

Minds on the Edge -- October 15, 2009

Facilitators Loretta Raider and Onaje Muid

Process Group Report

Process Topic: How should we incorporate the recovery model into the regional behavioral health system?

1. Introduction

- The group consisted of 10 participants, ranging in age from their twenties up to fifties, some from the previous *Minds of the Edge* forum in June and some not. Many were working professionals in the associated fields of mental health, substance abuse treatment and psychology, private and government associated entities, while others were parents, relatives and advocates of consumers, plus some retired persons passionate about reform. The reasons for people's presence also ranged from being there for personal, to practice to policy concerns. The level of sharing about their passion for the issue and their concerns were phenomenal, it set a tone of authenticity, openness and exploration, no matter from what perspective someone was for or against a recovery model or some aspect in contention

- Background to the work for this session
 - People in the earlier session and in the on-line conversation argued that we need a "recovery model" or a model of behavioral health that is not crisis-oriented, but that works to build long term stability into the lives of those suffering from severe behavioral health challenges.
 - Today we're going to try to address those arguments and see what parts of a "recovery model" we might incorporate into the regional behavioral health system.

2. Identifying what a realistic "recovery model" *would* look like in practice in this region

- Individually, then in three small groups, people were asked to identify *the key elements of a recovery model*...From the many ideas from the three groups ideal model was constructed
 - Ideal model: 12 Thematic Areas (Representing Principles, Practice and Policy)

1. *Consumer Driven-pace and treatment/ Begins with clients/ Age Related/ Vocation*
2. *Case navigator for individual family/ Coordination*
3. *Choice based on their needs as defined by them- in the front seat of car no longer in back seat*
4. *Risk- w/ support: understanding (and anticipating) natural consequences (that come with choice but being caution about paternalism*
5. *Holistic (part of the community, linked resources)*
6. *Continuity (smooth transition of services, i.e. going to program to an outpatient services (with accountability in place)*
7. *Paradigm Shift- human beings 1st rather than seen as a diagnosis-
-giving hope and changing expectations*
8. *Reduce Stigma through Public Education*
9. *Services (should be) community based and connected to natural supports*
10. *Strength Based Approach to services (not deficit model)*
11. *Peer Support/ Connections*
12. *Connect with other funding for services , i.e. not everything has to be paid for out of mental health budget*

The conversation around these 12 points was very rich, interactive, engaging and involved. No notes were captured to document the fullest of those conversations, yet the lessons weren't lost because there are a set of principles already in place that reflected many of the 12 points, so spoke a few participants. (Those reference documents will be posted at a later date).

3. Exercise : Identifying what we have now and what's missing.

- In plenary people were asked to individually review the list of key elements and individually decide which key elements are in place now and whether they are weak or strong now.

It was fairly well agreed upon that all 12 points existed to some extent or another and that assessment of strength or weakness was determined by who you were in the system, professional or provider, yet the final judge should be the consumer.

4. Action Ideas

- Define what a consumer driven system would look like
 - Some concerns:

- What values and standards?
 - How can an integrated plan be implemented?
 - How can we use this strength, and with what existing resources, to advance the recovery model?
 - Use of alternative medicine, not psychotropic medication all the time
- Major Goal #1: Work with public to increase understanding of mental illness
- Major Goal #2: Change our thinking
 - Start w/elements - legislation has to change to support model
 - Establish interest groups

- Major Goal #3: Initiate Collaborative Planning to Dialogue on WELLNESS
 - Identify players
 - Insurance
 - Providers
 - Outcomes/strength based

- **Over arching Major Goal : Create Public Relations Campaign to do the heavy lifting to create a paradigm shift**

Role Involvements

- Individual consumers and their families and advocates
 - Find actors for public service announcements
 - Conduct sessions like this to empower consumers
 - Take this list out to consumer and gage their thinking
 - Stakeholders direct own plans
 - Peer to peer education

- Providers in health care industries
 - Ensure easier transfer of records for continuity of services
 - Identify players
 - Insurance
 - Providers
 - Outcomes/strength based

- Insurers

- Withhold monies to providers if they don't release records on time as a disincentive (as it relates to above items 6, 2 and 1)
 - Expand diagnostic code to include many life matter not covered
 - Expand coverage for services necessary and provided but not reimbursable
 - Expand philosophical nature of codes to look at whole person
 - Ensure that someone is made responsible to educate public
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- Government and Public Education Websites
 - Require each provide to look at and present whole person
 - Create mental health caucuses
 - Use existing non profits to end stereotypes
 - Use social media, Facebook, You Tube, to provide visible models of people managing Mental Health challenges

Final Concern: Where do we go from here? How can this be used to transform the system?