

Michigan Department of Community Health

Recovery Council Meeting
September 18, 2009
9:30 am – 2:30 pm
LCC West Campus Facility
5708 Cornerstone Drive, Lansing
(517) 483-9300

Meeting Minutes

- I. Recovery Council members present:
 - a. Rich Casteels, Risa Coleman, Patti Cosens, Norm DeLisle, Jean Dukarski, Cheryl Flowers, Amelia Johnson, Tammy Lademer, Ruth Morad, Fran New, Greg Paffhouse, Marty Raaymakers, Ernest Reynolds, Phil Royster, Sherri Rushman, Pamela Stants, Wally Tropp, Pamela Werner and Irene Kazieczko.
 - b. Recovery Council partners present:
 - i. Kendra Binkley, Kris Burgess, Marci Cameron, Karen Cashen, Patricia Degnan, Debbie Freed, David Friday, Lisa Hayward, Sarah Ina, Michael Jennings, Mark Jones, Pamela Lang, Deborah Reynolds, Felicia Simpson, Patricia Thayer, Tison Thomas, Laura Vredeveld, James Wargel, Marilyn Wedenoja, Kim Zimmerman, Dwane Hight, Robert Gainer Jr., Clint Galloway, Jeff Capobianco, Melissa Kruce, Tom Burden, April Leone and Paul Leone.
- II. Announcements
 - a. Ernie read a note from Val Bishop extending her warm wishes to the Council and farewell as she will be moving to South Carolina.
- III. Approval of Minutes from July 17, 2009
 - a. Pamela Stants is missing from those attending.
 - b. Motion to approve the minutes; second, the minutes are approved.
- IV. Director Update: Michael J. Head
 - a. He went to the Peer Support training this past week. He thought it was great to hear the stories from everyone and to see transformation happening.
 - b. He has been asking around at different CMHs about how peers are treated – more specifically are they included or segregated? Have they had a chance to use their skills and share their stories? With the growing number of peers, there is some push back from people in the system and he/we need to spend some time working to resolve this. He has tried to spend some time with Executive Directors and he will talk more at the board association conference.
 - c. The Bureau of Substance Abuse & Addiction Services is now under his responsibilities within the Mental Health & Substance Abuse Administration. We are trying to get away from having two systems for people with co-occurring. If people have both issues, then let's treat them in the mental health system. Substance Abuse is trying to promote a recovery model too.

- d. Spent time in Detroit with Detroit Central City. He saw peers playing a significant role in helping Detroit Central City with homelessness and with people who are homeless and may have substance abuse and/or mental illness.
 - e. The State Budget – the hard question is - how do we make the cuts and still have a viable system across the state? He has been talking to the Legislature and CMH Executive Directors on how we can handle reductions. Making sure CMHs are planning for the cuts. Know that in some places there is opportunity to make change, keep some innovative approaches, keep evidence-based models and peers. Hopes you are at the table advocating with CMHs helping to make your case. This year is a prelude to next year – it's not getting any better.
 - i. Medicaid money is going to be OK. But the general fund money is getting the big cuts.
 - ii. Comment from Peer - He is doing well in recovery but then gets cut off from services. Mike appreciates hearing these types of comments. He talked a little about the Freedom to Work initiative that not everyone qualifies for.
 - iii. Ernie – spend down issue is always there. His is \$1500 a month. For people with disability who want to work. Mike says we have a workgroup working on this – to help make spend down easier, not promising that it will change but are working on it.
 - iv. Much discussion about disability income and people wanting to work but have fear and anxiety of losing this. Mike – there are some counselors that do work on these things but there are not many of them and we need more. The federal government has done a number of things to make it easier for people.
- V. Overview of Family Psychoeducation: Crystal Whitman from New Passages; Stephanie Lange from Macomb CMH; Jeff Capobianco from Washtenaw CMH and Michael Mitchell from Gratiot County
- a. Jeff Capobianco – involved with Family Psychoeducation for a long time and wants to get the word out about the model. It's out there and is an option for people. He wants to make people aware of this option.
 - b. Crystal Whitman – New Passages
 - i. She works with dual diagnosis team and now works with Family Psychoeducation. All educational and one more opportunity for peers to help other people. Gives her a chance to talk to other people – she didn't have anyone to talk to about mental illness or about recovery. Positive outcomes are that people's lives get back on track, less relapses, and it helps people find jobs.
 - c. Carol Egress – son and daughter in-law are with Gratiot County. Involved with CMH for about 19 years and in the Family Psychoeducation program. She can't say enough good things about Family Psychoeducation. She especially likes the problem solving part of the group. Great thing is that it brings the family and

consumer together. Families can be of help to each other – great to talk to other people having similar experiences. Easier to address issues in this type of setting because it is controlled. This has given them so much hope for recovery for her son and daughter-in-law.

- d. April Leone – supports her husband and is involved with the Family Psychoeducation group. She truly feels that it is a family. She says she learned so much about her husband's illness from the group. The problem solving part of the group has helped them so much. When you have a lot of stress, the group helps you figure out ways to release the stress which can prevent you from relapsing. She says they talk about medications, which is very helpful and educational. The group is a major support for her and her husband.
- e. Michael Mitchell – finds it so helpful to be able to talk to other people who are in the same boat as you. If you find something that helps you to get better, then you should stick with it. The group helps people to stay on track with their recovery and educates them about medication among other things. He is honored to be speaking today and really hopes the group never gets cut.
- f. Comments/Questions for panel
 - i. Partner in the audience (guy from Arizona) speaks about the group giving HOPE and helping each other. He thinks the education of family members is awesome.
 - ii. Marty – when did we roll this out? Jeff says 2005. Marty asks – how many people have moved on and taken interest in other evidence-based practice? (i.e., supportive employment, PATH)
 - 1. Jeff – Lots of people have heard about Family Psychoeducation. Tried to link motivational interviewing – other evidence-based practices with Family Psychoeducation. Says if someone wants a job, then they problem solve in the Family Psychoeducation group and it should link you to supportive employment opportunities. Jeff - yes we should be looking at how we can we be monitoring this better and get better ideas on outcomes.
 - 2. Marty – we are good at getting people sort of well – to a point and then parking them and leaving them and not helping them move on.
 - 3. Patti Degnan – All of this is still working with the system that is person-centered – increase the choices people have and it still comes down to the plan of service. Evidence-Based Practices are a choice and might not work for some people – our goal is to make the best types of services available and make people aware of them.

- a. Purpose of the Michigan Mental Health Evidence-Based Practice Initiative (MIMHEBPI)
 - i. Algorithm project is part of the broader evidence-based practice initiative.
 - ii. Consumer should be able to go to any doctor at any CMH and receive similar approach to treatment.
 - iii. Improve quality of prescribing.
- b. Evidence – Practice Gap.
- c. Improve Quality of prescribing
 - i. Based upon evidence for treatments.
 - ii. Based on thoughtful review of consumer status at each visit.
 - iii. Give treatments a chance to work.
 - iv. Change dosing to according to consumer response side effects.
 - v. Change treatments that are not working.
- d. Instructions on how to prescribe
 - i. Algorithms - the most specific.
 - ii. Protocols, guidelines, pathways.
 - iii. Recommendations – the easiest to ignore.
- e. Evidence hierarchies
 - i. Best evidence, multiple well-designed randomized controlled trials.
 - ii. Many levels in between.
- f. Basic principle of evidence-based prescribing.
 - i. Treatments supported by highest quality evidence should be tried first.
 - ii. Exceptions
 - 1. Less toxic treatment with less evidence for efficacy.
 - 2. Individual consumer is unlike those upon whom evidence is based.
- g. Limits of EBM
 - i. What gets studied?
 - ii. Validity of studies.
 - 1. Bias, statistics.
 - iii. Benefit vs. adverse effects, costs.
 - iv. Generalizability of studies.
 - 1. Consumers, disorders.
 - v. Comparative effectiveness.
 - vi. Consumer preferences.
- h. Who's paying for the evidence?
- i. Limits of EBM – proving the obvious.
 - i. The case of atypical antipsychotics as “mood stabilizers” or “anti-manic” drugs.
 - ii. Maintenance treatment of schizophrenia.
 - iii. If it works for 18 year-olds, will it work for a 17 year old a week before his next birthday?
- j. MIMHEBPI began in 2002

- i. Flinn Foundation
 - ii. MDCH
 - iii. MACMHB
 - iv. Other stakeholders
 - v. Project directed by Public Sector Consultants
- k. Phase I – 2002 – 2004
- l. Comments/Questions
 - i. Jean – as far as feedback from consumers - How is this empowering feedback?
 - 1. Dr. Dillon – at every visit there is a rating and ensures some input from the consumer. Determine if it isn't working. Jean – who determines if it's working or not? Her friend was told she is privileged to be on a specific drug but it isn't working for her. Jean- her concern with this – if we follow an algorithm will we stop looking at the whole picture?
 - a. Dr. Dillon – yes that's a fair concern but if you have a doctor then it's probably better to have him tied into this then something else.
 - ii. Marty – Comment about the people in Washtenaw and she thinks they voted with their feet. She feels at a disadvantage because we don't have the algorithm in front of us. She says - I want to know what drugs will cause me to gain weight and cause other health problems – she is tired of losing her friends 25 years earlier. She thought Mike said we weren't going to do this.
 - 1. Mike – we aren't talking about how Texas has a prior authorization, we aren't doing that. We haven't done anything yet – except run this test. It looks like in general the amount of medication gets reduced.
 - 2. Marty says the algorithm doesn't allow for multiple medications at first anyways.
 - iii. Cheryl – is concerned about the over-prescribing of medications. Why aren't we addressing this?
 - iv. Carmela – patients wouldn't have to change their medications but would they have to change their dosage of medications?
 - 1. Dr. Dillon says if you are doing well and feel your medication is working, then no you wouldn't change it.
 - v. David – would like to see the system as a whole take more responsibility and people take more responsibility.

- VII. Mike Head/Irene Kazieczko
 - a. Mike

- i. He said he doesn't want people to think he is killing the Council but really wants some time spent answering questions - What's this council about? Where are you heading?
- b. Irene – we should look at what we have accomplished and where are we going. Proposes that we structure the November agenda and really take stock of who we are, what we have accomplished and where we are heading. Make sure the Council continues to be involved with MDCH initiatives. Send out a survey.

Feedback:

- i. Norm – suggest that we figure out a way to break up tasks into small group work.
- ii. Marty – overall she is thrilled about the way the Council is going. Thrilled to see this many advocates and voices in the room helping shape the system in Michigan. Please think about how many people we have in the system that have gotten to the stability point and then don't move on. Marty thinks we need to see more people moving on. Thinks the Council should think about this.
- iii. Greg – should the focus be on the Council or the outcomes we are trying to accomplish on the system? Thinks this is a great group, leadership role that produces change. Don't just limit the agenda in November to the role of the Council but the system overall.
- iv. Mike - policy statement on recovery – what should the role be and what's the vision for the Council? We think this should start in November but it might not be finished in November.
- v. Leslie – thinks we are on a donkey trail and that we need to move a lot faster. Thinks just sitting here and doing nothing and just listening is a waste of time. We need to make movement. She spoke about the OQ 45 and said that they voiced their concerns but the Department did it anyway.
- vi. Jean – my understanding that the Council was supposed to influence and have a voice on policy. The OQ 45 was a good example of us not being heard. We spent a lot of time talking about it and expressing our concerns with it then it happened anyways. Doesn't feel that our voices are always listened to.
- vii. Duane – been in system for 16 years and with all the supports available and recovery sharing he still sees people who don't know what a PCP is.
 - 1. Sarah thinks this should be what the Council is about. Should think about this when strategizing role and mission of council.
- viii. David Friday - Getting positive things into the media. Agrees that there needs to be a strategy.
- ix. Robert – instead of waiting for things to happen – make things happen. Smaller groups make sense to him. Instead of sitting around talking about things and waiting for them – make change.

- x. Pamela – strongly agrees with Leslie and Jean. Thought the Council was going to be more of a workhorse. Thinks we need to really focus on what we are going to do.
 - xi. Sherri – this Council started with a lot of hope and we believed that recovery can happen and wanted to get it to everyone. Grassroots media – thinks we can or should be doing more of this. Talk to CMHs about what we are doing and how we can promote recovery and spread it.
 - c. Mike - the Council should be more efficient, not just about information sharing.
- VIII. Youth Eliminating Stigma (YES): Sarah Inda
- a. Youth Recovery – she has received services from CMH since she was 13 years old.
 - b. Walked through her “Young Recovery” presentation.
 - i. Mental Health America – “Estimates that more than 6 million young people in America suffer from a mental health disorder that severely disrupts their ability to function at home, in school or in their community.”
 - ii. 1 in 5 youth has a mental health issue.
 - iii. Common challenges identified by young people transitioning include:
 - 1. Education
 - 2. Employment
 - 3. Housing
 - 4. Social
 - 5. Lack of programs
 - 6. Substance abuse
 - 7. Attitudes and perceptions
 - iv. What is being done?
 - 1. Partnerships for Youth Transition
 - a. Meeting youth where they are
 - b. Creation of person centered transition plans
 - c. Leadership training
 - 2. Healthy Transition Act
 - c. Jean – wants to say thank you. I was a youth that didn’t transfer well and was homeless and didn’t have supports and it would have been so cool to have a group like this!
 - d. Rich – can we post your presentation on the Recovery Center of Excellence website?
 - i. Sarah says yes you can.
 - e. Leslie – challenge in education of young people – getting them to look at older people as having similar experiences and not just “old people”.
 - f. Provide peer support to age group 18 to 26.
 - g. Members and partners are saying they think Sarah should be on the Recovery Council. Irene says they could bring her on as representing youth.

IX. Public Comment

- a. Rich announces that there is an opportunity for a peer job at the Center for Excellence. He would like to publicly thank Andria Jackson for her hard work and dedication to her job.
 - b. Comment - Would like to see more things like peer support for younger crowds, younger than 18. She thinks her daughter would benefit so much from this type of interaction.
 - i. Irene says your comment is very timely and the Department is actively and aggressively working with the children's division.
- X. Irene thanks everyone for coming and participating today.