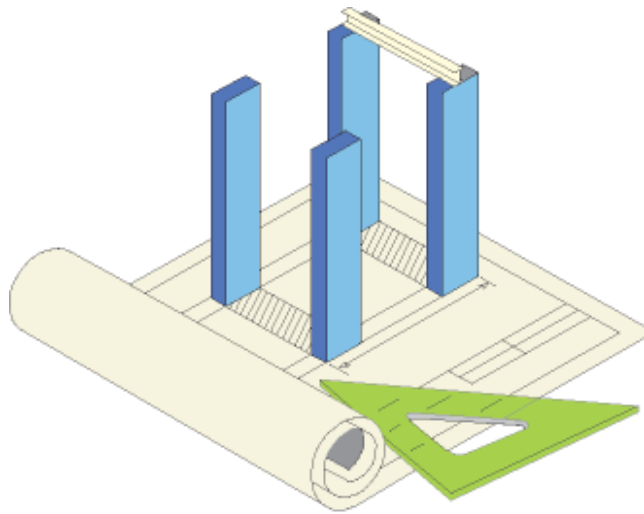

Dimensions of a Recovery-Based System for NLCMH

A Beginning Blueprint

Summary of Progress 9/25/08

BASED ON 12 ANTHONY SYSTEM DIMENSIONS

1) Design
2) Evaluation
3) Leadership
4) Management
5) Integration
6) Comprehensiveness
7) Consumer Involvement
8) Cultural Relevance
9) Advocacy
10) Training
11) Funding
12) Access
13) Change Management

Source: "A Recovery-Oriented Service System: Setting Some System Level Standards,"
William A. Anthony, Ph.D., Executive Director of the Center for Psychiatric Rehabilitation at Boston University,
Psychiatric Rehabilitation Journal, Vol. 24, No. 2, Fall 2000.

November 5, 2007

The President's New Freedom Commission on Mental Health
Achieving the Promise: Transforming Mental Health Care in America
July 22, 2003

We envision a future when everyone with a mental illness will recover, when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community.

Michigan Mental Health Commission
October 15, 2004

A NEW VISION FOR MICHIGAN

For our children and adults, from Northern to Southern Michigan, the mental health system needs to be reinvigorated and reinvested in to deliver on Michigan's constitutional promise that "institutions, programs, and services for the care, treatment, education, or rehabilitation of those inhabitants who are physically, mentally, or otherwise seriously disabled shall always be fostered and supported." To that end, the commission has determined that a new vision is essential for the mental health system in Michigan:

Michigan's children and adults enjoy good mental health and are served by a mental health system that responds effectively to the needs of individuals with mental illness and emotional disturbance while promoting resiliency and Recovery.

Making this vision a reality requires adherence to the following values for the system:

It must be shaped by the individuals who use mental health services and their families.
It must be focused on promoting recovery and resiliency and advancing good mental health.
It must be effective, focusing on clinical quality and system performance.
It must be equitable, providing accessible, available, and high-quality care to all Michigan citizens.
It must provide timely and easy access to a full array of services, with "no wrong door" to that care.
It should be efficient and work in conjunction with the rest of Michigan's human service network.
It must be accountable, integrated, coordinated, and collaborative. Mental health services must be integrated into the other parts of our system of opportunities and care for state residents.

Northern Lakes Community Mental Health
10-1-03

Serving the counties of
Crawford, Grand Traverse, Leelanau, Missaukee, Roscommon, and Wexford

OUR VISION

Communities of informed, caring people living and working together.

OUR MISSION

To promote the behavioral health of our individuals, families, and communities through programs that promote recovery, build resilience, create opportunity, and improve quality of life.

Recovery Is The Organizing Principle – The Expectation

Overarching Goal

A consumer and family-driven mental health system based on recovery principles with a recovery environment of excellence, encouragement and hope among consumers, families, staff, providers and community.

Guiding Principles

While Northern Lakes Community Mental Health employs and contracts with many excellent providers and has a sound foundation of recovery oriented services, including peer support services, peer operated services, and clubhouse services, we recognize we must and can do better. Our service delivery model has been developed based on a traditional behavioral health model and not one developed through recovery oriented planning or designed as a recovery oriented system of care. We are committed to making changes to promote consumer outcomes consistent with the Board of Directors recovery based outcomes. We acknowledge change is difficult and believe that competency in change management will be critical to transformation success. This Recovery Blueprint has been developed based on the work of William A. Anthony, Ph.D., Executive Director of the Center for Psychiatric Rehabilitation at Boston University, and through the excellent contributions from and wisdom of consumers and staff. This group believes that:

- The vision of recovery provides a sense of purpose and meaning to people who work at or contract with NLCMH.
- The organization and employees are energized and mobilized by a shared vision of recovery.
- The power of hope is recognized and valued.
- Person Centered Planning is the foundation of recovery.

Culture
- Recovery is part of our culture.
- Our culture identifies and operates consistent with recovery values.
- Everyone actively champions the cause of building recovery into the culture of NLCMH and promotes the recovery message.
- Organizational culture lives by key recovery values, embracing self-determination/individual choice, full partnership, people first, and growth potential.
- Transparency exists in all aspects of the service delivery system – shared knowledge, free flow of information.
- Recovery is embedded in all aspects of the NLCMH system – quality and strategic plans, policies, finance, etc.
- We are warm and welcoming and have inviting environments.

Partnership
- Providers and consumers are partners in care.
- Consumers play an active role in decision-making and responsibility for their recovery.
- Consumers and family members are full and equal participants.
- Consumers, families and the community are involved in design, administration, delivery, and evaluation of care.
- Consumer integration in all aspects of community membership is encouraged and supported (i.e., churches, clubs, schools, colleges, volunteering in nonprofit organizations such as Habitat for Humanity, etc.).
- Genuine opportunities to construct and maintain meaningful, productive and healing partnerships are available.
- Relationships and partnerships with faith-based communities are built.

Communication
- Recovery-based principles are promoted in the community.
- Communication is planned, continual and comprehensive and speaks to all audiences.

Driving Down the Details
- The system's major operations, be they clinical or managerial, support recovery values; e.g., a clinical process that values self-determination cannot coexist with a management process that values obedience and control.
- The system supports resilience rather than treats deficits.
- Every therapeutic intervention is guided by the ultimate goal of recovery as defined by individuals.
- Everyone (staff and providers, consumers, family members, community members) sees that case management is care coordination rather than "managing cases" and therefore should be available for all who need and want it.
- Stigma, discrimination, and stereotypes are eliminated – (impaired decision-making, dangerousness, belief drug dependence is solely volitional, the wrongful application of coercion, non-therapeutic clinical attitudes).
- Recovery blueprint is part of our ongoing Quality Improvement activity and will be reviewed annually by Recovery Council.
- We are committed to retaining and enhancing consumer directed services across counties in good and bad financial times.
- Recovery applies to children with serious emotional disturbances and their families. Their mental health needs are best met and enhanced through coordinated, community-based systems of care.
- Parents are partners in family-focused care for infants, children and adolescents. They are the experts on their family.

System Dimension 1: Design

Getting the Vision Right	Common definition and understanding of recovery across consumers, families, providers/staff and community. Excellent PCP process, based on the individuals' desires, drives support and/or treatment plans. Comprehensive array of services delivered in environments and a manner (warm, welcoming environment) that supports recovery and the individual's plan.
What we want to build is a system where…	• Mission includes recovery vision as driving the system. • Core set of needed services are identified for system (e.g., treatment, rehabilitation). • Care delivery is designed to support the Appalachian Consulting Group's Five Stages of Recovery and Dr. Anthony's 9 Essential Services (treatment, crisis intervention, case management, rehabilitation, enrichment, rights protection, basic support, self-help, wellness/prevention). • Care is experienced as: safe, effective, person-centered, timely, efficient, equitable – delivered in natural or community settings to extent possible. • Consumers clearly feel they have a number of things they can choose from for treatment and supports. • Staff feel empowered and excited about their work, with support to build the competencies and capacity to be most effective, the best they can be. • Evidence-based and promising practices are researched, implemented and strengthened • Certified Peer Specialists and other peer-operated services as well as other provider services are available in sufficient capacity to meet anticipated consumer demand. • More support groups and consumer business enterprises are available. • Locally-based models of recovery (pilot demonstrations) serve as learning environments for consumers, families, staff and providers. Fidelity is modeled across programs.

Action Steps	Leads	Timelines
Evaluate existing delivery system to present recommendations for improvements including possibility of redesigning services around the stages of recovery.	Greg Paffhouse, Val Bishop and workgroup	Seat workgroup; evaluate after first REE is complete, on hold from state
Identify assessment tool for staff to use to examine individual programs from staff perspective	Greg Paffhouse, Val Bishop and Mary Beth Evans	Achieved 8/08 (REE)
Examine individual programs' underlying values for compatibility with recovery principles, and recommend improvements.	COOs, Program supervisors, Program Directors and Recovery Coordinator Mary Beth Evans	On hold from state
Select an instrument to measure individual program compatibility with recovery principles.	State Recovery Council members and partners	Achieved (REE)
Review FY '09 block grant in regard to Recovery Course Catalog and further conceptualize, design and develop a contextual model of the Recovery education program.	Mary Beth Evans, Recovery Council and designated steering team	Achieved, improvements ongoing
Launch beginning Recovery Center activities including Virtual Recovery Center blog, and continue Anti-Stigma activities.	Greg Paffhouse, Val Bishop, Deb Freed and Mary Beth Evans	Achieved
Seat volunteer workgroup to plan for further expansion of Virtual Recovery Center blog.	Val Bishop and Mary Beth Evans	Seat group 5/1/08 Ongoing
Finalize work plan and budget for Anti-Stigma and Recovery block grants.	Greg Paffhouse, Val Bishop, Cindy Petersen	Achieved
Identify what is needed to address holistic wellness and propose changes to improve performance.	Greg Paffhouse, Val Bishop, Mary Beth Evans, Recovery Council	Achieved and ongoing
Make Pathways to Recovery curriculum available in all offices.	Val Bishop, Barb Quinn, Peer Support Specialists	SE – Achieved NW – Achieved 3/1/08
Develop a strategy for WRAP in all offices.	Mary Beth Evans	Achieved

Who should be involved	Consumers, families, providers/staff, NLCMH Board members
Barriers	Potential that some key staff don't support recovery. Make sure that individuals and groups have authority to make things happen.

System Dimension 2: Evaluation

Getting the Vision Right	A personal and system-level ongoing process that is simple, reliable, and consumer-driven, describing both formal and informal evaluation of an individual's progress toward quality of life and including their current hopes and dreams.
What we want to build is a system where…	• Primary consumer outcomes identified for each service are measurable and observable (e.g., number of crises, percentage of people employed) • Consumer and family measures of satisfaction are included in system evaluation. • Recovery is evaluated both for the system and the individual; evaluation is aligned with MDCH recovery and satisfaction measurement(s) and CARF accreditation requirements; and in addition promotes local evaluation. • High quality data is generated which yields information that is reliable, accurate, valid, complete and drives decision-making. • Personal accounts and recovery successes/challenges are included in the assessment of an individual's progress toward quality of life. • Hope is evaluated (i.e., Hope Scales).

Action Steps	Leads	Timelines
Develop a recovery evaluation plan and methodologies which are coordinated with MDCH outcome measurement initiatives and considers working with outside consultant(s), including: • Develop measures for individual consumers, individual practitioners, and organizations. • Develop measures that include baseline and ongoing measurement. • Link the measures to governance Ends policy. • Develop toolkit for the evaluation of programs to determine the degree to which programs reflect recovery values, practices and outcomes (program plans). • Train stakeholders including consumers, family, provider/staff in the use of tools used in evaluation. • Develop a plan to share information with intended recipients.	Dave Branding and Recovery Council	Completed preliminary draft recovery evaluation plan including bullet points – on hold by state (REE).
Adopt and utilize information from a single application for services across our service area that promotes Ends evaluation.	Greg Paffhouse, Val Bishop, Mary Hubbard, Barb Quinn, Dave Branding and Keith Huggett	Initial first draft welcoming packet completed for review. 1/1/09
Develop electronic data capacity to support recovery evaluation plan.	Keith Huggett and Dave Branding	10/1/08 – on hold from state (REE)

Who should be involved	Dave Branding, Recovery Council, consumer and family participation, Information Systems staff, other providers/staff, MDCH
Barriers	Time and resources

System Dimension 3: Leadership

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Paving the way to recovery by:
Providing and reinforcing a constant recovery vision;
Guiding, advocating, educating and communicating;
Staying committed until recovery becomes a part of who we are;
Shared leadership with those who have a true commitment and belief of recovery with sincere empathy for “walking the walk” and “talking the talk” of recovery;
All being change agents who demonstrate through words and action, our new direction towards recovery.</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• Leadership constantly reinforces recovery vision and recovery system standards.
• Leaders develop vision, passion, courage, and willingness to take on the challenge of leadership along with the risk and responsibilities that comes with being a change agent.
• Recovery leaders, through their words and actions, are the change agents for system transformation.
• Recovery leaders contribute to development of a shared recovery vision, commit to this vision, and commit to helping create an organizational culture that tries to live by key recovery values, including self-determination/choice, full partnership, people first, and growth potential.
• Leadership ensures commitment to and sustainability of our recovery values and vision and works to eliminate barriers to care to reduce the burdens on consumers and providers
• We participate in, show leadership on, and learn from state and affiliation activities and apply concepts learned in NLCMH operations; i.e., MDCH Recovery Council, Improving Practices Leadership Team.
• Our recovery blueprint continues to evolve over time.
• People receiving services have the right, responsibility and authority to control the resources associated with their services.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Review Board Governance Policy 1-1-01 Consumer and Community Ends to ensure commitment to recovery is present.</td><td>Board of Directors</td><td>Achieved</td></tr>
<tr><td>Present recovery blueprint to Executive Team for discussion and support including change management as defined in System Dimension 13.</td><td>Greg Paffhouse</td><td>Achieved</td></tr>
<tr><td>Finalize Appalachian Consulting Group contract and scope of work.</td><td>Greg Paffhouse and Val Bishop</td><td>Achieved</td></tr>
<tr><td>Determine size, composition, membership and responsibilities of the Recovery Council.</td><td>Greg Paffhouse, Val Bishop and Mary Beth Evans</td><td>Achieved</td></tr>
<tr><td>Seat Recovery Council and hold first meeting</td><td>Greg Paffhouse, Val Bishop and Mary Beth Evans</td><td>Achieved</td></tr>
<tr><td>Present concept of Learning Community.</td><td>Greg Paffhouse and Mary Beth Evans</td><td>Achieved</td></tr>
<tr><td>Develop Learning Community curriculum and hold initial Learning Community meetings</td><td>Mary Beth Evans and Val Bishop</td><td>Achieved</td></tr>
<tr><td>Define, interview, hire and train a primary consumer as Recovery Coordinator to carry out recovery initiatives in partnership with Recovery Council.</td><td>Greg Paffhouse and Val Bishop</td><td>Achieved</td></tr>
<tr><td>Evaluate existing system including The Standards Group and MDCH regarding self-determination to present recommendations to establish arrangements.</td><td>Dave Branding and Mary Beth Evans</td><td>7/1/09</td></tr>
<tr><td>Who should be involved</td><td colspan="2">• We would like many leaders and need administration to be responsible and accountable for making decisions that remove barriers, support recovery and ensure resources are available.
• Shared leadership as change agents who are persuasive, hopeful and the mouthpiece of change.</td></tr>
<tr><td>Barriers</td><td colspan="2">Stigma—consumer/family/staff/community attitudes</td></tr>
</table>

System Dimension 4: Management

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Everyone part of NLCMH and all services purchased shall support, value and demonstrate principles that promote and expect recovery.
Management is responsible to adhere to the vision of recovery and ensure partnerships between the providers of services and supports and those who receive services
NLCMH will only employ and contract with providers who are committed to recovery values</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• System management, through system level policies and procedures, ensures that each individual service define itself by the unique process they use.
• Service protocols are developed and implemented so that the basic service processes are possible to monitor.
• MIS system collects information on service process and outcomes, ensuring access to data to drive recovery decision-making and promoting consumer success.
• Service programs are recovery friendly (i.e., procedures are compatible with recovery values)
• Assignment of service staff, to greatest extent possible, is based on competencies and preferences
• Excellent administrative, business support, and clinical services promote consumer and organizational success.
• Skill sets promote our recovery model; performance targets and performance-based job descriptions tailored for each position, with an incentive system to ensure that changes implemented take root
• Innovative strategies are developed to promote recovery
• Policies promote sharing of power, risk, and expertise and maximize the utility of existing resources
• Policies support recovery and the Five Stages of Recovery.
• Facilities are welcoming and support recovery and partnerships.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Develop a policy which defines recovery, building upon the recovery blueprint.</td><td>Recovery Council and Greg Paffhouse</td><td>11/1/08</td></tr>
<tr><td>Adopt recovery policy.</td><td>CEO (Greg Paffhouse)</td><td>1/1/09</td></tr>
<tr><td>Start to create a recovery-oriented environment (comfortable, involved, active, participating) by assessing for barriers and negative messages and make recommendations for initial improvements.</td><td>Mary Beth Evans and Recovery Council</td><td>Implementing!</td></tr>
<tr><td>Create recovery-oriented hiring practices, job descriptions, evaluations, training opportunities, including Five Stages training video and facilitator manual.</td><td>Tom Denton</td><td>Postings, ads, job descriptions achieved by 1/1/08.
Evaluations by 11/1/08.
Training opportunities in process.</td></tr>
<tr><td>Review administrative policies to determine if they are compatible with treatment and recovery and the role of peer support specialists as employees. Recovery is the filter through which policies are reviewed. Eliminate identified recovery barriers in policy.</td><td>Val Bishop and Mary Beth Evans</td><td>1/1/09</td></tr>
<tr><td>Develop and implement a strategy to educate workforce and consumers on the role and value of certified peer support specialists.</td><td>Val Bishop and Peer Support Specialists</td><td>Have done some work; work in progress.</td></tr>
<tr><td>Who should be involved</td><td colspan="2">Lead managers, recovery council, facility committee, consumers, family, and providers/staff.</td></tr>
<tr><td>Barriers</td><td colspan="2">Changing attitudes and “old” non-recovery oriented beliefs.</td></tr>
</table>

System Dimension 5: Integration

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Consistent with individual choice, people access treatment and support services necessary to help them make progress toward their individually desired outcomes (recovery).</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• The function of case management is expected to be performed for each consumer who needs or wants it.
• Planning process across services is standardized and guided by consumer outcomes.
• System integration strategies are developed and implemented to achieve specific consumer outcomes.
• Referrals between services include the service outcomes expected of service providers.
• Linkages across all systems are enhanced; including community mental health, physical health, housing, vocational, substance abuse, education, criminal justice, child welfare, faith based.
• Excellent person centered planning leads to a coordinated array of treatments and supports that may involve multiple agencies in a single plan of care.
• All people have more opportunities for life in the community.
• Consumers have genuine opportunities to construct and maintain meaningful, productive and healing partnerships with staff.
• All staff are knowledgeable and share with consumers about formal and informal community resources.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Adopt and implement a consistent Individual Plan Of Service form and person-centered planning process organization-wide.</td><td>COOs and Operations Managers</td><td>Fully implemented 9/1/08.</td></tr>
<tr><td>Define the most critical existing community resources to consumers and make a plan to collect, maintain and share information in 2-county clusters where currently unavailable.</td><td>Recovery Council (with input from Clubhouse/Drop-In Programs)</td><td>2/1/09</td></tr>
<tr><td>Identify who maintains directories of the most critical health and human service resources for staff referral purposes and make a plan to collect, maintain and share information with staff.</td><td>COOs/designees</td><td>Achieved and ongoing</td></tr>
<tr><td>Create a strategy to regularly collect via current consumer venues the gaps in community resources needed to support consumers.</td><td>Recovery Council</td><td>Achieved.</td></tr>
<tr><td>Prepare talking points to advocate for resources as identified above.</td><td>Communications and Public Relations Committee</td><td>3/1/09</td></tr>
<tr><td>Review and revise all existing community partner coordination agreements to ensure that they address recovery and identify other possible community partners.</td><td>Bill Slavin and Greg Paffhouse</td><td>Achieved.</td></tr>
<tr><td>Who should be involved</td><td colspan="2">All people are care coordinators….everyone is responsible and accountable – staff and providers, community partners, consumers, family members, community members.</td></tr>
<tr><td>Barriers</td><td colspan="2">Lack of clarity on dimension. Time and resources.</td></tr>
</table>

System Dimension 6: Comprehensiveness

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Consumer goals and opportunities are based on their hopes and dreams to include where they live, learn, work and socialize and the natural and agency supports they have or need to develop to support those goals. The criterion of recovery is that the individual, except for our individuality, is indistinguishable from others in the society in which he or she functions.</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• Consumer goals include functioning in living, learning, working, and/or social environments.
• Consumer goals include functioning in non-mental health environments, not controlled by the mental health settings (e.g., faith-based organizations).
• Consumer goals include outcomes from any of the identified services.
• A well-planned, coordinated array of treatments and supports, involving multiple agencies in a single plan of care, are delivered in natural settings where people are located (jail, housing sites, schools) to the extent possible.
• More affordable housing, community integration, employment, and natural supports are available.
• Technologies such as telepsychiatry, videoconferencing, email, etc. are used to increase access to services, supports, information and education.
• Capacity is present to address the broad range of treatment and support needs for all ages.
• There is seamless collaboration with community resources to enhance awareness, education and early intervention for mental health.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Design consistent consumer application for services to include all the life domains including residential, work, educational and social environments.</td><td>Greg Paffhouse, Val Bishop, Mary Hubbard, Barb Quinn, Dave Branding, Bruce Bridges and Keith Huggett</td><td>Initial first draft welcoming packet completed for review. 1/1/09</td></tr>
<tr><td>Review current assessments and revise if necessary to ensure that the life domains (residential, work, educational and social environments) are addressed.</td><td>COOs</td><td>1/1/09</td></tr>
<tr><td>Identify and prioritize contractual community partners who are necessary to support recovery within our communities.</td><td>Identification: Contracts Mgrs
Prioritization: Recovery Council</td><td>Identify 7/1/09
Prioritize 9/1/09</td></tr>
<tr><td>Identify and prioritize our community partners with coordination agreements who are necessary to support recovery within our communities.</td><td>Identification: Deb Lavender, Ken Brehmer and Katie Deller
Prioritization: Recovery Council</td><td>Identify 7/1/09
Prioritize 9/1/09</td></tr>
<tr><td>Identify and prioritize other community partners who are necessary to support recovery within our communities.</td><td>Recovery Council</td><td>7/1/09</td></tr>
<tr><td>Create strategies to strengthen relationships with partners identified above (jobs, housing, education, social, faith-based, physical health care) and assist them in promoting recovery principles.</td><td>Identification: Contracts Mgrs
Prioritization: Recovery Council</td><td>11/1/09</td></tr>
<tr><td>Ensure adequate Independent Facilitator capacity to accommodate individual preferences.</td><td>Julie Burke and Dave Branding</td><td>Achieved</td></tr>
<tr><td>Who should be involved</td><td colspan="2">Consumers and clinicians, peers, significant others and support people, independent facilitators, community partners (in jobs, housing, education, social, faith-based organizations, etc.)</td></tr>
<tr><td>Barriers</td><td colspan="2">We may have materials, but we don’t make sure people are aware of them and use them.
We need to update distribution of materials regularly.</td></tr>
</table>

System Dimension 7: Consumer Involvement

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Nothing about us without us! Consumer participation is expected and enhanced in all aspects of operations – design, administration, delivery, training and evaluation of care across our service area. Consumers are actively involved in promoting recovery in the community. The NLCMH system is based on consumer strengths, not deficits.</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• Consumers are actively sought for employment at all levels of the organization with expanded use of certified peer support specialists.
• User-controlled, self-help services are available in all geographic areas.
• Consumers and families are integrally involved in system design and evaluation.
• Network of consumers wanting to help change the system is created and supported.
• Staff and consumers partner together in planning for system change.
• Consumers are actively involved in anti-stigma (grant) activities such as: sharing their recovery stories through personal presentations, print, video, audio; selecting documentaries for public broadcast/events; serving as point people for facilitating public events; planning art shows featuring various art forms, etc; helping create presentations for a variety of venues (see grant for more ways).
• Consumers are informed/educated about treatment and supports to help them make informed choices.
• There is a focus on self-care/management and self-advocacy (consumers and family members need to identify the education, training, orientation, and supports they need to be effective in this role).
• Consumers unlearn the “patient role” and adopt “person first” participation.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Write a general “consumerism” guideline, incorporating ideas such as:
• how consumers and family may become involved,
• ways to recruit and collect contact information.
• a process by which consumers can be fully involved in ongoing planning, review and evaluation of their progress, including satisfaction. (May include co-authoring progress notes, etc.)
• training of consumers and family members about committee membership</td><td>Greg Paffhouse, and short-term work group of staff and consumers to be appointed by CEO (Greg Paffhouse)</td><td>To be completed by 4/1/09</td></tr>
<tr><td>Write an employment “consumerism” guideline, incorporating ideas about employing peers, such as:
• accommodations, orientation and training for successful employment;
• evaluation of roles where peers could enhance services, including person-centered planning, welcoming/providing support, education and comfort at point of access;
• assessment of needs and capacity;
• use of peers (paid and non-paid) to act as mentors and to encourage others to explore their hopes and dreams;
• continued education requirements.</td><td>Val Bishop, Tom Denton and short-term work group to be appointed by CEO</td><td>To be completed by 7/1/09</td></tr>
<tr><td>Develop job description for peers providing Peer Support Specialist services.</td><td>Val Bishop and Peer Support Specialists</td><td>Achieved</td></tr>
<tr><td>Identify consumers interested in becoming the leaders for identification, creation and promotion of holistic wellness (i.e.: nutrition, smoking cessation, exercise, self-care).</td><td>Mary Beth Evans and Learning Communities</td><td>In process.
7/1/09</td></tr>
<tr><td>Who should be involved</td><td colspan="2">Consumers, peer support specialists, provider staff, family members, administration, key community members.</td></tr>
<tr><td>Barriers</td><td colspan="2">Competing priorities</td></tr>
</table>

System Dimension 8: Cultural Relevance

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Everyone has access to treatment and supports that promote recovery within the context of their culture.</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• Assessment, planning, and services interventions are provided in a culturally competent manner.
• The knowledge, skills, and attitudes of personnel enable them to provide effective care for the culturally diverse populations that might wish to use the system.
• Settings, programs, and services are accessible and responsive to ethnic, cultural, and linguistic differences reflective of our communities; e.g., rural population, Native American and Hispanic communities, poverty.
• Broad cultural representation in transformation activities is included.
• Informational materials consider the needs of people beyond race and ethnicity, e.g., sign language.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Review curriculum available in Essential Learning modules and identify if additional training is necessary or desirable for NLCMH employees.</td><td>Tom Denton, Staff Development Training committee and possible community volunteers</td><td>Achieved</td></tr>
<tr><td>Explore current local curriculum initiatives, and opportunities to partner with local Native American community for possible development of an Essential Learning course unique to our local needs as well as potential for making this available to contract providers in another medium.</td><td>Cindy Petersen</td><td>7/1/09</td></tr>
<tr><td>Identify and build strategic relationships and coalitions with the various cultures in our area.</td><td>PIHP Network Administration (Terri Kelty and Dick Osburn)</td><td>10/1/09</td></tr>
<tr><td>Schedule a meeting with migrant clinic staff to discuss mental health service needs and a possible role for NLCMH.</td><td>Greg Paffhouse</td><td>4/1/09</td></tr>
<tr><td>Review current information on interpreters, identify gaps, create a plan to address gaps.</td><td>Julie Burke</td><td>Achieved</td></tr>
<tr><td>Communicate information about interpreter availability among provider network.</td><td>Bill Slavin and Rosemary Rokita</td><td>Achieved</td></tr>
<tr><td>Who should be involved</td><td colspan="2">Peer support specialists, Grand Traverse Band, migrant offices, customer services, contractual specialists.</td></tr>
<tr><td>Barriers</td><td colspan="2">Competing priorities</td></tr>
</table>

System Dimension 9: Advocacy

Getting the Vision Right	Voice of consumers and family members is heard, valued and provides impetus for change. Create a community of full inclusion where recovery is the expectation. It doesn't happen unless it's everyone!
What we want to build is a system where…	• Consumers and potential consumers are seen as people first. • Consumers have the opportunity to participate in community roles. • Everyone understands that all people have the potential to recover. • Communities recognize that persons with mental health conditions are valuable and contributing members of society. • Stigma is reduced, and there is positive movement in public perception and attitudes about people with mental illness. • A network of consumers trained in public speaking and willing to share their stories with the public is created and supported. • The general public has opportunities to have direct contact with people with mental illness, and to participate in mentoring programs (both peer-to-peer and business professional-to-consumer). • Anti-Stigma and Recovery grant goals are achieved and sustained, i.e., speaker's bureau, art classes. • Decision-making support is provided to consumers, including peer support and advance directives. • Schools and universities collaborate with NLCMH on recovery education.

Action Steps	Leads	Timelines
Outline potential elements to be included in an advocacy plan. Topics that may be considered are promotion of community inclusion, workforce, housing, volunteer opportunities that demonstrate consumers' positive contributions to the community.	Consumer Advocacy Council (CAC)	Achieved
Develop advocacy plan which involves consumers and families to be self-advocates and promotes recovery in the community.	Mary Beth Evans, Recovery Council, Greg Paffhouse and Val Bishop, Cindy Petersen	4/1/09
Develop a presentation using the Ambassador Training material.	Cindy Petersen and CPR Committee	Achieved
Develop recovery community presentation.	Greg Paffhouse, Val Bishop and Appalachian Group	2/1/09
Create in-depth recovery course with course objectives and readings using recovery training video.	Val Bishop and Mary Beth Evans	12/1/08
Approach faculty leads at our colleges and universities about including recovery units in their existing courses.	Cindy Petersen	Have started. 1/1/09
Advocate with MDCH so that college credits received for peer support training are transferable to other college/university settings in our service area.	Greg Paffhouse	Achieved. 3 credits at Lansing Community College for Peers available.
Implement Anti-Stigma block grant action plan.	Cindy Petersen and CPR Committee	Implementing!

Who should be involved	Consumers, families, staff, administration, board members and business and other community leaders.
Barriers	Need to clarify Consumer Advocacy Council interest in being Lead in advocacy plan development.

System Dimension 10: Training

Getting the Vision Right	• "Core knowledge," competency and capacity of the workforce about recovery is established. • A "virtual" Recovery Center staffed by consumers with a core recovery curriculum that can be taught anywhere across the service area with a goal to evolve into a consumer-operated array of classes – participants would mostly be primary/secondary consumers and could include college students.	
What we want to build is a system where…	• All levels of staff understand recovery vision and its implications within service categories. • Selection and training methods are designed to improve knowledge, attitudes and skills necessary to conduct the particular service that staff is implementing. • Training is designed so that delivery of specific services is improved. • Consumers are trained in recovery through various means (including the Recovery Center) to apply recovery principles and methodologies– to include classes, workshops, forums, learning groups and support groups. • Screening, diagnosis, assessment, and skills in writing goals and objectives are enhanced. • Providers understand their recovery facilitation role. • There are opportunities for continuing education, enhanced skill development and/or specialty skill designations for peer support specialists.	
Action Steps	**Leads**	**Timelines**
Review and revise Training Plan to include recovery as a mandatory staff training for all staff.	Tom Denton	12/1/08
Design recovery training video for staff, providers and independent facilitators.	Appalachian Group, Val Bishop, Greg Paffhouse, consumers, Deb Freed	Achieved 4/1/08
Develop Recovery 101 course objectives (e.g., utilizing recovery stories, recovery statements/definition, WRAP curriculum.)	Val Bishop, Mary Beth Evans, Recovery Council, Learning Communities, Deb Freed and Cindy Petersen	Have started. 1/1/09
Develop a recovery training plan for consumers, staff and contractual providers.	Tom Denton, Val Bishop, Mary Beth Evans and Bill Slavin	12/1/08
Provide all NLCMH staff the updated Member Handbook with training opportunities to review and discuss.	Julie Burke	Achieved 12/1/07
Build NLCMH capacity to provide WRAP facilitators in all offices	Val Bishop	Achieved.
Provide for immersion learning about recovery; e.g., The Village in Los Angeles, University of Kansas.	Val Bishop and Greg Paffhouse	Achieved 11/1/07
Assess value of possible external training and certification programs for NCLMH staff; e.g., Boston University psychosocial rehab training/certification, USPRA (U.S. Psychiatric Rehabilitation Assoc) Certified Psychiatric Rehabilitation Practitioner certification.	Mary Beth Evans, Val Bishop and Tom Denton	Assessed value and determined not feasible at this time.
Who should be involved	Recovery Council members, Recovery Coordinator, consumers, families, board members, staff, providers, community stakeholders (schools, DHS, law enforcement, judicial, faith based, etc.)	
Barriers	Involves many people and will need to be well coordinated. Time lines dependent on other action steps.	

System Dimension 11: Funding

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Funds are prioritized to those treatments and supports that are aligned with a recovery-oriented system of care.</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• Dollars across services are expended based on the consumer’s recovery goals as specified in the individual plan of service.
• Funding directly supports the processes and outcomes that the system is designed to achieve.
• Individual budgets, consumer control of budgets, and consumer choice is promoted.
• Multiple sources of financing provide flexibility to pay for effective mental health treatments and services.
• In our role as clinical service purchaser increased weight is given to quality, outcomes, commitment to recovery and use of evidence-based practices.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Review FY 08 federal block grant budget and revise as needed.</td><td>Greg Paffhouse, Val Bishop, Cindy Petersen and Bruce Bridges</td><td>Achieved</td></tr>
<tr><td>Finalize a plan to sustain commitments made for the recovery and anti-stigma block grants that are prioritized to continue beyond the grant.</td><td>Greg Paffhouse, Val Bishop, Cindy Petersen and Bruce Bridges</td><td>Achieved. Plan to sustain in place.</td></tr>
<tr><td>Develop model or plan on how incentives (monetary and non-monetary) could potentially be used to facilitate and support recovery-based practices by staff and contract providers.</td><td>Greg Paffhouse, Bruce Bridges, Tom Denton and Barb Quinn</td><td>10/1/08</td></tr>
<tr><td>Identify and contract with fiscal intermediaries.</td><td>Dave Branding and Greg Paffhouse</td><td>Achieved</td></tr>
<tr><td>Identify and pursue external funding sources to help build and sustain recovery efforts.</td><td>Greg Paffhouse and Val Bishop</td><td>Have started and ongoing.</td></tr>
<tr><td>Who should be involved</td><td colspan="2">Through advocacy many have a role in helping to assure continued funding. Key role for staff with board member, community, and consumer input.</td></tr>
<tr><td>Barriers</td><td colspan="2">Block grant is for two years only. Continued risk for reduction in base funding.</td></tr>
</table>

System Dimension 12: Access

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Persons seeking initial services experience a welcoming environment where there is an expectation of recovery.
Access to services is individualized based on consumers' vision of a meaningful life. Access to services and supports is accomplished through listening and engaging consumers in self-direction.</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• Access to service environments is by consumer preference rather than professional preference.
• Access to service environments is not contingent upon using a particular mental health service.
• Access to living, learning, working and social environments outside the mental health system is expected.
• Access is simple and options are easy to understand.
• Persons are well informed of available services and encouraged to choose services consistent with their desired outcomes.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Study and potentially revise access policy/process to be more consumer friendly and welcoming.</td><td>Workgroup of Access staff and Recovery Council</td><td>2/1/09</td></tr>
<tr><td>Present demand and capacity report to the Recovery Council for input on adequacy of capacity.</td><td>Bill Slavin</td><td>1/1/09</td></tr>
<tr><td>Examine and make recommendations about utilizing the most promising technologies to increase access, i.e., video conferencing, emerging technologies, email, etc.</td><td>COOS and Keith Huggett</td><td>Achieved and ongoing</td></tr>
<tr><td>Examine and make recommendations about utilizing emerging practices such as Pat Deegan's University of Kansas Peer Controlled/Friendly Access.</td><td>Val Bishop and Mary Beth Evans</td><td>Visit achieved.
Recommendations by 1/1/09</td></tr>
<tr><td>Who should be involved</td><td colspan="2">Consumers, staff (inc. reception, access), community leaders, family members, recovery council, Improving Practices Leadership Team, etc.</td></tr>
<tr><td>Barriers</td><td colspan="2">Competing priorities</td></tr>
</table>

System Dimension 13: Change Management

<table>
<tr><td>Getting the Vision Right</td><td colspan="2">Change is desirable, predictable and manageable.
Consistently commit to change and hold accountable.
Measure and celebrate successes.
Sustain the quality of services while the change is occurring.</td></tr>
<tr><td>What we want to build is a system where…</td><td colspan="2">• System transformation truly occurs as a result of our change efforts and recovery change plan.
• The NLCMH culture is one of optimism.
• Change is accepted at the individual, unit and organization level.
• NLCMH is recognized as a model for state/national systems change.
• Our skilled and dedicated workforce is a valued partner in our change effort.
• Our commitment to change is unwavering.
• We share a clear, inspiring and achievable picture of the future we are trying to create.</td></tr>
<tr><th>Action Steps</th><th>Leads</th><th>Timelines</th></tr>
<tr><td>Create a steering committee to broadly oversee overall organization system transformation.</td><td>Greg Paffhouse</td><td>7/1/08</td></tr>
<tr><td>Designate a group dedicated to system transformation on mental health recovery.</td><td>Greg Paffhouse, Val Bishop, Mary Beth Evans, Deb Freed, Barb Quinn, Barb McNitt</td><td>Achieved</td></tr>
<tr><td>Produce periodic reports on the status of all recovery system change activity.</td><td>Greg Paffhouse</td><td>Achieved first 4/1/08. Next will be June 2008, September 2008, and December 2008</td></tr>
<tr><td>Make a decision regarding benefit of consultant relationship to support change management/system transformation and the work of the steering committee.</td><td>Steering Committee</td><td>1/1/09</td></tr>
<tr><td>Develop a plan for each of the eight steps for leading successful change: 1) Increase urgency (need for change); 2) Build guiding teams; 3) Get the vision right; 4) Communicate for Buy-In; 5) Enable action; 6) Create short-term wins; 7) Don't Let Up; and 8) Make it Stick.</td><td>Steering Committee</td><td>4/1/09</td></tr>
<tr><td>Create measurement tools, timelines and expectations for periodic assessments regarding status and communication thereof.</td><td>Steering Committee</td><td>4/1/09</td></tr>
<tr><td>Monitor progress and when obstacles are encountered, refer to appropriate parties for solution.</td><td>Steering Committee</td><td>ongoing</td></tr>
<tr><td>Who should be involved</td><td colspan="2">Consumers, providers/staff with Greg Paffhouse, Deb Freed, Val Bishop, Mary Hubbard and Barb Quinn leading the way</td></tr>
<tr><td>Barriers</td><td colspan="2">Change management expertise and competing priorities</td></tr>
</table>

Background Information from Anthony

Essential Services in a Recovery-Oriented System – Used in Design Dimension		
Service Category	**Description**	**Consumer Outcome**
1) Treatment	Alleviating symptoms and distress	Symptom relief
2) Crisis intervention	Controlling and resolving critical or dangerous problems	Personal safety assured
3) Case Management	Obtaining the services consumer needs and wants	Services accessed
4) Rehabilitation	Developing consumers' skills and supports related to consumers' goals	Role functioning
5) Enrichment	Engaging consumers in fulfilling and satisfying activities	Self-development
6) Rights protection	Advocating to uphold one's rights	Equal opportunity
7) Basic support	Providing the people, places, and things consumers need to survive (e.g., shelter, meals, health care)	Personal survival assured
8) Self-help	Exercising a voice and a choice in one's life	Empowerment
9) Wellness/ prevention	Promoting healthy lifestyles	Health status improved

Assumptions About Recovery	
Factors/Items	**Reasons**
1. Recovery can occur without professional intervention.	Professionals do not hold the key to recovery; consumers do. The task of professionals is to facilitate recovery; the task of consumers is to recover. Recovery may be facilitated by the consumer's natural support system.
2. A common denominator of recovery is the presence of people who believe in and stand by the person in need of recovery.	Seemingly universal in the recovery concept is the notion that critical to one's recovery is a person or persons in whom one can trust to "be there" in times of need.
3. A recovery vision is not a function of one's theory about the causes of mental illness.	Recovery may occur whether one views the illness as biological or not. The key element is understanding that there is hope for the future, rather than understanding the cause in the past.
4. Recovery can occur even though symptoms reoccur.	The episodic nature of severe mental illness does not prevent recovery. As one recovers, symptoms interfere with functioning less often and for briefer periods of time. More of one's life is lived symptom-free.
5. Recovery is a unique process.	There is no one path to recovery, nor one outcome. It is a highly personal process.
6. Recovery demands that a person has choices.	The notion that one has options from which to choose is often more important than the particular option one initially selects.
7. Recovery from the consequences of the illness is sometimes more difficult than recovering from the illness itself.	These consequences include discrimination, poverty, segregation, stigma, and iatrogenic effects of treatment.