2013

NC Recovery Summit

Creating consensus for a Recovery-Oriented System of Care in policy and in practice.

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Background

The NC Recovery Summit was organized to engage key stakeholders to create consensus around factors that aid in the implementation of a Recovery-Oriented System of Care.

The State of North Carolina has had a long history of recovery initiatives in various parts of the state from the substance abuse and mental health communities, advocacy organizations, service provider agencies, and the state agencies. For example, many initiatives have been centered on the development and implementation of evidence-based practices; training and education focused on reducing stigma and eliminating barriers to services and community integration; projects around outreach to special target populations.

North Carolina also sponsors the annual *NC "One Community in Recovery" Conference* held every fall. The conference is an inspiring, informative event designed to foster the continuing growth of the North Carolina Recovery Movement, to teach participants how to create recovery programming in their own communities, to showcase some of the most progressive recovery practices, and to bring the community of providers and individuals in Recovery together as partners.

The NC Department of Health and Human Services (NCDHHS) recognizes the importance of an individual's personal recovery journey and the development of a system that focuses on recovery. NCDHHS is working to ensure that North Carolinians in recovery can contribute to their own health care needs and maintain purpose and hope.

> "INDIVIDUALS HAVE ACCESS TO THE ARRAY AND INTENSITY OF SERVICES AND SUPPORTS THEY NEED TO SUCCESSFULLY TRANSITION TO AND LIVE IN COMMUNITY SETTINGS, INCLUDING SUPPORTED HOUSING. SUCH SERVICES AND SUPPORT SHALL: BE EVIDENCE-BASED, RECOVERY-FOCUSED, AND COMMUNITY BASED."
>
> -NC'S USDOJ SETTLEMENT AGREEMENT

Recently, North Carolina has been implementing "systems change" in a variety of ways. Two major areas include the state's move towards Managed Care through its 1915(b/c) Waivers and the TRANSITIONS TO COMMUNITY LIVING INITIATIVE- North Carolina's plan to implement the USDOJ Settlement Agreement[1] which calls for ensuring we develop recovery-focused services.

[1] USDOJ Settlement Agreement: http://www.ncdhhs.gov/mhddsas/updates/usdoj_plan_10-1-12.pdf

Pathway to a Recovery Policy

It is a critical time in the state to begin a unified focus towards Recovery.

With a variety of recovery initiatives happening across the state, this Summit was an effort to join the multiple stakeholders to build consensus around the state's direction on a Recovery-Oriented System of Care and fully integrate NC's recovery movement.

The NC Recovery Summit was held on March 27, 2013 in Winston-Salem, NC. The Summit focused on discussing recovery principles for use within state policy and services as well as fostering the use of recovery components which include Peer Supports. Recovery experts and leaders joined together to identify and create consensus around factors that promote recovery and its components as valuable, evidence-based and cost-effective approaches to support individuals in the community.

The Summit was attended by **71** individuals, which included subject matter experts and leaders from statewide consumer-run and advocacy organizations, peer support providers, service providers and practitioners, family members, managed care organizations, and state agencies.

The day's program was focused on a discussion of "where we are now" and "where we are going" as a state, in reference to systems changes and state goals, as well as an overview of national initiatives in recovery and healthcare integration. A handout for Summit participants, introducing definitions of Recovery, was developed by the Planning committee titled "RECOVERY IS A REAL THING" - see Summit Handout.

Presentations included the Purpose of the Summit, overview and state updates, Recovery-Oriented System of Care national initiatives and practices, and an Introduction to Recovery Workgroups and Facilitators – see Agenda.

This audience then chose to attend 1 of the 5 workgroups which addressed the following topics:

1. Recovery Integration- Mental Health and Substance Abuse
2. Recovery in Practice- Increasing Peer Support, Consumer-Operated Services, and Self-Determination:
3. Recovery in Practice- How Can Clinical Services Be More Recovery Oriented
4. Recovery in Policy- Managed Care, How Can LME-MCOs Be More Recovery Oriented
5. Recovery in Policy- Developing a Mission Statement and how the State can support principles for a peer-driven, recovery-oriented system

Each session's goal was to discuss similarities, differences, barriers, and recommendations around Recovery. Sessions were facilitated by 2-3 subject matter experts and members of the Recovery Summit Planning Committee.

Descriptions of the findings are delineated in the following topic sections.

Topic 1 – Recovery Integration: Mental Health and Substance Abuse

Workgroup Facilitators: Jessica Herrmann, Mike Weaver, Emery Cowan

This workgroup made several observations about the purpose of the Summit. This summit is not only for those people in recovery- it is also for stakeholders who want to help people to move towards recovery by influencing the system. Recovery is a message of hope through all levels of a person's live, but especially from the start (i.e., first time seeing a doctor about concerns, receiving the first diagnosis, receiving services). The following stakeholders were not present at the Summit: primary care providers, first responders, policymakers, DSS, social workers/licensed professionals and representatives from faith based organizations. Outreach efforts should be made to include individuals from the above mentioned fields to ensure that recovery efforts include all systems and supports that can be champions of recovery.

The similarities and differences between mental health and substance use issues were discussed and the group's consensus was that there are more things in common across a variety of disability groups and issues.

The following includes specific areas discussed:

<u>Differences</u>

There is still a differing level of anonymity between SA recovery based programs and MH recovery based programs. The focus of recovery and self-help has been integral to SA treatment, but is just now becoming widely recognized in MH treatment (although it has long been used). AA has a long and solid history of anonymity and focus on avoiding formal organization. "*Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities"* (AA Fact File, www.aa.org)

Funding discrepancies continue to exist, with broader funding and coverage for individuals diagnosed with MH or IDD. At this point, individuals with a SA diagnosis do not qualify Medicaid, which in turn significantly limits the types and duration of services they can access. This is a huge barrier for individuals with SA diagnoses that are actively seeking treatment. Part of this funding discrepancy is due to the continued stigma towards individuals with a SA diagnosis. According to

results from the 2011 National Institute on Drug Use and Health (http://www.samhsa.gov/data/nsduh/2k11results/nsduhresults2011.htm#2.7)

*males are more likely than females to use illicit drugs (9.3% vs. 4.9%)

*rate of use among: Native Americans/Alaska Natives- 13.4%
Native Hawaiian/other Pacific Islanders- 11%
Blacks- 10%
Whites- 8.7%
Hispanics- 8.4% (up from 7.2% in 2002)
Asians- 3.8%

The three racial/ethnic groups with the highest rates of use are all minorities, and the Hispanic population was the only racial/ethnic group that had a statistically significant increase from 2002 to 2011. Additionally, regardless of racial/ethnic group, the general population continues to believe that substance abuse is a choice and a criminal behavior, not a disease. There is a significant difference in the quality and accessibility of the first responder system for individuals with SA and individuals with MH.

Similarities

Both MH and SA diagnoses are part of the DSM V, result in societal stigma, cut across race, gender, ethnicity and sexual orientation, and are regarded as health care issues. Individuals with MH or SA diagnoses can and do recover, be active participants in their community, in their chosen vocational role and in their family. People with MH or SA diagnoses can get married and have children, purse their education, and do everything that individuals without MH or SA diagnoses do. Without recovery oriented systems, access to evidence based treatment programs and the elimination of stigma, fulfilling these life roles can be difficult for individuals with MH or SA. The impact of an illness focused service system with little belief in recovery and self-determination can be seen in our jails, in our homeless population and in our hospitals. All systems directly feel the impact of a system of care that cannot meet the needs of the area it is in: families, primary care providers, police officers and firemen, churches and schools. Recovery from MH and SA isn't a destination, a place an individual arrives and stays at. Instead it is a journey, one that has ups and downs, twists and turns, and that the individual perpetually moves through during their life. As such, individuals should not be viewed in a negative light when they experience a setback. We all are human and entitled to make life choices that others might not agree with. Services should not attempt to limit or assume a parental role for individuals with MH or SA diagnoses, but instead encourage and support self-determination. When difficult times or situations arise, services

provided should continue to be based on the individual's preferences and needs. All providers working with individuals diagnosed with MH or SA need to be aware of best practices in trauma informed care. The National Center for Trauma Informed Care reports, *"Although exact prevalence estimates vary, there is a consensus in the field that most consumers of mental health services are trauma survivors and that their trauma experiences help shape their responses to outreach and services."* (http://www.samhsa.gov/nctic)

Ultimately, these two different diagnoses (MH and SA) share many common traits: from the role that triggers play in a relapse or a return of symptoms, to a stage wise approach to both treatment and recovery, to sponsorship and peer support. Most importantly for individuals with MH and SA diagnoses, wellness is a personal path, and what defines wellness for one is different from wellness for another. We are all different, and none of us (people with and without MH and SA diagnoses) are perfect.

Barriers

If we avoid addressing barriers, we limit the quality and extent of system change we seek. In North Carolina, our system of care would benefit from supporting educational programs in adopting recovery oriented and holistic training programs that teach and preach psychiatric rehabilitation. Training and education programs should encourage professional competency across the disciplines of MH and SA as individuals frequently struggling with both. If there are professionals that chose not to be trained to work with individuals with MH and SA, there needs to be a system in place for a warm transfer to a specialist. Individuals receiving services should never find themselves either lost in the system or working with a professional practicing outside their scope of expertise. On-going training and support regarding HIPPA laws and how they impact referrals and transfers would further support individuals receiving care from appropriately trained individuals. Supports and services for families need to be strengthened and expanded.

There is a current gap in wrap-around care, which can be vital in supporting individuals remaining in the community and in their housing. As stated above, individuals with SA have many barriers to treatment, as their diagnosis excludes them from Medicaid and other state funding sources. Finally, stigma continues to be a barrier. Not only does stigma from individuals without MH and SA serve as a barrier, but also the stigma and beliefs around medication that some in the SA community have. This is especially difficult for individuals that have both MH and SA, with some in the SA community hinging 'sobriety' on total abstinence from any chemical, but individuals who willingly take medication to manage their MH symptoms.

Recommendations

First and foremost, dignity of risk needs to be recognized as a natural part of the recovery process by family, friends, MH and SA providers, and by ourselves. We as a culture cannot continue to view choice as a negative thing, and must promote self-determination at all costs. The ultimate goals of individuals with IDD, MH and SA are no different from individuals without IDD, MH or SA: to have a life worth living, meaningful relationships with family and friends, work in areas we are passionate about and be part of our community. The best way to support individuals with MH and SA are integrated evidence based practices, and support at all levels (state, MCO and provider) for use of evidence based practices, and for everyone to realize that, regardless of how long they have been working in this field, on-going training and technical support will only help them provide quality services to the individuals they serve.

While we respect the AA tradition of anonymity, supporting individuals that identify as having a MH or SA diagnosis can directly address stigma. This provides living proof that recovery is real, recovery can happen, and that individuals with MH and SA can make significant contributions to society when they have access to the right supports and systems of care. This change can be brought about by advocacy across the state and across all systems. Peer to peer advocacy, linking with universities to support the implementation of psychiatric rehabilitation programs and elimination of stigma, outreach to our faith based communities, our primary care providers, hospitals, schools…this is the work that will break down stigma and support recovery and understanding. Cultivating and maintaining support networks for our family and loved ones, so they can get the information and support they need as they travel this journey us. Supporting family members and loved ones indirectly supports individuals with MH and SA diagnoses

The message we need from society is hope: hope for us, hope for our families, our co-workers, our friends and loved ones. Hope when we are in crisis and we have difficulty feeling it ourselves and hope when the waters are smooth and easier to travel.

Topic 2 – Recovery in Practice: Increasing Peer support, Consumer-Operated Services, and Self-determination

Workgroup Facilitators: Cherene Allen-Caraco, Wes Rider, Ron Mangum

Barriers

North Carolina is a geographically diverse state. Its 100 counties stretch from mountains to sea, encompassing urban and rural/remote areas. Likewise, resources are also inconsistent across the state, from areas that have ample resources to areas that have minimal funding and support. Ensuring that all residents of North Carolina have access to Consumer Operated Services and Peer Support will require collaboration across multiple stake holders. Additionally, ensuring that the provider networks, LME/MCOs and individuals in recovery are aware of and actively utilizing Consumer Operated Services and Peer Support will take support and accountability from the top down. Active outreach and engagement regarding Consumer Operated Services and Peer Supports, as well as possibly incentivizing evidence based practices with positive outcomes (to include Consumer Operated Services and Peer Supports) could increase the amount of individuals receiving and benefiting from peer led services.

Currently, our resources do not reflect the culture we envision for NC. Peer Supports until just recently wasn't structured as a stand-alone, billable Medicaid service. To ensure a vibrant, expansive network of Consumer Operated Services and Peer Support programs, both the LME/MCOs and DMA need to examine expanding the current array of services for individuals receiving Medicaid and state funded (IPRS) services to include these programs.

Recommendations

North Carolina must make steps towards embracing and recognizing Peer Support and Consumer Operated Services as equals in the area of mental health, substance abuse and dual diagnosis treatment. Recovery champions and stake holders must push for funding reciprocity for these services to ensure they have the support needed to expand and remain current in practice training.

All of our practices and programs, including peer support and consumer operated services need to embrace and reflect the recovery model. NC DHHS has shown movement in the right direction by revising and implementing the peer support service definition, but it cannot stop there. DHHS, MCO/LMEs, provider agencies and peers need to continue to identify and support different avenues to increasing peer support across our state. Providers of peer support services and consumer operated services should identify and implement outcome tracking to synthesize the many benefits these services will provide to the individuals they serve. From Charlotte to Topsail

Beach, individuals with MH or SA should have access to peer support services to support them in their recovery. Consideration needs to be given to further specialization of the CPSS.

Other states are currently employing peers that specialize in: substance abuse (Indiana) gambling (Indiana) and physical health (Georgia). All individuals, from professionals to peers, need to recognize that there is no one plan for recovery, and an individual's recovery cannot be measured against another's. Likewise, there can be no discrimination based on perceived severity of illness. Doing this creates segregation in the recovery movement, weakens our message and lessens the experience of all individuals in recovery. Instead, we must stand united, represent all different kinds of recovery, and show society that recovery can happen.

Finally, those in recovery need to give back to the community, as this will foster awareness and education. Giving back by participating in the Recovery Coalition meetings, by advocating for and supporting legislation in support of the peer and recovery movement, by leading training and mentoring others in the field. Finally, instead of continuing a system that places multiple barriers in the way of individuals in recovery that want to work, the system needs to incentivize the return to work.

This could be done through expanding the Medicaid Buy In for Working People with Disabilities, the Ticket to Work and Work Incentives Plan and other Medicaid services that support employment. Another service structure to consider is the Personalized Recovery Oriented Services (PROS) that the New York Office of Mental Health developed. This service bundles four different types of services and levels of care, and is flexible to meet each individual's current needs. Clinical services can be added to the bundle if this is requested by the individual.

Topic 3 – Recovery in Practice: How can Clinical Services be more Recovery Oriented

Workgroup Facilitators: Sharon Young, Chris Budnick, Laurie Coker

Barriers

Current service definitions in use in NC infrequently use recovery oriented person first language. Statewide, there is a lack of recovery focused training for professionals. Specifically, there is a lack of training focused on psychiatric rehabilitation and person centered thinking. The few trainings that are in state do not have the follow through in place to ensure that concepts and theories reviewed in trainings are implemented in practice. There is little on going, site or practice specific technical support for these trainings. For individuals seeking services, it is difficult to access the services needed or desired, as some services have little flexibility on entrance criteria. Often times service provision is not based on individual need, medical or clinical necessity, but instead on what is available and what the MCO will authorize. When individuals are able to enroll in service, there are times and services that enlist punitive measures when symptomology becomes more severe, sometimes resulting in expulsion from services.

Recommendations

In order for the clinical services provided in NC to become more recovery oriented, recovery language and beliefs must be imbedded in our clinical coverage policies, our service definitions, our person centered planning, and even our funding. On a service delivery level, it can no longer be appropriate for individuals receiving services to have goals that focus on the removal of things (I don't want to go into the hospital. I don't want to lose my housing. etc.) Instead, a person's goals should focus on what they want to add to their life that is vital to their recovery (I want a job working at a pet store. I want to find a significant other. I want to live in an apartment and go back to school). Likewise, stability is not an option. Stability is stagnation, and stagnation can lead to a loss of hopes and dreams. Goals and success should be defined by the individual pursuing it.

This could be addressed in developing and implementing a statewide person centered training that is recovery focused and uses recovery language. In addition to the training, there needs to be on going technical support to both providers and MCOs to ensure the skills taught in the training are implemented consistently and correctly. NC has already seen that training alone without support and follow up is not effective in supporting the development of recovery oriented person centered plans.

MCOs can further shift the focus to recovery oriented systems by exploring and supporting innovative recovery programs. This could be done by posting RFPs for identified recovery oriented practices, providing training for agencies to ensure that providers are trained in and aware of recovery oriented practices, and incentivizing the successful use and integration of NC CPSS in clinical settings. By doing this, MCOs can also expand the array of services offered in their catchment. Individuals would benefit from a service array that includes services they can access prior to failure, such as peer operated systems and wellness centers. As these new practices are implemented, MCOs can also use creative, recovery oriented systems to gather outcome data, including employment of NC CPSS to complete service feedback from individuals.

DMA/DMH can support the adoption of recovery oriented clinical services by thoughtfully revising current service definitions to use recovery language and supporting funding mechanisms that promote innovative recovery programs that also target increasing cost savings, increasing employment for individuals with MH/SA and decreased number of hospital days. This should happen across all disabilities and co-occurring disorders: MH, SA, and IDD.

DMA/DMH and MCOs should support all providers in attending training and on-going support/technical assistance addressing recovery, psychiatric rehabilitation, evidence based practices and person centered thinking. A training focusing specifically on integrating NC CPSS into clinical settings could break down barriers and also ensure that clinically trained staff is aware of how NC CPSS services can complement the clinical work they are doing and, as a result, increase positive treatment outcomes.

Pathology language is often used versus recovery language and Treatment plans are often based on pathology versus hopes and dreams

All stakeholders should realize that episodes of treatment cannot be short, unconnected and acute, but instead, need to flow into one another and cover an individual's full array of needs. From acute crisis to recovery supports, services should be based on what the individual needs to remain an active participant of their community and their family. Likewise, stakeholders need to realize that clinically there is no 'one size fits all' to treatment, and services provided need to be respectful of the individual's preference, culture, family and background.

Topic 4 – Recovery in Policy: Managed Care, How can LME-MCOs be more Recovery Oriented

Workgroup Facilitators: Glenda Stokes, Richie Tannerhill

Barriers

The North Carolina system of care for individuals dealing with mental health and/or substance use issues is currently undergoing significant structural changes. One specific change is the shift to LME-MCOs as managers of their care system. LME-MCOs are responsible for the providers they identify as being in their 'network', reviewing and authorizing or denying requests to provide care, utilization management and quality management for providers in their network and managing both state and federal dollars to fund mental health and substance abuse services to individuals residing in their catchment. Since each LME-MCO is responsible for their specific catchment, there is variable consistency across the state in regards to: rates for services, funding model used, services offered/endorsed, level of oversight and administrative action and IPRS services.

Currently, treatment expectations are not truly person centered. The array and focus of services tend to center around acute episodes of care and short term stabilization. Few systems have an array of services that support individuals seeking to prevent episodes of decompensation, services that involve faith based organizations or peer run organizations, or systems of care that include family members/support systems. The services that are funded are typically fee for service, meaning that in order to receive reimbursement for services, individuals and agencies at times receive services that aren't person centered or the best fit for the individual, because those services are what is offered and what is covered by the individual's insurance. When services are authorized, the Person Centered Plan or Treatment Plan that is required is often negative in tone, as agencies are at times fearful if they accurately reflect progress they will shortly lose the ability to continue to work with the individual (even if there is still work to be done towards the individual's life goals.) Also related to billing, peer supports cannot be provided/billed for while an individual is in jail or hospitalized. This is a significant barrier, as this is a point in time when an individual could benefit greatly from support and outreach, and to have someone that is there with them, through a traumatic experience, to help them through it and when they are discharged or released. The potential for building rapport and motivation for change is monumental.

There continues to be a barrier to clinical staff appropriately linking with NC CPSS staff. Arizona also found that clinical staff had difficulty successfully integrating peer supports specialists

in treatment, and that often these difficulties were due to clinicians holding to the belief that they could control treatment, and also deem people 'not ready' to enter treatment. There is also difficulty consistently ensuring that family members and community supports have access to the resources they need to support their loved one.

MCOs should be leaders in dispelling stigma within their catchment area

Finally, the process and use of outcome measures doesn't reflect a quality and breadth of care, nor does it appear to impact strategic system reform. Outcome measures are not always directly tied to the service being provided, resulting in important data not being collected and overlooked.

Recommendations

There are several very significant and powerful ways that LME-MCOs can not only operate in a way that supports and promotes recovery, but also ensure that agencies providing services in their network support and promote recovery oriented practices. MCOs have access to extensive information on the network they oversee, and are able to identify not only gaps in services, but also ways to support and integrate preventive care in their network. This list of resources needs to be shared with all stakeholders: individuals seeking care, their family members, agencies providing services, technical assistance centers and with DMH/DMA. Increasing awareness of the services available ensure that individuals are accessing services based on their personal preferences and needs. MCOs have the ability to begin the shift from a medical model or deficit based system to a strengths based, recovery oriented system.

Funding should be moved to cover preventive services, as in the long run, this can Person Centered Plans should be reviewed for being strengths based and recovery driven, not just that they link individuals to specific treatments or services (which sometimes the individual doesn't want or necessarily need). While an advantage of operating under an MCO is the potential in cost savings, The Behavioral Health Recovery Management Project of 2000 voiced concern that by focusing on cost reduction, progressive, community based models of care that might seem costly initially might be overlooked or eliminated. The danger of overlooking these progressive, community based treatment models is we will continue to be an acute needs system where 54% of our national expenditures ($42.7 million out of $79.3 million in 1996) on acute, short term care.

Additionally MCOs can explore different funding options, either bundled or contract based. Different funding delivery systems can ensure that providers have the financial resources they need

to provide the services they are contracted to while minimizing the amount of administrative paperwork that must be completed.

Outcome measures should be directly related back to the intended outcomes of the treatment model being used, and can support the identification of centers or agencies of excellence which could tie back to possible incentives (increased funding, discounted or free training, sponsoring staff from identified agencies to attend state and national conferences, etc.) When undergoing their own system of care change, Philadelphia found it cost effective to provide funding to 'enhance' existing systems of care, using funds to update and upgrade to reflect the values and services they wanted their system to have in place. This was more cost effective than funding start up and/or new programs, and allowed the city to strategically focus on a wider array of providers as opposed to one provider and one service.

Additionally, given that some individuals experience spontaneous recovery, regularly measuring and using fidelity measurements specific to treatment models being used would specifically look at the agency's implementation of the treatment model and help identify ways they can increase their fidelity to said model. These outcomes and fidelity measures should be consistent across all MCOs to allow comparison between providers and services. As the outcome and fidelity measures are gathered, it should be made accessible to all stakeholders to promote transparency in services.

MCOs can also explore supporting co-located services (MH/Primary care, MH/SA/primary care). This was also an area that Philadelphia explored through mini grant funding, specifically the efficacy of co-locating mental health and physical health care in clinics where the community had a high level of ethnic diversity. Further related to integration of care, MCOs need to explore how they can support in reach, completed by NC CPSS, when individuals are hospitalized or incarcerated. This linkage needs to happen upon admission, not just when the individual is getting ready to be released. NC CPSS staff doing in reach needs to be included in treatment team meetings and discharge planning to ensure there is no break in care.

Finally, MCOs should coordinate with DMH/DMA to develop one centralized site to access MCO information. Through this site, individuals could find links taking them to MCO sites, to outcome measures and fidelity results, to provider information, information about success stories and promising practices being used, information on CFACs and highlight individuals in recovery. This centralized website could bring the message that people do recover to the state, and the resources on this site will show you how North Carolina is making recovery not just a reality, but the outcome for all individuals with mental health and substance use issues.

Topic 5 – Recovery in Policy: Developing a Mission statement and how the State can support principles for a peer-driven, recovery-oriented system

Workgroup Facilitators: Jimmy Cioe, Marc Jacques, Roanna Newton

Core issues

For a recovery movement to really take hold, a unifying mission statement should be developed that conveys the movement's overarching goals, ways to move towards the goals and how the movement's goals will not just impact individuals receiving services, but families and communities as well. It must be clear and concise, so those not aware of the recovery movement will have an understanding of what the purpose is and why it should be important to them. DHHS should ensure their mission statement and vision align with principles that support a peer-drive, recovery-oriented system. Consistency across stakeholders ensures that our communities understand why this is important.

While DHHS no longer directly manages the network of providers in NC, the rates for services or the way in which services are reimbursed, there are steps DHHS can take to support recovery oriented principles across the state. DHHS, through DMH, can ensure that appropriate outcomes are identified, that they are consistently tracked and that the information is accessible to the public. They can also ensure that fidelity monitoring is completed by agencies other than the MCOs, as this creates a dual relationship and could potentially cause providers and programs to not be as transparent during the fidelity monitoring process. DHHS can establish expectations for the state as a whole that align with the Transitions to Community Living Agreement in areas of housing, employment and services that must be provided to individuals regardless of their identified disability. Creative ways to fund services (i.e.- braided funding, block grant money, grant opportunities) can be explored by DHHS, and the information can be shared with the MCOs. Additionally, DHHS can explore incentives for providers that are making notable efforts in implementing recovery oriented, peer driven systems, including sponsoring in state trainings facilitated by national experts in the field.

Outcome-based funding versus Fee for Service

DHHS is in a position to centrally organize information for all 11 MCOs to ensure that individuals in any part of the state know what MCO to contact based on their location, the service array in that MCO, where their nearest clinical agency, peer operated system and community partners are and have an idea of how these supports are providing services. It should also have information on how to go about accessing needed services in each MCO. Individuals seeking mental health and/or substance abuse services should have access to quality data to support them in making informed choices.

Strategies/Recommendations

DHHS, MCOs and providers should consider adopting and implementing a stigma reduction initiative. For reference and guidance, SAMHSA published '*Developing a Stigma Reduction Initiative'* which provides guidance for event planning, partnership development, outreach to businesses and schools, mental health resources, marketing to the general public and grassroots outreach. By reducing and eliminating stigma, we can support individuals live more fully in the community, ensure that individuals with mental illness and/or substance use issues are considered for employment opportunities and eliminate one of the main barriers individuals encounter when considering seeking help.

DHHS can and should lead the charge in coordinating with other states that have implemented recovery based, peer driven systems. The exchange of ideas, of what has and has not worked can speed the implementation of these systems in NC. DHHS is an ideal agency to spearhead and support on going fidelity monitoring, as they are not directly linked to providers of services or payment mechanisms for services rendered. They are unbiased and can approach agencies from a genuine standpoint of quality management and improvement when coordinating fidelity measuring. The state can also explore creative ways to develop health homes in collaboration with CCNC and MCOs. Finally, DHHS can identify and endorse trainings as best practices across the state. Far too often, a treatment model is identified but there is no quality monitoring and management surrounding the trainings available to providers. This can create significant differences in program quality across the state for the same service.

DHHS Vision Statement (options)

- Attaining a state of wellness through recovery and self-determination principles for all people to achieve independence, productivity, integration, and inclusion.

- Attaining a state of wellness for all people through recovery and self-determination principles to achieve independence, productivity, integration, and inclusion.

Part A:

To accomplish this, DHHS will incentivize and fund the achievement of holistic outcomes: including, but not limited to, education, employment, stability in housing, greater independence and integration in the community, improved health, social connectedness and participation in meaningful quality of life e activities.

Part B:

DHHS will develop integrated funding models and practices which maximize flexibility & creative use of natural and professional resources to meet these objectives.

Conclusions and Next Steps

This report provides a comprehensive summary of the results and findings of the Summit, along with resources to help promote the mission of expanding recovery, peer support and peer-driven services statewide. All of the topics presented produced barriers and recommendations in the implementation of a North Carolina Recovery-Oriented System of Care. This report is the foundation of an Implementation Plan for North Carolina.

Additionally, the Summit initiated a new statewide recovery advisory council. The objective is for the group is to be an independent ongoing advisory group for the state. This document was reviewed at the first meeting of the group (now known as NCROCs- North Carolinians for Recovery Oriented Care) on May 22, 2013 and endorsed as a draft.

This group will include members of the Recovery Summit Planning Committee and additional stakeholders recruited through the Summit such as peers, stakeholders, state agency staff, and managed care organizations. This effort aims to recommend recovery fidelity measures at an organizational and individual level, initiate discussions around recovery within special populations such as co-occurring disorders and youth in transition, as well as begin the development of concrete operational technical assistance- answering the question *"what does Recovery look like in practice".*

North Carolina would benefit from developing and endorsing a state-level Recovery Policy that is consumer-driven and developed through effective processes so that the authenticity of recovery concepts becomes a shared value by system users, service providers, and administrators. Furthermore, the ownership of the policy would extend through agencies of NCDHHS so that funding and system structures would support recovery principles and best practices at the local level.

In North Carolina, Recovery Policy needs to be inclusive- taking into account mental health, substance use and addiction recovery values and goals; it should also increase the focus on youth in transition to adulthood, community integration through employment and housing, cultural and linguistic competency, and health and wellness.

Additionally, a goal would be for North Carolina to develop a conceptual framework or operational plan for focusing efforts on recovery as an outcome of services and state funding. Historically, the state's service structure and its funding have been targeted often to crisis response and stabilization, maintenance and not focused on future goals such as recovery.

References

NCDHHS has recently developed a webpage on Recovery to provide references and links to this initiative. This Summit report can be found on this link: http://www.ncdhhs.gov/mhddsas/services/recovery

NC Certified Peer Support program: http://www.ncdhhs.gov/mhddsas/services/peersupport/index.htm

- Breaking the Silence - Teaching children about mental health http://www.btslessonplans.org
- Bringing Recovery Supports to Scale Technical Assistance Center (BRSS TACS) http://www.center4si.com/whats_new/index.cfm
- Copeland Center for Wellness and Recovery http://www.copelandcenter.com/index.php
- Depression and Bipolar Support Alliance (DBSA) http://www.dbsalliance.org/site/PageServer?pagename=home
- Emotional-CPR http://www.emotional-cpr.org/
- Faces and Voices of Recovery (addictions) http://www.facesandvoicesofrecovery.org/
- In the Rooms- online global SA Recovery community http://www.intherooms.com/
- Institute for Recovery and Reintegration http://www.mhrecovery.org
- Magellan Health e-training on Recovery and Resiliency http://www.magellanhealth.com/training/
- Mental Health America (MHA) http://www.nmha.org/
- NAMI - National Alliance for the Mentally Ill http://www.nami.org
- NAMI STAR (Support Technical Assistance Resource) Center http://www.consumerstar.org/home.html
- National Empowerment Center http://www.power2u.org
- National Mental Health Consumers Self Help Clearinghouse www.mhselfhelp.org/
- NIDA Blending Initiative: Institute for Research, Education, and Training in Addictions http://ireta.org/NIDAblendinginitiative
- Partners for Recovery http://partnersforrecovery.samhsa.gov/recovery.html
- Recovery Is Everywhere http://www.recoveryiseverywhere.com/
- Resiliency Center: http://www.resiliencycenter.com/definitions.shtml
- SAMHSA Center for Mental Health Services http://mentalhealth.samhsa.gov/
- SAMHSA Statewide Consumer Networks Technical Assistance Center http://www.policyresearchinc.org/fcnhome/sitepages/SCN_Grantees.aspx
- Taking Charge http://www.pljunlimited.com/takingcharge/tc.htm
- What a Difference a Friend Makes! http://whatadifference.samhsa.gov/learn.asp?nav=nav01_7&content=1_7_recovery
- WRAP (Wellness Recovery Action Planning) http://www.mentalhealthrecovery.com/

Summit Handout

Recovery is a Real Thing

We can talk all day about what Recovery is, but for those who haven't felt it or studied it, recovery is a bit hard to grasp. It feels amorphous, like a cloud. But it isn't. It's very real and concrete.

Once you open the door for Recovery and Recovery Oriented Systems of Care, it is a paradigm shift. It's not that complicated but it is *hard*, which is different than complicated. Recovery begins to shift and change all areas of life. This includes the impending tsunami we know as healthcare because a truth of healthcare is: we must participate in our own recovery--and that includes the medical. This leads us to:

Recovery Oriented Systems of Care (ROSC) – ROSC is, by definition a full(er) picture and deeply embedded in the tableau that we call *Wellness*. And this *Wellness* snapshot demands all the blessings of recovery, which lead ultimately to independence. As individuals participate in their own recovery, they increase self-reliance (while leaning on support networks!), build self-esteem and increase not only level of functioning but the ability to give back to the world. This is but a glimpse into the upward spiral dynamic that creates the velocity which guarantees success.

As this success picks up speed, and as each recovering member strengthens the wheel of Recovery and the web of our state's ROSC, we see practical, concrete:

Financial Savings – $$ hard cold cash savings by the buckets. There are cities in our fair land that approached the multiple issues of mental illness, addiction and homelessness with an organized plan that, within a year, saved millions of dollars (San Diego, Seattle, Denver, etc.). The spiral increases ever upward because individuals feel the sense of accomplishment from a system that actually works effectively.

The Economics of Recovery are probably the best catalyst of change in an economic environment of scarcity.

- People in recovery tend to use up to 45% less service dollars.
- People in recovery tend to ask for help in a continuum of care rather than go into Crisis.
- People in recovery tend to use community supports rather than emergency departments.
- People in recovery value paying rent and use their resources better.
- People in recovery tend to return to work.
- People in recovery tend to stay out of trouble.
- People in recovery tend to give back: i.e. peer supports.

People Can and Do Recover!

SAMHSA (2012) defines Recovery from Mental Disorders and/or Substance Use Disorders as:

> *"A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."*

SAMHSA has also described the major areas that support a life in recovery, including Health, Home, Purpose, and Community. Additionally, the Guiding Principles of Recovery include:

1. Recovery emerges from hope
2. Recovery is person-driven
3. Recovery occurs via many pathways
4. Recovery is holistic
5. Recovery is supported by peers and allies
6. Recovery is supported through relationships and social networks
7. Recovery is culturally-based and influenced
8. Recovery is supported by addressing trauma
9. Recovery involves individual, family, and community strengths and responsibility
10. Recovery is based on respect

Bill Anthony (1993) identifies recovery as:

> *"a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."*

The PAIMI Advisory Council (2002) defines recovery as:

> *"an interpersonal dynamic process of embracing hope, defining oneself, and participating in meaningful roles in community."*

Recovery Innovations' definition:

> "*Recovery is remembering who you are and using your strengths to become all that you were meant to be."*

WHY RECOVERY?

The word recovery has been used in our mental health industry since 1830 when John Perceval published his journal Personal Recovery from Psychosis. It may interest you to know that in 1937 Abraham Low began "Recovery International"- a peer led self-help movement that is still going strong. To offer a little perspective, it wasn't until 1939 that the first working manuscript of AA Big Book appeared. The truth is that mental health recovery and substance recovery have always been parallel movements.

The tenets are nearly the same which are that by taking care of yourself, you can recover skills and pieces of your life that have been damaged by the illness. In this process an individual can:

- Recover the ability to learn (resiliency).
- Recover a meaningful role or identity.
- Recover a sense of value & self-esteem.
- Recover the ability to be employed.
- Recover lost relationships or ability to have relationships
- Recover our ability to live in the community
- Recover self-direction & empowerment
- Recover helpful values
- Recover health and wellness

SYSTEMS, MODELS, AND RESEARCH

A *Recovery-Oriented System of Care (ROSC)* is a service system that emphasizes recovery principles throughout policy and practice through strategic planning and transformation. It promotes "individual, program, and systems-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce discriminatory barriers" (SAMHSA, 2011).

The ***Recovery Model*** is a treatment concept wherein the individual has primary control over their care and treatment. When individuals have control and choice in the treatment and services they receive, they learn personal responsibility and are empowered to take control of their own lives. The Recovery Model is holistic and focuses on the person, not just the diagnosis or symptoms. This model changes the treatment of mental health and substance use disorders from an acute care model to recovery-focused model. Whereas the acute care model often traps individuals in a continual cycle of assessment, symptom stabilization, and discharge, the recovery model provides individuals with ongoing, long-term support which includes peer support.

WRITTEN ON BEHALF OF THE RECOVERY SUMMIT PLANNING COMMITTEE

BY JIMMY CIOE & MARC JACQUES

MARCH 27, 2013

References:

http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/

http://partnersforrecovery.samhsa.gov/rosc.html

http://www.mhrecovery.com/definition.htm

Summit Agenda

2013 NC Recovery Summit

The 2013 NC Recovery Summit was organized to engage key stakeholders to create consensus around factors that aid in the implementation of a Recovery-Oriented System of Care. Although recovery occurs in a variety of forms, the focus of this summit and subsequent report is to make general recommendations for improving recovery integration, recovery in practice and recovery in policy.

Summit Goals

- Define the key characteristics of Recovery in North Carolina.
- Initiate the development of recovery policy recommendations that will define the direction for the state.
- Outline a Recovery Mission Statement.
- Develop concrete next steps.
- Establish a broad, independent and diverse ongoing Recovery Advisory Council for North Carolina.

Agenda

8:30 – 9:00	Registration
9:00 – 10:45	Purpose of the Summit/ Opening Remarks– Stuart Berde, Jimmy Cioe Guest Speakers: Jim Jarrard – Acting Division Director, DMHDDSAS Harvey Rosenthal – Executive Director of the New York Association of Psychiatric Rehabilitation Services, Inc.
10:45 – 11:00	Break
11:00– 11:30	Introduction to Recovery, Workgroups, and Facilitators– Emery Cowan
11:30 – 12:00	Workgroups (Choose 1 of 5 groups)

12:00 – 12:30 Lunch (provided)

12:30 – 2:30 Workgroups (Continue to work with same group)

2:30 – 3:30 Reporting Period for each Workgroup

3:30 – 4:00 Next Steps– Harvey Rosenthal

4:00 – 4:30 Recovery Advisory Council– Marc Jacques, Cherene Allen–Caraco

Workgroup Descriptions

Each workgroup will be led by facilitators that include persons with lived experience, MCO, provider, and DHHS staff.

1. **Recovery Integration- Mental Health and Substance Abuse:** similarities, differences, barriers, recommendations
2. **Recovery in Practice- Increasing Peer Support, Consumer-Operated Services, and Self-Determination:** barriers, recommendations
3. **Recovery in Practice- How Can Clinical Services Be More Recovery Oriented:** barriers, recommendations
4. **Recovery in Policy- Managed Care, How Can LME-MCOs Be More Recovery Oriented:** barriers, recommendations
5. **Recovery in Policy- Developing a Mission Statement and how the State can support principles for a peer-driven, recovery-oriented system:** barriers, recommendations

Next Steps

All workgroups will discuss barriers and recommendations- the Recovery Summit Planning Committee will compile all the feedback and develop notes from the meeting into a report. The ***2013 NC Recovery Summit Report*** will be the beginnings of an implementation and strategic plan. This report provides a comprehensive summary of the results and findings of the Summit, along with resources to help promote the mission of expanding recovery, peer support and peer-driven services statewide.

This Summit report will be available for viewing on a new ***DMHDDSAS Recovery webpage*** (forthcoming).

An independent, grassroots ***Recovery Advisory Council*** will be developed to work on implementation recommendations for this report and for other guidance around recovery best practices for the state, LME-MCOs, providers, peer groups. Anyone participating that would like to be part of this Council will have the opportunity to sign up at the Summit.