

Mental Health Recovery

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North Carolina has new opportunities for orienting its mental health care system toward client recovery as the system shifts to managed care with the possibility of offering more innovative services. Ways of accomplishing this reorientation are explored and instances of progress are noted.

Recovery is quite the mental health buzzword these days. But recovery is more than just “the process of combating a disorder” [1]. What are the essential components of mental health recovery? And what opportunities currently exist for changing our mental health care system in ways that will promote recovery?

A group of experts convened by the Substance Abuse and Mental Health Services Administration (SAMSHA) in 2004 produced the following consensus statement on recovery:

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 [2].

The consensus statement goes on to describe 10 fundamental components of recovery: (1) Recovery is self-directed; those with illnesses “lead, control, exercise choice over, and determine their own path of recovery.” (2) Recovery is individualized and person-centered. (3) The person in recovery is empowered “to choose from a range of options and to participate in all decisions.” (4) Recovery is holistic; it “encompasses . . . mind, body, spirit, and community . . . and embraces all aspects of life.” (5) Recovery is nonlinear; it is “not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.” (6) Recovery is strengths-based, building on the “capacities, resiliencies, talents, coping abilities, and inherent worth” of the person in recovery, rather than focusing on correcting deficits. (7) Peer support and the sharing of experiential knowledge encourage recovery. (8) The person in recovery deserves respect, acceptance, and appreciation. (9) The individual takes responsibility for his or her own self-care and recovery. (10) Hope is “the catalyst of the recovery process.”

Recovery is a way of thinking that can be adopted both by the individual in recovery and by the mental health care system. It differs greatly from the approach of having an expert, generally a psychiatrist, control and direct the treat-

ment. In fact, it turns that approach upside down by putting the person with the illness at the center of all decisions. Professionals are part of the recovery team, but they function more as consultants. Services and supports become oriented around what really works for the consumer, based on his or her strengths.

Recovery Stories

At age 36, Jon returned home to live with his parents after having spent many years living in low-income housing or on the streets, with periodic enrollment in college. As a person living with schizophrenia, the voices he heard and the tactile hallucinations he felt were so troubling to him that he could not tolerate being around people. By the time he moved back in with them, Jon’s parents had graduated from the National Alliance on Mental Illness (NAMI) Family-to-Family psychoeducation program. Jon underwent peer training and is now working 24 hours a week as a recovery educator and peer support specialist. He has overcome his fear of crowds and of driving on the highway. He makes presentations to audiences frequently and enjoys being in a band. The costs to the system are much less (eg, he has had fewer hospitalizations and trips to the ED, and fewer police interventions), and his family is paying less of an emotional cost. Jon is recovering.

Janice had dyslexia early in life and did not learn to read until she was in her 20s. Her learning difficulties were compounded by bipolar disorder and substance abuse. She was put into group and foster homes because of her behavior and was restrained and secluded frequently. She had 4 children and lost custody of them all. At age 40, she started to experience hope and began her recovery journey when she began to attend classes to learn more about her illness. She became a peer support specialist and now serves on a NAMI affiliate board. She learned how to drive and got a full-time job. Now, at age 46, she owns a house and a car, has gotten married, and has regained custody of most of her children. She has decreased her dependence on public services and manages her own recovery.

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George's life was decimated by a troubled home life, schizophrenia, and crack cocaine use. During inpatient treatment, he was frequently restrained and put into seclusion, which aggravated his symptoms. Finally, he was exposed to a self-advocacy approach and learned how to make a recovery plan that included managing his symptoms. (Recovery plans are written by the person with mental illness. The plans typically include strategies to keep the person healthy, as well as tactics to identify and de-escalate situations that can exacerbate symptoms of their illness.) He has become a leader in promoting a system based on ideas of hope, empowerment, education, choice, and support. He is a leader in government and advocacy organizations. He still receives publicly funded mental health care, but at a minimal level.

These 3 individuals are experiencing recovery because of effective professional intervention and the existence of role models of recovery in their communities. One of the beliefs that supports self-directed recovery is that people need to see recovery as part of their lives, and to do this, "they need to be surrounded with possibilities of recovery" [3].

Opportunities to Create a Recovery-Focused Mental Health Care System in North Carolina

By 2014 North Carolina will have made changes to comply with the Affordable Care Act. In addition, because of state legislative changes, its mental health care system will have transitioned to a fully capitated, managed care model. What are the opportunities to move toward a system that supports recovery? In order to live within their capitated budgets, managed care organizations (MCOs) will be motivated to provide services and supports that help people get well and stay well. Under the old fee-for-service system, billing had no capitated limit each year. The new system will offer an incredible opportunity to make recovery the focus of care by giving the people who need help a personal stake and role in maintaining their own recovery. Lessons learned from people like those in the stories above can be applied.

Reinvestment of savings. MCOs must manage their state and Medicaid funds in order to achieve the best possible health for those in need within a capitated amount. They must pay for all of the needs of the population within their region with that pot of money. What a terrific opportunity this presents for moving from a provider-defined system to a system that compiles data about which services really work and which providers achieve the best outcomes. In this new system, the MCO can attract high-quality providers because they can pay them more and can limit the total number of provider contracts. Since there will be fewer providers, the communication between the MCO and provider will be enhanced. If the contracted providers support recovery, they will have more successful outcomes. It will be difficult to shift priorities and sever old contracts in favor of services and providers that are focused on recovery, but doing so is essential to achieving this vision. The MCOs will have the tools to restrict the number of providers and to adjust rates;

these are big changes.

Former LMEs that convert to MCOs will have to determine which services will help promote patient self-directedness, empowerment, and responsibility, as well as the other characteristics of recovery. People with mental illnesses want decent housing, and for many of them jobs are both necessary and appropriate. Hospitalizations must be planned for, but in the community, recovery services are most important—and most lacking. Supported housing, employment, psychoeducation (to help patients and their families better understand their illness), and specialized peer support are services that MCOs should endeavor to add to their array. Previous rules prevented spending funds on housing per se, but with the opportunities afforded by managed care, savings from a better-managed system can be reinvested in housing. Ensuring that people with mental illness have safe and affordable housing greatly contributes to stability; doing so results in savings, as does helping people avoid hospitalization.

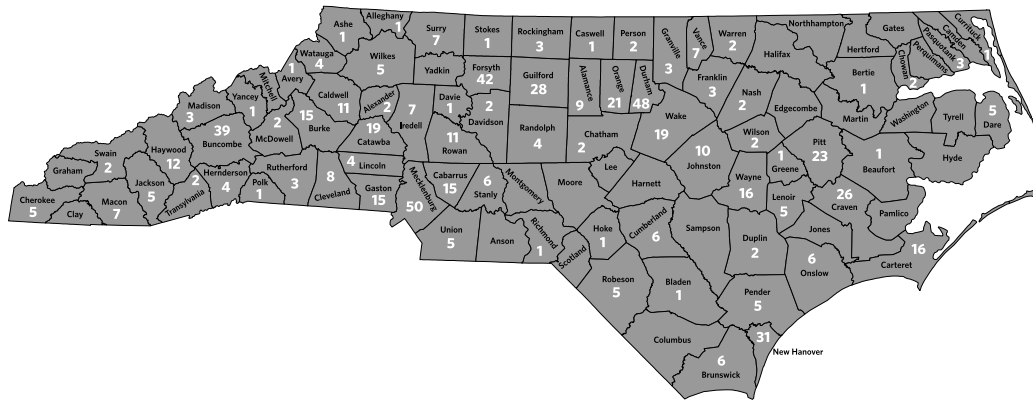
If money is spent to support people in finding and keeping jobs, everyone wins. People who were once consumers of government subsidies achieve taxpaying status. Trained individuals who have experienced mental illness are paired with people who have recently been hospitalized or have spent time in jail or prison, and help them transition back to wellness. No one can offer credible, relevant assistance as well as someone who has been through the same thing.

The freedom to adjust rates is one of the tools available to MCOs. Instead of paying providers based solely on the number of visits, the MCO can reward those providers who achieve the best outcomes by paying them at a higher rate. MCOs should also contract only with those providers who do a good job of keeping people at home (out of the hospital and out of jail) and helping them find jobs, decent housing, and meaningful relationships. This is a win-win-win approach for those living with an illness (who get to live as they wish, rather than being confined), for the MCO (which saves money by avoiding unnecessary hospitalizations), and for the providers (who get paid at a rate commensurate with their performance).

The MCOs can also examine local conditions to see what needs to be changed. Trying to find out why the same people cycle in and out of hospitals or jails would be a great place to start; then the MCO could try to design a system that would break those cycles. Changes that might help accomplish that include providing housing supports and case management services in addition to ongoing medication and therapy. Sometimes people land in a hospital bed because they couldn't afford to refill a prescription.

Provider monitoring. North Carolina's mental health care system needs to take definite steps to ensure that providers are offering recovery-focused treatment. Provider monitoring should include some examination of whether recovery principles are being adhered to; tools such as the Recovery Oriented Systems Indicators Measure (ROSI),

FIGURE 1.
Number of Certified Peer Support Specialists Residing in Each North Carolina County



Note. As of April 23, 2012, there were 649 certified peer support specialists residing in North Carolina as shown here. These numbers are updated weekly.

which includes both a consumer self-report survey and an administrative-data profile, can be useful in this regard. Feedback from people living with mental illness and their family members can be a useful measure of the success of providers in establishing a recovery organization. Here are some questions monitors may want to ask: Does the provider organization include people with mental illnesses or their family members on its board of directors or its staff? Are paid peers among those providing services? Do staff and board members understand and accept recovery principles? Do treatment plans reflect a consumer-driven process? Are all printed materials and policies aligned with recovery principles? Are the recipients of services interviewed about whether their treatment has been based on the 10 principles of recovery? Both the funder (the state) and the provider organizations themselves should be interested in knowing the answers to these questions. A focus on recovery must be reflected throughout the agency—in its policies, the composition of its board, and the way its staff members interact with consumers. The ultimate measure is how well the person receiving services has been supported in finding his or her own path toward wellness.

Progress in North Carolina

North Carolina is definitely making progress in orienting its mental health care system toward recovery. NAMI North Carolina offers free to family members and those living with mental illness a number of psychoeducation programs and support groups—including Connection, a NAMI support group run by people who are themselves living with mental illnesses. The peer-to-peer psychoeducation program helps people develop a crisis plan that serves them well; the crisis plan can include the development of their own advance directive, in addition to other general recovery strategies. We are beginning to see more paid peer support specialists throughout the North Carolina system. It is encouraging that a peer support specialist was recently hired at Cherry

Hospital; now the other state hospitals need to follow suit. There are a number of wellness centers and recovery centers in the state that offer psychoeducation and other educational programs. There is talk of including recovery language in the statutes defining mental health services in North Carolina. A legislative study commission is considering a requirement that local MCO boards contain consumers of behavioral health care and their family members. And under the managed care Medicaid waiver, MCOs can offer a Medicaid-reimbursed individual peer-support service.

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services contracted with the Behavioral Healthcare Resource Program at University of North Carolina at Chapel Hill to manage the North Carolina Certified Peer Support Specialist program. From February 2007 through February 2012, a total of 649 individuals were certified, roughly 47% of whom were living in recovery from a mental illness; another 38% were living in recovery from a substance abuse disorder, and 15% were living in recovery from both a mental illness and a substance abuse disorder. These peer-support specialists have widely varying educational backgrounds. Half (50%) have a high school diploma, 7.3% have a GED, and 2.9% are not high school graduates. The remaining peer-support specialists have education beyond high school. Specifically, 5.6% have an associate's degree, 4.1% have some college, 22.5% have a bachelor's degree, 5.5% have a master's degree, and 1.7% have a doctoral degree. Only 55.6% of the total number of peer-support specialists are employed, so there are many certified individuals who could be hired by providers to further the use of recovery techniques in their agencies. Figure 1 shows how many trained peer support specialists live in each county in the state [4].

Meeting the goal of orienting North Carolina's mental health care system toward recovery will take time; it is a lengthy process, not to be achieved by a certain date. But we must work toward that goal by holding the Division of

Mental Health, the MCOs, and providers accountable for reshaping the system to adhere to the 10 principles of recovery. And perhaps the most important task of all is to involve those with illnesses in directing their own recovery. **NCMJ**

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Odds of a child becoming a professional athlete: 1 in 16,000

Odds of a child being diagnosed with autism: 1 in 110

Some signs to look for:

No big smiles or other joyful expressions by 6 months.	No babbling by 12 months.	No words by 16 months.
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To learn more of the signs of autism, visit autismspeaks.org

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