Michigan Department of Community Health

Recovery Council Meeting
Friday, September 19, 2008
10:00 am – 3:00 pm
LCC West Campus Facility
5708 Cornerstone Drive, Lansing
(517) 483-9300

Meeting Minutes

I. Introductions
   a. Recovery Council Members:
   b. Recovery Partners:
II. Recovery Stories
   a. Donna Orrin
      i. There are 6 books available at no charge from the Substance Abuse and Mental Health Services Administration. Created support groups that got together to help people go through them. Have developed a curriculum to help people. The groups will be open to all in the public, not just consumers and CMH staff.
      ii. Lucy Olson – U.P. Consumer Conference was wonderful. She handed out magnets that consumers and staff created.
III. Minutes from July 18, 2008
   a. Motion to approve, second, all approve. The minutes are approved.
IV. Director Update: Michael Head
   a. Concept Paper
   b. Draft Application for Renewal and Recommitment
      i. The Department will hold several meetings for review and feedback from CMHSP/PIHP staff as well as public – anyone that is a stakeholder. The first meeting is on October 7 in Lansing. Then we will have one in Grand Rapids and one in Detroit.
      ii. Strong expectation for PIHPs to involve consumers in a significant way. The Department is looking for evidence that PIHPs are involving consumers and families in ongoing ways in the way they do business. There needs to be a plan for how PIHPs are going to continue to evolve. Also important are both person-centered planning and self-determination.
      iii. The Department will use these plans going into the next contract negotiations meetings.
   c. Peer Support Specialist pay levels – he talked about this issue at the Director's Forum. He discussed how peers are effective and salaries need to reflect that.
   d. Access Standards – please review this. This is much more then screening people "in" or "out."
   e. Encourage people to take part in the election.

f. Advocacy in the budget process will be crucial this year.
g. Questions
    i. You talk about pay for Peer Support Specialist; did you also talk about health care?
        1. Mike - we do talk about getting the information out to people about their options on health care, having staff investigate if people have access to health care and if at all possible, help connect them and make it happen.
    ii. With peers working and trying to navigate through the benefits process, things get complicated. It's difficult to figure out how much they can work before they lose benefits. Shouldn't we be walking hand in hand with people in creating a system that helps people navigate through this?
        1. Mike - people should always talk with a benefits counselor. There are some options available so that people can work and have it not affect their benefits. He mentioned the Freedom to Work program. We are trying to grow this option in Michigan.
    iii. Pamela Stants - Have we heard any of the Presidential nominees talk about mental health?
        1. Norm – neither has said much. Obama does have a plan though. At the Democratic National Convention, there was a Recovery room that was well attended.
h. Mike – encourages everyone to contact your legislators to vote for the Parity Law that is before Congress.

V. Welcome Improving Practices Leadership Team (IPLT)
    a. All 18 PIHPs in the State have convened Improving Practices Leadership Teams (IPLTs) in order to join in statewide practice improvement. The formation of the IPLTs is aimed at fostering a learning organization within the public mental health system so that emerging, promising and evidence-based practices can quickly become part of the choices available to consumers during the person-centered planning process.

VI. Overview of Recovery Enhancing Environment Scale (REE) – Priscilla Ridgway, Ph.D., Yale Program for Recovery and Community Health
    a. Congratulations to Michigan for being so dedicated to promoting recovery within your system.
    b. The REE is a way to measure how well the environment is enhancing the potential for people to recover.
    c. Practices either facilitate recovery or hinder it. She is all about promoting the practices that facilitate recovery.
    d. The REE is being used around the world and in several states in the United States.
    e. Your Involvement in the Recovery Process section – what stage of change are you in? This is based on Prochaska's Stages of Change. The first

stage is Pre-contemplation; the second is Contemplation; the third stage is Planning; the fourth stage is Active Recovery; and the fifth stage is Maintenance. The idea of set-back was added to this. The further you go in the stages, the more markers of recovery you see. Set-back has the fewest markers.

f. The next several pages of the REE instrument are the Elements of Recovery Enhancing Programs. Not all of these elements are important to everyone. When you analyze this data, you can look at several different things. You can look at what the staff is doing well. You get variability by person and program. You can differentiate between top performing programs and low performing programs.
g. She says you can analyze within the program. You can look at the average or look at each individual thing or look at how important they are to the people you are serving.
h. Michigan will be the first state where the REE is required statewide .
i. Questions
    i. Some CMHSPs do not hire peers and this seems not to be a culture of recovery. So, how would the REE fit in?
        1. Priscilla – discusses the process of change. Some people jump right on board with change and other people lag behind. Hopefully this measure along with the CMHSPs that have hired peers will help move the lagers and the system forward.
    ii. Peer reports that many times in her experience talking with consumers, if you ask them if their case manager talked to them about recovery, they will say yes. But then when she talks to them more in depth – they admit they haven't heard about recovery.
    iii. How would you handle people who don't know what it means to be empowered? Have you ever encountered anyone that doesn't understand the first question?
        1. Priscilla – hasn't run across this in the states that I have worked in. But, you could have guiding words, so if someone asks "what does empowerment mean?" you can explain it to them.
    iv. What about when people say, "I already had hope before I got here, so no, the staff did not help me"?
        1. Priscilla - look in the Recovery Markers section, page 9, in understanding of needs and you'll see this here.
    v. Question about the absence of a "neutral" option.
        1. Priscilla says you can still write that in. Many Likert Scales have gotten away from having that option.
    vi. Do you assign values to each marker in order to evaluate? And what are they?
        1. Priscilla – yes we assign values and you can look at relationships between them. You can also look at the mean across the agency to gage the score for the agency and then

use that to compare agencies. You can't rate where people are at in their recovery. Over time, in repeated measures, you want to see a move towards recovery. Performance measures are where you would rate agencies, you would not use the data on people's personal markers to rate the agency.

vii. Is there a way to get a total score?
    1. Priscilla says yes you could do that. There are ways to do that.

viii. Question to Irene – couldn't this be integrated into the services that people are getting? So that each year you could look at where people are at?
    1. Irene – Two ways we will use the REE. One for the statewide view, and then the individual markers are definitely a place that can be utilized in the way you are saying. We will talk about this in the implementation process.

VII. Implementation Plan – Advocates for Human Potential (AHP) – Darby Penney

a. Presentation - How the REE in Michigan will be implemented.

i. The REE-MI will be implemented in each CMHSP and provider agency.
    1. With representative samples in selected program types in each CMHSP/agency.
    2. With people who've been in the program a minimum of 90 days.

ii. Two implementation phases
    1. Planning.
        a. CMHSPs develop narrative plan and tables describing samples at each CMHSP/agency.
    2. Data collection.
        a. Consumer surveyors administer paper/pencil or online surveys to people in samples in each CMHSP/agency.

iii. Narrative plan from CMHSPs.
    1. Complete sampling plan table for each program.
    2. Describe how consumer surveyors will be selected and deployed.
    3. Describe how survey will be administered with individuals in each program.

iv. Program types to be surveyed.
    1. ACT, Targeted Case Management, Psychosocial Rehabilitation, Consumer-run Drop Ins, Supported Employment, Medication Clinics, Group Homes.

v. Sample selection.

1. No hard and fast way to do this. Various options available. Will take into consideration if the program has a suggestion on how to come up with a sample from their organization.

vi. Consumer surveyors.
1. May be Peers, staff of consumer programs and/or individual contractors.
2. No conflict of interest.
3. Question – who is going to hire them?
    a. Darby - there is still some discussion on how this is going to happen. Irene or Pam could answer this better. But thinks some money from block grant could be used.

vii. Selection of surveyors.
1. MDCH will determine responsibility for selection of consumer surveyors.
2. Either CMHSPs or the Michigan Recovery Center of Excellence will recruit, hire and deploy surveyors.

viii. Plan: Survey administration.
1. Preferred method is on-site by consumer surveyors to groups of consumers in sample.
2. Other methods based on what's practical in each setting. Such as: One-to-one in clinic waiting room or web-based administration onsite or offsite.

ix. Plan: Summary
1. Data collection method should be appropriate to program organization.
2. Method must result in a fair selection of program participants.
3. Method must include consumer surveyors at the point of data collection.

x. Plan: Submission and Review
1. Plans will be submitted to MDCH.
2. Plans will be shared with AHP which will develop a master data collection plan.
3. Plan developers may call AHP staff with questions.

xi. Data Collection
1. Schedule
    a. To be developed my MDCH and the Recovery Council.
    b. Phased in over 10-month period during 2009.
    c. 2-month window for survey administration per area.
2. Administration
    a. REE-MI will be administered in phases according to schedule developed by MDCH.
    b. Surveyors will administer REE-MI in each CMHSP/agency according to approved plan.

3. Training
    a. Consumer surveyors will be trained by AHP to administer the REE, handle questions, enter data online and ensure quality.
    b. Michigan Recovery Center of Excellence will facilitate training through technology: video conferencing and webinars.
4. Assistance
    a. AHP will produce a survey administration manual for consumer surveyors.
    b. AHP will maintain a 1-800-number for consumer surveyors to call with questions.

xii. Report Findings
1. No individual information will be reported in any form.
2. AHP will provide MDCH with aggregated results of the REE-MI.
3. Reports for individual agencies and programs will be provided to each agency, but will not be public.

xiii. Questions/Comments
1. Can we translate this into Spanish?
    a. Irene- it will be routine for MDCH to produce the survey in Arabic, Spanish and brail.
2. Does the survey identify who the person is?
    a. Darby – no the surveys are not identifiable. The purpose is not to track individual people's recovery. However, people have said that the recovery marker section would be helpful to use in their person-centered planning process .
3. What's the advantage of doing the survey in a group?
    a. Darby – everyone hears the same exact instructions and has an opportunity to ask questions of the survey administrator and all hear the same answers.
    b. Priscilla says that by doing it in a group, it is less costly. She has done it in group settings.
4. For CMHSPs in rural areas, could we give people the survey to take home?
    a. Darby – we will be exploring different ways on how to handle this. There are issues with letting people take it home though. Some options:
        i. Web-based administration onsite or offsite.
        ii. One-to-one in clinic waiting room.
5. The presentation is confusing. Who is responsible for what?
    a. Darby – CMHSPs develop a plan and MDCH will approve and provide guidance.

6. What are the options for people who have sight impairments and/or Arab-Caldean and they want to do the survey on their own?
    a. Darby – there are options.
    b. Irene- says it will be routine for MDCH to produce the survey in Arabic, Spanish and brail.
7. Question from Pat Baker about sample size.
    a. Irene - we will work with each CMHSP to figure this out. We need to define what we are talking about when we talk about programs. Beauty of having an individual plan for each CMHSP.
8. Marty – we are doing a survey with public dollars and to not report what the results is wrong. This is something that I am not comfortable with, nor do I agree with. She says it's all about choice – if I am a consumer and could see the results of this survey and what programs are working and what ones are not, then I would have the right to choose. Consumers throughout the state should be able to use these results to choose a program that facilitates recovery. Other Council members and partners verbalized support regarding Marty's concerns.
    a. Irene – we don't want a survey to create a list of "bad" agencies. We would want to show what we have learned about what's going on in the state. Learn from it and then determine how we can move the system forward. I understand your concerns on wanting the results to be shared openly. At this time we are focusing the efforts on a quality improvement initiative.

xiv. Question for Irene - Are you keeping all the other instruments, like the MHSIP? Or are you thinking about replacing them with the REE?
    1. Irene says REE can be used as a satisfaction tool. The issue with the MHSIP is that it is required by the federal government.

VIII. Role of Recovery Center of Excellence (RCE): Rich Casteels
    a. Access to survey on-line. We have taken into consideration the rural areas and people that can't access the web.
    b. There are two positions now available for the RCE - a Project Coordinator and a Peer Support Specialist.

IX. Other Comments
    a. Jean – Michigan has a statewide network of consumer-run organizations. We have the capacity in the organizations to have trained surveyors.

i. Pat Baker – is that something that MDCH would then contract directly with JIMHO? He says this would be a great idea.
ii. Irene –will address the conflict of interest issue and look at the resources we already have in place.

b. Pat Baker – Mike Head has made comments twice now about where we are going as a Council. Pat believes we need to meet and tell MDCH where we are going. **He recommends that we work this through a committee process and develop a formal recommendation. Pat Baker will head this group. People that want to participate are: Norm Delisle, Stephen Batson, Leslie Sladek, Marlene Lawrence and Greg Paffhouse, Jean Dukarski.**

X. Next Steps
   a. Follow-up meeting **for technical implementation group.**
   b. Information at next Council meeting in December will be discussed.
   c. Irene says we will be supporting the survey process through the Federal Block Grant dollars.

XI. Meeting Adjourned.
   a. Irene thanks everyone for coming and participating.