MIFAST Review Notes 7-20-17

1. Reviewer Report on experience-
    a. Mara shadowed another agency team so saw team from Adm/Staff and MIFAST sides; found agreement on scores or easy to agree; learned about new resources; SAMHSA MIStep-stage matched to increase IDDT practice-send, no credentialed SA specialist on either Lincoln Behavioral Health ACT Teams, will have 2-3 consultative phone calls for staging non-responders; high ACT score, mid IDDT score-expectation that addressing IDDT will also enhance ACT score
    b. Lena reported very similar experience; would be handy to have tools present
2. Laura wonders about schedule for reviews, process to sign up, master place for reviewers to access?

OTHER Discussion-ask for demonstration capacity in providing multiple county ACT services

1. Memo re bundled ACT for reviewer support in TA in ACT –sent earlier
2. CPSS 'on-call' for 24/7 service availability in ACT discussion:
    Mara: con
    a. Out of scope of practice (no official 'scope' document but scope well described
    b. Same problem w para w/o BS SW
    c. w/ para using specific documented training
    d. peers handle daytime crisis as regular part of team
    e. but service high level crisis situation? Would expect peer to immediately forward or get advice/support from authorized professional and professional to sign off on incident
    f. we do this w/all new staff-until confidence/training/supervision for work 'in the moment'
    g. need practice and written policy spelling out concerns of what can and should happen

    Roberta: con
    a. nature of crisis intervention means nature is unknown
    b. not a chat line and liability is tied to crisis
    c. Peers have no advanced training and if something negative happens it is on the organization

    Virgil: pro
    a. Off front line, but wonders what the 'certification' for peers means; a full team member, but not clinically credentialed
    b. His review of documentation indicates that peers may handle crisis better than the other team members because of lived experience
    c. Case managers should be trained in crisis because he sees more CM on Michigan teams than LMSW
    d. Recommends weekly of bi-monthly calls until issues like this are worked through

    Stephanie: con
    a. No peers on call and certain other team members don't take on-call for a variety of reasons
    b. Some peers have been trained in crisisLaura: con
    a. No peer on team on call; sometimes could be very qualified to do it; no black and white
    b. Peers & para both 'certified' both capable to deal w/ issues if chosen on a case by case basis for abilities

Other discussion:

Mara-credentials to deal with 'crisis' on-call doesn't seem to be anywhere; credentialed for therapy, group, cm, etc.; Mara looked at IL, MN and NY and very unclear

Virgil-specifying for peers would be a state, system, network, agency change of expectations and change the entire system; noted use of MI Strength model as pro-active

Tim-CPSS not trained; hospital screens, etc.

John Moir- define CPSS scope of practice clearly

Stephanie is involved with multiple State Centers of Excellence and will seek further information.

Other issues: voluntary/non-voluntary on call; need more 'psychologically' solid staff;

Steve noted stress/potential for re-traumatization, isolated, working alone; agencies need a mechanism in place to deal with traumatic events to everyone-including staff; Steve noted in his Trauma reviews agencies don't embrace this and it is an agency responsibility; Amy has no questions; Sheila con for on-call peers