

Michigan Department of Community Health

Recovery Council Meeting

Friday, July 16, 2010

LCC West Campus, Lansing

I. Introductions

- a. Irene thanks everyone for being here today. There are new Council members present today. Also wants to announce Marlene Lawrence as the new co-chair of the Council.
- b. Recovery Council Members present: Nancy Auger, Patrick Baker, Stephen Batson, Joel Berman, Daniel Burleigh, Gerald Butler, Rich Casteels, Risa Coleman, Norm DeLisle, Jean Dukarski, Mary Beth Evans, Cheryl Flowers, David Friday, John Fryer, Amelia Johnson, Irene Kazieczko, Sheila Kennedy, Carmela Kudyba, Tina Lauer, Marlene Lawrence, Ruth Morad, Deborah Odocha, Cheryl Pace, Greg Paffhouse, Marty Raaymakers, Pamela Stants, Sally Steiner, Dona Tatum, Wally Tropp, and Pamela Werner.
- c. Recovery Council Partners present: Kendra Binkley, Karen Cashen, Peggy Conley, Sue Eby, Deb Freed, Stephanie Harris, Michael Jennings, Steve Kuhlman, Pamela Lang, Lucy Olson, Deborah Reynolds, Alyson Rush, Laura Vredeveld, Amy Juntunen, Eric DiCenso, Kari Chappell, Charlotte Lamb, Marcia Probst, and Casy Clark.

II. Recovery Stories to Share/Good News

- a. Mary Beth – Northern Lakes hired a Peer Support Specialist to be a case manager.
- b. Joel – fulfilled his last goal of getting his own computer.
- c. Pam – The Peer Support Conference was a huge success. Dona Tatum did a wonderful job as keynote.
- d. Amelia – a person that she works with recently became a homeowner!
- e. Nancy – Has completed her bachelor degree and works as a case manager and just got accepted into graduate school at MSU.
- f. Cheryl – has an 18 year old that just graduated and will be going to college this fall.
- g. Marty – adjusting to life since losing the national election for NAMI. She is sorry she won't be able to bring those perspectives to the Council anymore. Jean says just because you aren't on NAMI doesn't mean you can't contribute and be an important part of the Council.
- h. Jean - Aug 18 celebrating our 30th anniversary with JIMHO and would like to invite everyone to come out and help celebrate. Next Thursday is the Consumer Conference at the Kellogg Center.
- i. Marcia runs an inpatient peer support group.
- j. Nancy - Genesee County has opened a Recovery Center.
- k. Aug 24 at LCC West there will be a Self-Help Support Group Conference – contact JIMHO for more information.

- III. Approval Of Minutes from May 21, 2010 - Mary Beth motions to accept the minutes, Cheryl seconds the motion, the minutes are approved.

- IV. Director's Comments – Irene Kazieczko
 - a. Mike Head couldn't be here today as he is in Washington DC. The biggest issue in Lansing is next year's budget. Things look really grim here in Michigan for the next 3 years. Important for all the Recovery Council members to go to the hearings and/or let your Representatives and Senators know how important mental health services are.
 - b. The Mental Health Block grants went out and applications came back into the Department. Initiatives will be starting on October 1, 2010.

- V. Anti-Stigma Committee Report - Stephanie Harris
 - a. Started in June 2009 by MDCH. Designed to focus on stigma that people face in the mental health system. Research shows that people face stigma from providers and other people within the system.
 - b. Made up of people from all across the state.
 - c. Look at efforts in MI and nationally
 - i. There haven't been many efforts to target this type of stigma.
 - d. Creating a toolkit. Resources, give interventions, ways to measure the interventions.
 - e. Organize an anti-stigma clearing house – organize anti-stigma efforts across the state – provide communication and organization to people across the state; also provide an avenue for people to learn and share.
 - f. Marlene – what's impressive about this group is that we talk about people at all levels in the system – how do we reach the CFO as well as the case managers.
 - g. Deb Freed – also putting together documents that help staff learn about stigma. This is part of the toolkit.
 - h. Joel – how much is the committee addressing internal stigma? Stephanie – that comes up in almost every meeting in our discussions. Norm – I think the internal stigma can only be addressed in small groups, peer supports can really help here. Efforts at the local level.
 - i. Rue – Things they are doing at Central Michigan CMH– Ad Campaign “Have you Seen Me.” This is being advertised on in the public transportation system.
 - i. Stephanie says we need to put that type of stuff in our clearing house.
 - j. Cheryl – Look at the schools and there are no peer supports that work along with social workers in the schools. Stigma starts early in people's lives and it would be very helpful to have peer support and anti-stigma efforts in grade schools. Is this committee looking at schools and kids? She thinks this should be included with the stigma stuff.
 - i. Stephanie – we do have a representative for children and youth on the committee.
 - k. Comment about importance of creativity and not stifling creativity which can inspire.
 - i. Stephanie – we want to provide a place for people to have a start and to get ideas. Not interested in stifling creativity.

- VI. Recovery Council Work Group Report: Michigan Recovery Center of Excellence – Jean Dukarski
 - a. Jean, – Workgroup is charged with providing consultation, technical assistance and recommendations to the Council regarding the Recovery Center of Excellence (RCE). Identified 3 areas to work on, and action plans are being developed in each of these workgroups:
 - i. Work on the website – look for ways to optimize the website, information and accessibility.
 - ii. Finance – how to maximize and target funding available to get the most that we can out of the RCE.
 - iii. Marketing workgroup – ways to market the website.
 - b. At September meeting, we will provide update of our work.

- VII. Recovery Policy and Practice Guideline: Working Session and Final Recommendations
 - a. Remembering December 16, 2005
 - i. Key Issues at that Meeting
 - 1. How do we put together a system of recovery?
 - 2. How will it be measured?
 - ii. Member Input 2005
 - 1. Move from measuring system-based outcomes to measuring person-centered outcomes
 - 2. Decrease segregated housing
 - 3. Increase employment
 - 4. Increase education on recovery
 - 5. A key theme was people being in the system – improving the relationships with CMH staff
 - 6. Did not include discussion regard exiting the mental health system or the possibility of needing to re-enter the system
 - iii. Where the RC is today
 - 1. Has a leadership role in the state
 - 2. A commitment to develop a recovery policy
 - iv. Input at May 2010 meeting
 - 1. Recovery is inclusive
 - 2. Recovery is life-long
 - 3. Recovery requires education
 - b. Today - How do we know the system has changed? What is the outcome of a recovery-based system of care?
 - i. What are we going to measure at the end of the day? How will we know it has happened? What is the outcome?
 - ii. Norm DeLisle
 - 1. His journey with Recovery
 - a. Dawn Tredders in the 70's

- b. Models of Madness, Models of Medicine
 - c. Crisis Intervention Centers leading to consumer-run organizations
 - d. More and more people talking to and supporting one another
 - e. NAMI and other National Organizations
 - f. December 2005 and the first Recovery Council Meeting
 - g. 700+ CPSS – really thinks about this as a civil rights movement
2. Who and what this Policy Affects
 - a. Ideally: Who
 - i. All CMH and PIHP staff
 - ii. All providers
 - iii. All people on contract
 - iv. Most of all - everyone who uses and interacts with the system
 3. What
 - a. All state policy affecting supports and services
 - b. All CMH and PIHP policies
 - c. All local building policies
 - d. All program, supports, and services policies regardless of where or what
 4. Recovery Outcomes
 - a. Outcomes are quality changes in the life of a person over time, like paid work, friends, marriage, own home, etc.
 - b. Output – is how many sessions, how many units, how many hours of training, etc.
 - c. Output is supposed to lead to outcomes, but we know they often don't. The system can't create outcomes directly but uses outputs to affect outcomes.
 - d. The system only wants to be judged on its outputs because it thinks it can control those.
 - e. Major outcomes are what we want to develop as the signs of success for the Recovery Policy. What are the best single measures of your values? Beware of gaming.
- iii. Principles of recovery as the basis for the first try of developing outcomes
 1. Supports and treatment will be driven by the choices of the person.
 - a. Pat Baker – the outcomes of the system are different than the outcomes of the person. Thinks we should go after the outcomes of the system and that will affect the outcomes of the person. Does not want to get into something where MDCH auditors have a checklist. Wants more to say that the CMH has to have a policy and outputs. He thinks that each organization would work under an overall arching principal that they should

work under. And develop their policy. He thinks that a policy should come out of the Council and that would direct the MDCH and all CMHs to have recovery policies. For example - he thinks that you could put in a policy that “services will focus on integrated care.” He thinks that the MDCH should mandate that each CMH have a policy that addresses recovery.

- i. Jean – an overriding state perspective that would require/direct each CMH to develop their own recovery policy that is consistent with national and state literature that is out there.
 - ii. In terms of recovery, outcomes for the individual is more than symptom management, it’s getting a life, a job. He thinks each CMH should have a policy that is very comprehensive and MDCH looks at them and really looks to see if training is happening.
- b. Marty – Her system didn’t want to serve her and she watched other people get a life. That is what is most important – her system didn’t want to tie into outcomes, all they cared about was a paycheck. She wants to make sure that we don’t forget this.
 - c. Cheryl Flowers – the goal of a social worker is to help people not need you. The things that happen are different from county to county. What is OK in one county is not OK in another county. Things that are measurable are things like seeing people get a life and seeing them get a job. When you are looking at policies – and if you don’t have the same policies for each county, then each county will do things differently.
 - d. Irene – if MDCH has a recovery policy guideline that is part of the contract with PIHPs and CMHs, that in effect becomes their policy and then it is the responsibility of MDCH to monitor and enforce it. So everyone would have the exact same policy. We would expect that they would implement it and we would work with the Council to figure out how to monitor and enforce it.
 - e. Pam – Back in 96 PCP policy was developed, CMHs wanted to take the policy and make one of their own. Many eliminated half of it. We still have people who aren’t receiving a true PCP. She wants to make sure that the policy doesn’t get watered down and lose the principals. Can’t lose the intake and the input process.
 - f. Dona – totally agrees with Pam – PCP should be the same and uniform across the state. Thinks PCPs are not recovery-driven or directed.

- g. Marlene – an outcome for the competencies of providers to measure could be about PCP.
- h. Joel – wonders how many PSS are working and find out why they aren't working as one outcome measure.
- i. Pat – some of those principals are part of the overall health care system. Norm – yes with the new legislation we will see how that gets flushed out. Pat – thinks we should work within the avenues that we have right now.
- j. Cheryl – training is very important
- k. Norm says the best training for PC P is as an apprentice.

VIII. Break into Groups and come up with one outcome per principal. With the idea that the individual's life is going to improve.

a. Principal #1 – Revise laws and other policies to support communication between providers.

- i. Group work: People will have reasonable confidence that:
 1. Medical records systems will facilitate and enhance fast and appropriate care.
 2. Providers will know when and how to share relevant information.
 3. They know what is in their records, how to protect it, correct it and access it when needed.
 4. They can use advance directives to facilitate the exchange of relevant information.

b. Principal #2 – After exiting the system, if reentry is needed it will be effective and seamless

- i. Group work: It may be seamless but there are cracks, when you try to get your treatments back. When no longer getting Medicaid they no longer give you aid. So what if you're going crazy they'll give you samples to make you lazy. Not sick enough for their level of care, they send you away to go elsewhere.

c. Principal #3 – Change control from external rules, regulations, staff to individual self-control and management.

- i. Group work: Individuals using CMHSP services will report a sense of empowerment from accomplishing their personal goals. Increased sense of choice, increased self-confidence, increased respect from staff, increased utilization of coping skills, increased self advocacy and increase advocacy for others.

d. Principal #4 – Certified Peer Support Specialists will be part of every CMH work force.

- a. Group work: Peers are valued as equal members of the organization and included as part of the team. They are not limited to contractual positions and are afforded the same opportunities for growth and staff development; in addition, the individual needs of the PSS will be recognized and supported by the organization.
 - i. Some brief discussion on how do you measure this - Pat says to look at the agency's policies on hiring. Look at how many peers are working there full and part-time. Also, a survey would get at if they feel equal. Compare job descriptions.

- e. **Principal #5 (3 of them):**
 - i. **Establish a system goal for quality health care the same as is done for employment, housing, etc.**
 - ii. **Collect and report state wide data to see if life expectancy is increased for individuals with SMI.**
 - iii. **Build adequate capacity to provide integrated mental and physical health care.**
 - 1. Group work: The individual, based on their trust and comfort, chooses and directs an integrated team with various members and specialties including spiritual, nutritional and occupational with the goal of allowing multi faceted opportunities toward full health.
 - 2. Some brief discussion on how to measure this - as a part of the PCP process, they should include someone that isn't just a staff person at the CMH. Include those in the advance directives as well.

- f. **Principal #6 (2 of them):**
 - i. **As a health care purchaser, Medicaid should provide coverage for health education and primary prevention and cover smoking cessation and weight reduction treatments.**
 - ii. **Join Medicaid and Public Health to support screening, treatment and access to health care.**
 - 1. Group work: Unencumbered access to all health services. People would be healthy based on their definition of health and be confident of having normal life spans. Individuals are empowered by the knowledge of the ability to impact their health. Mental health and physical health will be seen as the entire human health experience.

- g. **Principal #7 – Supports and treatment will be driven by the choices of the person.**
 - i. Group work: All individuals who use Michigan’s mental health services will choose the supports and services that help them achieve their goals through the PCP process. All services provided will support these personal goals such as housing, employment, relationships, spirituality and education. Services and supports are flexible and change as the person grows and changes.

- h. **Principal #8 – Competencies of providers will be measured.**
 - i. Group work: I have found belief in myself and hope for the future. I am better able to see possibilities for myself that I never saw before. I am better able to choose my own path to recovery and live the life of my choosing.

IX. Public Comment

- a. Lucy Olson – She is excited that she came to the Council today. Given what we have done today, she wants to encourage people to read the PCP guideline and provide feedback.
- b. Laura Vredevelde – The Standards Group
 - i. Wants to encourage Council members to provide feedback to the draft competencies policy. She welcomes the Council’s feedback.

X. 2010 Meeting Dates (both are from 9:30 am to 2:30 pm at LCC West in Lansing)

- a. Friday, September 17
- b. Friday, November 19