- The plan for re-tooling staff job descriptions, duties, and performance evaluations to include recovery competencies.
- The plan for increasing the number of consumers employed by the agency
- How consumer choice will be incorporated into individualized, person- centered recovery plans
- How recovery principles and practices will be incorporated into the agency at all levels (e.g., administrative, clinical, support functions)
- Specific plans for implementing evidence-based practices of supported employment, wraparound, peer support/family support services, and other recovery oriented best practices
- Plans for accessing these services on behalf of enrolled consumers, if not offered directly by the agency
- How recovery oriented services and recovery principles will be tailored for special populations served by the agency (e.g., diverse cultural/linguistic populations, youth, elders, etc.)
- How the agency's quality management/quality improvement process will improve performance related to consumer-driven outcomes and performance goals.

MHCADSD created a summary grid that documented the most creative and thorough

implementation of the recovery elements as reported on the Agency Recovery Plans. This grid was distributed throughout the network. Agency management staff report appreciating both the recognition (celebrating successes!) and the information about where they might go for suggestions for improving specific elements of their own Agency Recovery Plan. MHCADSD will continue to develop opportunities for providers to share their expertise within the network.

MHCADSD determined that there are sufficient Medicaid resources available to build infrastructure to support recovery practices. Providers were given an ongoing 2.5 percent rate increase beginning May 1, 2007. From July through December 2007, up to five percent additional incentive funding was available for those providers that meet established goals in the delivery of new recovery practices. Funds will continue to be available in future years to sustain the available incentive pool.

Among the challenges of implementing recovery is the non-linear nature of the journey and coping with unexpected changes. Understanding of and commitment to recovery principles are solid and clear from the federal Substance Abuse, Mental Health Services Administration. That commitment is less clear from the federal Centers for Medicare and Medicaid Services (CMS). Recent changes in the way some Medicaid funded services, including supported employment, are captured and categorized by CMS, resulted in the need to make changes to the Incentives Plan. While the intention was to provide incentives for supported employment at all agencies, the changes by CMS dictated the plan change to pay incentives only to those agencies that were awarded a Specialized Supported Employment contract.

In 2005, the Washington State legislature passed a bill to allow counties to increase local sales tax by 1/10<sup>th</sup> of one percent to fund mental health and substance abuse services. In November, 2007, the King County Council approved the sales tax. The resulting planning and implementation process known as the Mental Illness and Drug Dependency Action Plan (MIDD) and the funding from the sales tax will provide programming that explicitly and implicitly supports the goals of the recovery initiatives. Planning for programming is underway through a prescribed process involving a 30 member Oversight Committee. A list of the MIDD strategies that support transformation of the mental health system to one that truly supports mental health recovery is provided (Attachment C).

#### D. Strategies, goals, action steps and timelines

In the Recovery Implementation Plan, MHCADSD articulated three strategies. The progress made using each strategy in Phase II is summarized as follows.

##### **Strategy I: Rewarding structures, processes and outcomes that promote mental health recovery**

In Phase II, the mental health recovery stakeholder groups and the Voices of Recovery (a consumer advisory group,) made recommendations for the domains for which outcomes should be identified. These include:

1. Employment, education, and meaningful activities of life
2. Community Tenure (meaning staying out of the hospital or jail)
3. Quality of Life.
4. Housing

Development of incentives focused on the first three of these domains. All stakeholders, including MHCADSD, understand that having safe place to live of one's own is the foundation of recovery. Housing development is a long term, high cost venture and the amount available for incentives was determined to be too small to be useful in that arena. Housing must be developed in conjunction with housing authorities, other housing developers, and housing fund sources. In order to assure mental health agencies get a fair share of development funding, the MHCADSD director works with Seattle Housing Authority and the King County Housing Authority to advocate for housing development for mental health consumers. This includes intensive and ongoing efforts to develop housing with community partners. In addition, ending homelessness is one of four key foci of the King County Department of Community and Human Services (DCHS). Jackie MacLean, Director of DCHS, participates in the Interagency Council of the Committee to End Homelessness. The committee is a broad coalition of government, faith communities, nonprofits, the business community and homeless and formerly homeless people working together to implement the Ten-Year Plan to End Homelessness in King County.

Under state and federal law, mental health funds are for treatment and services, not for capital expenses such as the development of housing. Ensuring that the people who participate in mental health services have safe housing that is as independent as possible is a priority. As outcomes in the other three domains are reached, incentive dollars can be reallocated to other domains, including housing. Data accuracy improvement efforts will provide the reliability in the data necessary to set benchmarks.

For the three domains selected, incentives are initially being paid for structures and processes. Structures are the service delivery models that meet fidelity standards and/or are priority services or practices that promote recovery. Processes are the activities agencies engage in that ultimately result in desired outcomes for consumers. For example, defining the role of consumers in the agency or implementing high fidelity supported employment are structural components. Examples of process components are employing consumers at a variety of levels in the agency or delivering an increased number of supported employment services.

Incentives will gradually shift over time toward payment for actual outcomes. This is to assure that there are systemic changes in practice and infrastructure at the agency level. Once recovery structures and processes are firmly in place and functional, progressively more emphasis will be placed on paying for the recovery outcome measures that are most valued by consumers and family members.

As noted, in 2007 MHCADSD began paying incentives for the establishment of structures such as the commitment on the part of mental health agencies to participate in system

transformation efforts, in a “Letter of Intent.” MHCADSD provided incentives for their participation in recovery initiatives, including a 65% one time increase in case rate payments in June of 2007 and a 5% increase in their case rate for July through December, 2007.

To receive the incentives in 2008, agencies were required to submit an Agency Recovery Plan, based upon their Self-Audit. The Agency Recovery Plan details the strategies the agency will employ to put new or expanded system structures and processes in place to effect broad change within the agency. All 16 outpatient provider agencies earned this incentive.

Multiple process and outcome measures have been identified for three of the four domains and all of these measures will be tracked. In order for the incentive payments to have sufficient weight to motivate change, however, only a subset of these measures will have incentive payments attached initially. The selected process measures are tailored to address the differences in the needs of children and youth, adults, and older adults:

#### Youth and Families (Age 0-17)

1. Increased number of developmental assessments
2. Increased number of collaborative contacts
3. Parent/peer support is provided

#### Adults (age 18-59)

1. Supported employment services
2. Face to face services are provided within 7 days of release from incarceration or hospitalization
3. Peer support is provided

#### Older Adults (age 60+)

1. Care plans reflect older adults are engaged in meaningful activities
2. Care plans reflect client voice and choice

Through the work of the Incentives Implementation Workgroup, a workgroup of county staff and providers, ways to weight, measure, and prioritize the incentives was defined. That group completed their work in May 2008. On June 27, 2008, MHCADSD provided a presentation for the mental health network and allied groups to explain the incentives plan for the next several years.

The Plan allows for incentives to be individualized to each agency, taking into account their size, the population they serve, and their unique challenges as they transform to a recovery orientation.

For 2009, agencies will have the potential to earn incentives based on their performance on the developing necessary structures and for a select set of process measures. During 2010 incentives will be based fully on process measure performance and in 2011, incentives will begin to shift toward outcome measures and away from structure and process measures.

Based on what has been learned from efforts in other parts of the country, as incentives are

earned and the processes are fully integrated, they can be considered established. New measures will then be selected to have incentives attached.

While incentive funding is a great advantage, it can not be the sole source of funds for developing new services or increasing the provision of the most desirable services. Provider agencies will need to examine their own practices and business plans, retool their service systems and redeploy their staff and financial resources to promote recovery-oriented practices.

### **Strategy II: Provide workforce training in recovery practices**

A Request for Proposal was issued in June 2007 to find a training consultant to develop and provide workforce training. The training plan was to include design and development of training workbooks and training sessions consistent with adult learning theory. There were to be three full days of training at each agency site, spread over the course of a year, with homework assignments and mentoring offered between didactic sessions. In addition, training videos were to be developed to provide real life examples of recovery oriented practices. Training was to be completed for all agency staff over the course of the next two years. A training consultant was selected and the first three trainings occurred in early 2008.

The training design proved to be flawed and was terminated altogether after the third training session. While to some extent, the content of the trainings was informed by input received in Phase I, the process was relatively one-sided. The misfit was due to the fact that parts of the system have made progress toward a recovery orientation and the system generally was not in the same place as it was early in Phase I.

This experience in Phase II demonstrated that the system will maximize flexibility, strength and integrity, inasmuch as recovery principles are expressed throughout the transformation process and across all levels of the system. For example, the workforce training plan articulated above was largely developed by county staff. The planned training would have provided exactly the same training for everyone and the one-size- fits- all approach was not effective.

Progress in a recovery journey, for an individual or for a system, is a non-linear process. A more thoughtful planning process that better incorporates recovery principles is underway. A stakeholder group is collaborating on a training plan that will include the ability to assess the strengths and needs of each person to be trained in order to develop a training plan individualized to the participant and the agency's needs. Recovery competencies have been identified and training methods are being explored that will take into account existing skills, costs, and value over a number of variables, and the varied needs of people receiving training, including psychiatrists, case managers, management, and administrative staff. The provider network is participating in a survey process to ascertain strengths and needs, technological capability and capacity, and number of staff in various categories. The Recovery Training Plan will be informed by and developed by stakeholders and will be responsive to individual needs.

**Strategy III: Use of regulatory practices to promote change, including more focused monitoring of policies, procedures, and contracts**

In addition to taking the lead on many of the recovery initiatives, the Recovery Specialist has and will continually review and recommend revisions as appropriate to the King County Mental Health Plan Policies and Procedures to enhance recovery and to ensure people-first language throughout.

The level of regulatory activity needed to transform practices is greater during times of rapid change. MHCADSD devoted additional resources to more closely monitor emerging new recovery practices to include the following:

1. Revised policies, procedures, and contracts to include enhanced recovery language and concepts by January 2008. Further refinement and attention to “person-first” language in revision occurred in August, 2008.
2. For 2008 contracts, developed contract language that articulated performance expectations. Language addressing incentives and participation in other recovery initiatives will be added for 2009 contracts.
3. Targeted follow-up and oversight subsequent to provider site reviews, with emphasis on implementation of certain recovery-oriented practices, starting in spring 2008. The 2008 annual contract compliance site visits focused on Diagnostic and Practice Guidelines, the provision of culturally, developmental, linguistically, and disability competent services, and integrated and coordinated services. For the first time, providers and consumers and their families were invited to present their experience of participating in services, in addition to the usual review of documentation.

E. Defined outcome and other appropriate performance measures

The process of system transformation involves putting processes and structures in place so that all consumers have access to services that are recovery oriented. Once those processes are well established, incentive payments will be rebalanced toward outcomes. Priority services in identified domains will be measured and monitored.

The following examples illustrate how process and outcome measures are related to the priority domains:

Domain: Employment (for adults)

Process: Increased number of supported employment services provided

Outcome: The number of individuals who acquire or maintain paid competitive employment

Domain: Education/Life activities (for children and youth)

Process: Increased number of developmental assessments

Outcome: Children/youth progress along normal developmental trajectory

Domain: Community Tenure (for children, adults, or older adults)

Process: Face-to-face service provided within seven days of release from hospitalization or incarceration

Outcome: Decreased number of hospital days

Outcome: Decreased number of days of incarceration

Domain: Quality of life (for children and adults)

Process: Increased number of peer support services are reported

Outcome: Increased consumer hopefulness about the future and sense of control and choice

For 2008 and beyond, to some extent, mental health agencies have defined for themselves the structures, processes and outcomes they are targeting, within the recovery elements defined by the Agency Recovery Plan. Each agency developed goals and objectives with timeframes for each. The targets for each agency will also be individualized based upon their current performance.

As a system, the structures, processes and outcomes that will be incentivized and monitored for the next several years are detailed on “Process Measure Definitions and Implementation” (Attachment D).

#### F. System for monitoring, evaluating, and reporting progress in implementation

The primary sources of data for measuring progress on recovery structures, processes, and outcomes are service and status data submitted by providers to the MHCADSD information system (IS), agency site visits/audits, and reports from the agencies regarding their progress toward the goals on their Agency Recovery Plan.

The data improvement process is fundamental to establishing an accurate baseline from which to assess subsequent progress towards outcome goals. MHCADSD has a robust information system that captures a great deal of data. A number of the recovery measures that have been defined are “soft” measures, however, that cannot be reported with a simple service code. MHCADSD has been working with providers to develop operational definitions, reporting methodologies, and improvements to the accuracy of the data.

MHCADSD determined that an array of new and existing measurement tools is needed, in order to evaluate and report on progress toward recovery transformation.

1. The quality of the data being submitted to the IS continues to show room for improvement. In calendar year 2008, a portion of the incentive pool dedicated to building infrastructure was contingent on an assurance of data quality in the Letter of Intent. Some of the incentives for 2009 will be related to actual data quality. Through site visits, MHCADSD is assessing all of the agencies’ data processes.
2. Data is collected from consumers, family members, and case managers regarding recovery outcomes using an instrument required by the state, the Washington State Consumer Outcomes Survey (Telesage). This survey is designed to be completed by consumers at intake and at prescribed follow-up intervals. It is intended to yield data regarding employment, quality of life, housing, and other recovery indicators. The plan

in Phase II was to use the data from Telesage to determine progress toward outcomes. To date, however, Telesage data is considered to be unreliable for that purpose. MHCADSD staff are working with the state and the mental health agencies to improve Telesage with a goal to creating a product that will be useful in determining progress toward outcomes.

3. Data regarding the use of recovery-promoting services (such as peer support, clubhouse, supported employment, and wraparound services for children/youth) will be submitted by providers to the Information System. MHCADSD will carefully monitor the number of these services that are provided.
4. Case managers and other staff are expected to report changes in consumer employment, housing, and related recovery measures to the IS at the time of the change.
5. The King County Regional Support Network quarterly report card already tracks a number of recovery outcomes and will be modified as needed to reflect additional recovery measures.
6. Agency-specific reports tailored for assessing recovery outcomes and services across the system will be developed. These published reports will show how each provider agency is performing.
7. MHCADSD will be visiting each agency in the fall to review progress toward implementation of their agency specific recovery plans. Members of Voices of Recovery will be included as reviewers. Agencies will also be encouraged to invite the participation of their consumers, for example their consumer advisory council, if the agency has one. The review will include:
  - Progress toward their Agency Recovery Plan goals.
  - A review of chart records for client voice, choice and the reflection of assistance to develop meaningful activities.
  - A review of agency policies and procedures.
  - A review of agency training records.
  - A review of data quality processes.

The Mental Health Advisory Board, the Voices of Recovery group, and the Recovery Advisory Committee will all be reviewing reports and progress toward the structures, processes, and outcomes that will signify the transformation of the King County publicly funded mental health system. In addition, the Executive Oversight Committee is tasked with reviewing progress toward established goals and making recommendations for course corrections should they be needed.

## **Summary and Conclusion**

King County and its provider network have made considerable progress to date. The publicly funded mental health system is moving toward completion of Phase II and on to Phase III, “Increasing in Depth and Complexity.”

MHCADSD has begun to pay incentives for structures and processes that will lead to defined outcomes, continues to increase awareness of and engagement in recovery-oriented quality improvement activities, is engaging in a recovery-based planning process to develop intensive county and provider staff development, and will continue to increase consumer voice and empowerment. A number of best practices are already being implemented and relevant system and consumer-level data is being collected and reported. These various initiatives support and potentiate one another. This additive effect will increase the momentum and ease the way for continued transformation of the mental health system.

Work in Phase III will be revealed as the system evolves on this recovery journey. Incentives will be tied directly to consumer identified outcomes. Evidence-based practices will be available to any consumer participating in services.

Issues on the horizon for further exploration include involving the voice, passion, and energy of youth in recovery initiatives, investigating the possible role of trauma in the lives of the people participating in mental health services and how to address this potential barrier to recovery, and how we may increasingly move the system itself to one that is more truly consumer-driven.

The recovery movement for persons with mental illness was launched by consumers who noticed that some of them were recovering. When professionals began to listen and understand what consumers had to say about their experience with treatment, the potential for everyone to engage in recovery began to manifest. In King County, consumer voice is being promoted at all levels of the system – in individualized treatment/recovery planning, in agency and county-level policy decisions, in governance and oversight functions, and in the workforce. Services identified as recovery-oriented or recovery-promoting are those that consumers themselves identify as the services that they need, want, and will use. By listening to their voices and implementing the services that will most assist them in their recovery journeys, King County is making a fundamental change in the philosophy that guides the way the mental health system does business. The result will be an exemplary, recovery-oriented mental health service system that one day will be a national model of excellence.