Michigan Association of Community Mental Health Boards

SUMMER 2017

Connections

for communities that care

COMMITTED TO INNOVATION, RESILIENCE, AND THE BEST OF OUR TRADITIONS

Robert Sheehan, CEO, Michigan Association of Community Mental Health Boards

As you may have heard, the Michigan Association of Community Mental Health Boards (MACMHB) will be changing its name later this year, expanding its affiliate membership to include a rich diversity of organizations and individuals who ally with our association's mission and those of our members. These changes are symbolic of much of what defines our association, its membership, and its values. Symbolic of our commitment to innovation, to resilience in the face of ever changing environment (both opportunities and threats), and to the vision of the community mental health movement.

Born out of the community mental health movement and the signing, by President Kennedy, of the federal Community Mental Health Act, Michigan's system was a community based system of care from its inception. When called on, by the federal government with funding under the CMH Act, to design and operate a community-based mental health services system, Michiganders, in communities across the state, designed and built such a system. When called to adapt this system to serve as a service network to allow tens of thousands of Michigan's residents to leave the isolation of the state's psychiatric hospitals and developmental disability centers and return to their home communities, our system responded. When called upon to innovate, our system championed, refined and implemented a wide range of evidence-based practices (EBP) – from trauma informed practices to family psychoeducational practices, from dialectical behavioral therapy to medication assisted treatment – EBPs that ensured that high quality research-based care was woven throughout the public service delivery system. When the state converted its Medicaid system, statewide, to a managed care system, our CMH system stepped up and took on the role of managing the state's Medicaid mental health services for adults, adolescents, and children; services to persons with intellectual/developmental disabilities, and persons with substance use disorders—making it the only state in the country managing the Medicaid benefit for all of these populations. The success of this partnership with the State of Michigan is underscored in the development of the broadest array of innovative community-based services in the country and the proven ability to control Medicaid costs and sustain that cost control every year since taking on that role in 1998.

Whether the call was for ensuring that safe and affordable housing is available for persons with behavioral health or intellectual/developmental disability (BHIDD) needs, or that community-based employment and educational opportunities existed for persons with BHIDD needs were available, or school-based BHIDD services were needed to support the academic performance of students with BHIDD needs, we were there in designing and implementing a wide range of cutting edge initiatives. From responses to the emerging needs of pre-school children to the opioid crisis, from responding to the needs of the growing segment of our community's populations made up of seniors, our system was there.

Most recently, when healthcare providers, payers, and policy makers have come to recognize the value of healthcare integration, our system took the lead in communities across the country in implementing hundreds of integration and coordination efforts between the CMH, PIHP, and provider members of our association and the primary care providers and hospitals in those communities. Our system does not simply talk about integration. Our system gets to work in making integration happen.

The changes in which our association will be undergoing recognize our system's commitment to innovation and change while remaining equally committed to the traditions of our movement, the community mental health movement. The new name and broadened membership will underscore that, in the midst of all of this innovation and in our system's ability to respond to an ever changing environment (both opportunities and threats), our system has never forgotten our roots in the community mental health movement – a civil rights movement in every sense of the word. A movement that is grounded in the commitment to the dignity of the person and to each person's right, regardless of ability or disability, to self-determination, full citizenship, community inclusion, and equality of opportunity.

We look forward to taking on the challenges that lie ahead, the innovations that our association and system will lead, and our continued commitment to the deep roots, proud traditions, and value-based core of the community mental health movement. ■

PRIMARY AND MENTAL:

TWO COMPONENTS OF HEALTH

Clint Galloway, Editor

The current healthcare debate, now referred to as "sections 234/ 298" is focused on the administration of one segment of our systems of care. Who is better equipped to manage the system of care for individuals manifesting behavioral health symptoms?

Robert Sheehan, CEO of the Michigan Association of Community Mental Health Boards, in an article he recently penned cites the innovation, resilience, and the best of our traditions accomplished in the last 50 years of the Community Mental Health movement, a state-wide collaborative effort to build a system of care for these individuals. Given the severity of the symptoms and sheer number served, the accomplishments are incredible. However, due in large part to the stigma attached to the symptoms of behavioral health, those achievements remain largely invisible to the general public.

Another critical factor is that effective treatment in behavioral healthcare invariably requires the inclusion of others. Relationships lie at the heart of our mental wellbeing. Our community becomes the locus of healing. You will not see an impressive "Medical Mile" (Grand Rapids, Michigan Avenue) emerge to treat behavioral health because our neighborhoods are the treatment rooms. Effective treatment for behavioral health requires an enormous leap in addressing the complexity that has its origin in the *infinite qualitative difference* between the mind and the brain. This categorical distinction is the proverbial elephant that needs to be recognized, not only in the legislative assemblies attempting to provide for the basic needs of the most vulnerable citizens, but also in the administrative systems that have evolved to manage services, as well as the settings that have been developed to heal.

Until this complexity is acknowledged and addressed, health care will be seriously compromised. "Health" comes from the Greek word (hugiés) meaning sound, whole, healthy. "Community Mental Health," three distinct words, capture the indispensable components of being whole; as such it requires the inclusion and management of unique skill sets. Integral systems of care, *yes!* Reductionist principles of management and practice, *no!* The mantra for quality that embraces both the effectiveness and efficiency of practice in health care is "transcend and include."

Change: *What Does It Take?*

Al Condeluci, PhD

CEO, Community Living and Support Services

I chose a career in Human Services because I wanted to help people be more included in the greater community. Growing up I witnessed how people treated my cousin Carrie, who had Downs Syndrome, and although she was a natural part of our family, often the greater community members treated her in negative and distantiated ways. These negative behaviors prompted me to go into the field.

When I started graduate school of social work at the University of Pittsburgh we talked about being "change agents," and I took the moniker to heart. Initially, I was taught that the change that was needed for Carrie to be accepted rested more with how she functioned and behaved. The manifestations of her Downs Syndrome suggested that she needed to learn things so she would behave more "normally" to fit into the community.

After years of trying this route it became clear to me that the change that was needed did not lie with Carrie, but rested more in the behaviors of the greater community. This kind of change we call "macro change", it is much more challenging and difficult to realize. It demands a shift in thinking and moving outside of the box.

This kind of change starts with a recognition that seems to defy that which seems clear. It is captured in a quote I recently saw attributed to Henry Ford. He said, "The light bulb was not the result of continuous improvement of the candle." This quote suggests that meaningful change might require that we move to another platform, adopting a different perspective of the world.

Einstein famously said, "The problems we face today cannot be solved with the same level of thinking that created them." Both of these quotes suggest a paradigm shift, moving beyond what seems obvious to a better, more evolved perspective. People in the greater community see disabilities as the problem, when, in fact, the real problem might be their attitudes.

So the next time you are looking at a problem that needs to be solved or a change you believe needs to occur, look again. Stand back and be sure you have the complete picture. It might be that the solution lies in another place.

Community Living and Support Services (CLASS), a community based support system for individuals with all types of disabilities is located in Pittsburgh, PA. Dr. Condeluci serves as a consultant and collaborator, and lectures extensively around the country often on material from his books. To learn more, visit: www.alcondeluci.com

Integration of Physical and Behavioral Health for Persons with IDD

Paul Newman, LMSW, Chief Operating Officer
Community Living Services, Inc.

Michigan has progressed a long way from institutionalizing persons with intellectual and developmental disabilities (IDD) to providing supports to live and work in the community. Much of the information being shared today in research articles, best practices and recommendations regarding the need for the integration of physical health with behavioral health lacks specificity and it is unclear about how it will impact people with IDD. Much of today's discussion about integration concerns people who are not seen by a physician or by behavioral health agencies. But, according to National Core Indicators data, the most recent adult consumer survey (2015-2016) indicates that 97 percent reported that they had a primary care doctor. It was as high as 99 percent in 2011-2012. These surveys demonstrate that persons with IDD have established long lasting relationships with primary care physicians and specialists. It is not unusual for those same physicians to have followed that person since early childhood. This article will highlight some of Michigan's past, compare that to the present and provide some recommendations on how to proceed into the future. This is critical given integrated health care funding and service delivery models are being evaluated with specific considerations for individuals with IDD.

A Brief History of the Original *"One Stop Shop"* Institutions

In Michigan, more than 30 years ago, medical professionals advised parents to send their loved ones with IDD away in institutions where they would presumably be safe and receive good care. All medical and behavioral health services were to be provided in the institution. Unfortunately, people who were institutionalized did not receive the health care, training, and basic safety that were expected. A concerned group of parents and advocates had discovered daily abuse and neglect were happening behind those closed institutional walls. For "convenience and efficiency," people were not treated with dignity and were:

- Bathed together in large rooms with staff hosing them down,
- Provided congregate meals at pre-set times, no individual selection, and with the cheapest, low-quality food,
- Routinely left in isolation and with no social or physical activity,
- Placed on hard, cold floors often scantily clad or wearing rags.

Additionally, medical and behavioral health providers did not deliver quality or, sometimes, any care. The hospitals and cemeteries were located on the grounds of the institutions. Deceased individuals were interred with only a small stone marked with his or her case number. At one time there were 13 state institutions for people with IDD in Michigan with about 14,000 people residing in them. Those individuals were essentially incarcerated with their only crime being their disability.

Often each institution "specialized" in the treatment of a different type of condition and specific buildings on campus were dedicated to treating a type of medical or physical disability. For instance, persons with Epilepsy were sent to live in one of two locations in the state regardless of how far they were from their families. The same was true for people with Cerebral Palsy, for those who had severe behavioral issues, blindness and other significant medical issues. The health care providers authorized the services to be provided regardless of the person's or their family's wishes. Families were even encouraged by their own physicians to forget their loved ones in order to make things better for the rest of their family; as a result, a significant number of individuals lost contact with their relatives.

A class action lawsuit was filed against the State of Michigan in the 1970s by a group of concerned and frustrated families and advocates. The lawsuit included the Plymouth Center for Human Development. While there was a growing movement to close institutions and transition people to community homes, the progress was slow and inconsistent across the state. That landmark lawsuit was the beginning of the end for all public, state run institutions for persons with IDD and gained national attention. Today, Michigan is the largest and one of only 11 states that does not operate institutions for persons with IDD.

There are many professionals in and outside of the physical and behavioral health fields who do not know this history and how far Michigan has advanced serving people in the public mental health system. This history is important to understand so that aspects of the past don't repeat themselves. It should also be noted that there are still thousands of people with IDD in institutions across this country and throughout the world.

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Intentional Communities for Persons with IDD

While much discussion lately has focused on integration of physical and behavioral health care, there is another trend that has been occurring across the country that contains aspects of the past. The model is "farmsteads" and "intentional communities." These communities are promoted as planned residential communities for protection and safety but contain similar aspects of institutional living such as communal housing, social activities, training and health care. These are provided within the confines of a single development set apart from the rest of the community.

Is the obsolete institutional model now being re-designed and re-named so that persons with IDD are placed together and removed from the mainstream of life without access to the same opportunities and services as anyone else? It is important to note that on many farmsteads or intentional communities, health care and behavioral health are provided on the grounds of that community; some "members" even work the farm together. This physical segregation of people based on disabilities adversely impacts the choices available to individuals by reducing or eliminating their exposure to opportunities to choose where, how and with whom they want to live, work, socialize, worship and obtain services.

Even though Michigan no longer warehouses people with IDD in rooms with 30 beds and communal showers, there is still work to be done to promote community inclusion. In Michigan—where many people with IDD live outside their family homes—nearly twice as many still live in licensed foster care facilities compared to those who live in homes where they have their own leases and choose their roommates. About 8,000 people with IDD still spend their days in segregated day programs. Michigan ranks below the national average of persons working in jobs and nearly 73 percent have guardians as compared to the national average of 51 percent. These data are reported in the 2015 National Core Indicator report.

A Story to Tell

Married couples are often asked "How did you two meet?" John and Gloria, who both have developmental disabilities and use wheelchairs, have a particularly unique story of how they met. Both had lived at several institutions including Plymouth Center for Human Development. They lived there for decades just because they were disabled.

Not the most romantic beginning perhaps but today John and Gloria live in a quiet apartment and use direct care staff they have hired. They go out to dinner, are involved in the community and travel. John also runs a small business. They have been married 18 years and indicate they are the happiest they've ever been.

Their happiness, however, is being challenged due to increased medical needs. John is 60 and Gloria is 58. For them to lose their long-standing physicians and other care providers would be a tremendous loss. They are particularly concerned about how changes in Medicaid may cause them to lose those valued relationships and/or cause access issues or unnecessary barriers to care.

Focusing on the Whole Person

Improvements in the lives of persons with IDD have resulted from the concerted efforts of advocates, caregivers, supports coordinators, service providers and policy makers. Today the focus is on the whole person and takes into consideration the right of self-determination and quality of life that everyone wants for themselves:

- health and well-being
- a place to call home
- relationships, social and community connections
- basic income and economic security and
- transportation

Michigan Community Mental Health (CMH) providers are mandated to develop a Person-Centered Plan—a continuous work in progress that outlines the supports, desires and a vision of a life that a person receiving CMH services would want. Across the state, such planning occurs daily in the CMH system. The public behavioral health system has moved to address the "social determinants of health" that are so often discussed in current research. Per the Kaiser Family Foundation, social determinants of health (SDOH) are "conditions in which people are born, grow, live, work and age." (KFF, 2015)

There is always need for further improvement within the current system including better access to physical and behavioral health care for individuals with IDD. And certainly, all individuals benefit from the better coordination of information relating to physical health, behavioral health and social support services. The role of the supports coordinator is to assure that a Person-Centered Plan is built upon the needs and desires of the individual and all behavioral and social supports are managed appropriately. Health and wellbeing are one part of the Person-Centered Plan and it is important that SDOH are considered.

Another area to be improved is the array of Community Mental Health services and supports. These services should be consistent throughout the state. There are significant differences in the services that are available in one part of the state compared to another and even among Community Mental Health service providers within the same area. Parents and families should be able to find the services they need in communities that appeal to all of their other preferences such as schools, distance from work or other family members.

People with IDD often have greater medical complexities. Creating effective, integrated treatment across the health care disciplines has become more

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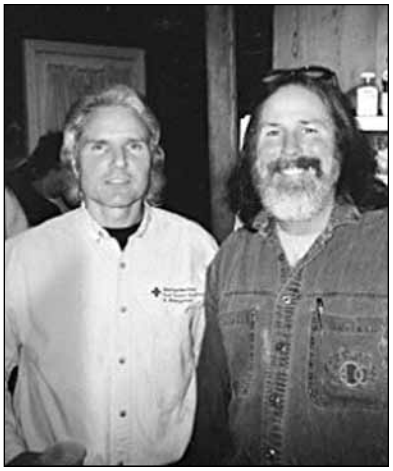
Suicide is Forever

Tom Watkins, President and CEO
Detroit Wayne Mental Health Authority

Suicide is God awful. It snuffs out precious life and leaves a wake of agony for those left behind. I know the pain all too well, as both my older and younger brothers took their own lives.



Phil and Ed Watkins—rest in peace.

Writing these words is painful, as it conjures up the memories of better times with two of my siblings, brothers Ed and Phil; the jokes, laughter, fights and enjoyment of the simplest pleasure of life. Now, they are gone and all I have are the memories.

There is even a tinge of shame and stigma associated with admitting this ugly family secret. This stigma, and yes I have to admit it is there—hurts as well. Stigma is a major barrier in getting people the mental health care they need.

I am a professional in the behavioral health field serving formerly as Michigan's state mental health director and currently as the president and CEO of the Detroit Wayne Mental Health Authority (dwmha.com). I know better, but admit the fear, embarrassment, shame, and judgment still clings to me like cheap cigar smoke in a darkened bar. We need to defeat this stigma.

I have spoken of the clinical causes of the disease that kills and have written about suicide, depression, mental health, substance abuse and other symptoms. With the support and leadership of the Flinn Foundation (www.flinnfoundation.org), we helped produce two documentaries: "Opening Minds, Ending Stigma" (www.dwmha.com) to help educate people about what to do and where to turn.

Yet, it is not enough. Suicide kills more than 38,000 Americans each year, translating into about 104 deaths by suicide a day, or one every 12-13 minutes. We must do more as a society to let people know there is both hope and help available. In 2014, suicide was the tenth leading cause of all death in the U.S., the second for youths aged 15-24, and fourth for adults aged 18-65.

Mental illness impacts every zip code—it is an equal opportunity disease. Mental illness does not impact "those" people, it is not simply a statistic to recite. It impacts our mothers, fathers, sisters, brothers and our sons and daughters.

I have witnessed, through my brothers' struggles, the joys when they were ready for help and the system was there to help them. I have also felt the pain as their disease prevented them from availing themselves of help, or worse yet, when a bureaucratic system let them down. We can and must do better.

Educate Yourself

Over the last couple years, DWMHA has achieved the ambitious goal of training more than 10,000 citizens in Mental Health First Aid (MHFA). This special free training is made available and equips people with the knowledge of the potential risk factors and warning signs of mental health problems, including: depression, anxiety, trauma, psychosis and psychotic disorders, substance use disorders, and self-injury. It also provides trainees with the skills, resources and knowledge to assess a situation, select and implement appropriate interventions, and help the individual in crisis connect with professional care.

The range of individuals trained through DWMHA includes teachers, youth, veterans, families, students, faith-based community members, social service providers, Spanish-speaking communities, and the general public. Recently we also began a MHFA instructor training for first responders in Wayne County. Our efforts were recently acknowledged on a nationwide level, receiving the Community Impact Award from the National Council for Behavioral Health Council.

Tom, sister Casey, Phil, and Ed Watkins in happier times.

Don't Do It

Suicide is irreversible. If you are contemplating suicide "because today is the worst day of your life," pause; knowing if this is true by definition, tomorrow will be better.

Across Michigan your local public community mental health agencies are here to help. The Detroit Wayne Mental Health Authority and our

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Michigan Association of Suicide Prevention—

Promoting education, training, research and community awareness for over 25 years

By **Tony Lewis**, President, MASP

Tony Lewis

In the United States, one suicide occurs approximately every 13 minutes. Tony Lewis, President of the Michigan Association of Suicide Prevention (MASP), is one individual who has been personally affected by suicide.

I lost a long-time friend and co-worker to suicide in 1995. It was not only impactful to me, but the entire community. No one would have thought that my friend would have attempted suicide. He was loved by the community and involved in a lot of things including sports and community events. He was a person who everyone looked up to for strength.

Suicide is one of the leading causes of death in the United States killing almost 40,000 people annually. Suicide rates have been increasing in the U.S. in recent years, particularly among youth, middle aged men and the elderly. Statistics show that on average, there are nearly 109 suicides per day. When one suicide is attempted or completed it can affect up to 115 people. A lot of the signs of suicide were missed due to the fact that no one thought my friend would attempt suicide. Often, this is the case, and many individuals fly under the radar when suicide signs go unnoticed by others. These statistics and facts prompt the urgency to raise awareness and education for communities to utilize resources to reduce the risks of suicide and to help prevent a suicide.

In Michigan, The Michigan Association for Suicide Prevention (MASP) has been working diligently to raise awareness and reduce suicides. MASP is a state-based suicide prevention initiative and is run by passionate volunteers who meet on a monthly basis. The main areas of focus of suicide prevention by MASP include reducing the number of suicides by offering intervention, training and supporting prevention plans, promotion of "post-vention,"—which includes providing support for people who have lost loved ones to suicide —and reducing the stigma associated with suicide and mental illness.

The personal impact of suicide on me is what prompted me to become involved in MASP. I became involved in 2010, and have served as President of MASP for the last three years. My goal is to move the coalition forward and advance suicide prevention statewide. My personal goal while participating in MASP is to be a helping hand to those who are struggling. I want to be the person for someone who—when they are tired of fighting and are struggling—is able to pick them up, and take the lead, and provide hope. I want to be able to help others and have them know that other people want to help when they are struggling.

MASP is working on many projects to prevent suicide statewide. A recent project that was implemented was cinema ads in six theaters in Michigan in areas with the highest suicide rates, including mainly areas in northern Michigan. The cinema ads are approximately 30 seconds long, run before popular movies, and provide statistics and resources to viewers. Additionally, MASP is working on coordinating a suicide prevention conference that individuals in Michigan would be able to attend. Participants will learn about suicide prevention, crisis intervention, and other mental health resources and services at the upcoming conference.

I believe that one of the most effective ways to have individuals and communities become prepared to prevent suicide is public education and awareness. To become educated, individuals can learn suicide signs on the MASP website, or the National Suicide Prevention Lifeline Website [https://suicidepreventionlifeline.org, or 800-273-8255]. Also, individuals may request suicide prevention trainings by MASP.

As important as it is to watch for the signs and signals of suicide in those experiencing suicidal thoughts, it is just as important to provide support to family and friends who have lost an individual to suicide. Not only are those who survive a suicide at risk of trauma and grief, they are at a higher risk of suicide themselves. Many counties in Michigan offer support groups to assist in reducing the trauma and stress experienced by a family member. Information on support groups can be found on the MASP website [www.masponweb.org] and on our Facebook page.

Suicide rates have been increasing in recent years and many are unsure of why. Due to advancement in technology, there is more access for the media to show suicide. The media portrays suicide as something that is easy to do, and I believe that many have lost hope because of this. If there was one thing I could tell someone who is feeling suicidal, it would be that there is hope and help. There are many avenues to address pain. Give me

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Welcome Home for a Hero

Charitable organization provides home for veteran

By **Moses Leos III**, Editor, *Hays Free Press*

The Lathers family (center), is joined by members of the Buda/Kyle VFW Post 12095, as well as members of the community in front of a gifted residence given by Building Homes for Heroes.

Cars lined the 100 block of Tupelo Drive in Kyle, Texas when police escorted Daniel Lathers and his family's SUV to the driveway of their new home.

Once there, numerous friends, family and well-wishers applauded and smiled as the Lathers looked upon the brick exterior residence. But for Lathers, a United States Marine Corps veteran who suffers from injuries sustained after three tours to Iraq, the home meant much more than a roof over his family's head. It also signified the willingness of volunteers to help disabled veterans such as he to find normalcy after combat.

Building Homes for Heroes (BHFH), a national 501(c)3 non-profit, builds or remodels homes for disabled or wounded veterans and gifts them mortgage-free. The program began to assist veterans following the events of Sept. 11 and the subsequent conflicts in the Middle East.

The Lathers family inspects the kitchen in their new home.

Jessica Baker, Texas Team leader with BHFH, said the goal of the program is to provide peace of mind for veterans. It also works to combat the issue of homelessness for veterans.

"We are slowly but surely making a meaningful impact to provide homes and families with a sense of stability, so they can focus on rehabilitation and not be bound by a mortgage payment or navigate a home they may not own," Baker said. Participants who apply must not own a home and must be 100 percent disabled, Baker said. While Baker said the program specializes in helping severely injured veterans, the program selects applicants on a case-by-case basis.

Baker said the program doesn't turn veterans away, and there isn't a veteran who's more deserving than another. Over 5,000 applications have been submitted nationwide since the program began, with over 2,000 of those seeking residence in Texas.

BHFH works with Chase Bank, which gifts foreclosed homes to the organization. From there, the organization works with selected applicants to ensure the home fits their needs and meets their checklist. That may require modifying the home to suit the veteran and his/her family.

Baker said the organization prioritizes the building of new homes for the most severely wounded or injured veterans. BHFH has four foreclosed modified homes being gifted in Texas this year and will have two ground up construction builds.

Lathers' persistence in checking on the program guided the BHFH staff to him, Baker said. But the process for Lathers' home took approximately two years, he said. Lathers and his family live in Schertz, located north of San Antonio, but he expressed interest in moving into the Kyle area. BHFH notified Lathers he would be gifted a home in February. Lathers worked with BHFH to make sure the home was in the right place and could suit his needs.

For Lathers, the chance to walk through his new home left him in a dreamlike state. "It's hard to believe. It was like a dream. It feels like a dream," Lathers said. "It's pretty exciting and overwhelming, but for the better."

Once the home is gifted, Baker said BHFH continues to check on the families, offering financial assistance and stewardship opportunities. Families can also network with other veterans who have been gifted homes as well. The home also gives veterans a chance to focus on the road to recovery. Primarily, a chance to start the healing process

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Welcome Home *(Continued from page 7)*

and focus on life and a career after the military.

The Lathers family was welcomed at their new home in Kyle in April

Lathers, who suffers from Traumatic Brain Injury and Post Traumatic Stress Disorder, said attempting to assimilate to civilian life after a wartime experience is one of the hardest things there is. "It's because you're so used to everyday life in the military and then it changes," Lathers said. "The biggest thing is the camaraderie. You lose all of the people you're around every day."

But Lathers also appreciated seeing support from the community, many of whom he's never met. "We're excited because there was so much community involvement," Lathers said. "That's how I want to raise my kids— in an involved community." ▪

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Dan Lathers is the son of Robert Lathers, CEO of The Right Door for Hope, Recovery and Wellness.

SUICIDE IS FOREVER *(Continued from page 5)*

24/7 crisis line, 800-241-4949, is there for you. With proper diagnosis, treatment and support, help and recovery are possible. We are thankful for the focus Governor Rick Snyder and Lt. Gov. Brian Calley have placed on mental health issues in Michigan. More needs to be done.

No matter what problems you are dealing with, people are there to give you reasons to keep living. By calling the National Suicide Prevention Network 1-800-273-TALK you'll be connected to a skilled, trained counselor at a crisis center in your area, anytime 24/7. (www.suicidepreventionlifeline.org)

Knowing where to turn and who to call can save lives. Save these numbers, share them with your circle of friends and colleagues so that everyone knows where to turn if they or someone they love are so desperate, distraught or ill that they are contemplating taking their own life.

Suicide kills. As a community, we are the ingredients that can help save lives. Know that you are important, someone loves you and their heart will ache with your loss. Pause, call and live. ▪

First published in "Dome Magazine" *on February 12, 2016, this article is published here with permission of the author. Tom Watkins is the President and CEO of the Detroit Wayne Mental Health Authority (www.dwmha.com). He has served the residents of Michigan as State Superintendent of Schools and State Mental Health Director. Email him at: tdwatkins88@gmail.com, or followed him on twitter: @tdwatkins88*

MASP *(Continued from page 6)*

a chance to help you. We are all in this together.

If you are a family, friend or you know someone who is experiencing suicidal thoughts or thoughts of wanting to die, help is available. The National Suicide Prevention Lifeline is a 24-hour crisis line that can be utilized to prevent a suicide. Call 1-800-273-TALK or 1-800-273-8255. The National Suicide Prevention Lifeline also offers a texting service or an online chat option if an individual prefers to communicate through writing rather than talking.

For more information, or to get involved in suicide prevention efforts in the State of Michigan, contact The Michigan Association for Suicide Prevention by visiting www.masponweb.org.

I close with this, motivation for all of us: Don't give up. Stay strong. Keep hope. Allow people to help you. We are all in this together. ▪

FINDING NEW STORIES

For People Who Experience Disabilities

David Pitonyak

Imagine is the name I give my consulting practice which is dedicated to supporting people who experience disabilities and exhibit, what some have called, "difficult behaviors." In my view, what's most needed when a person engages in difficult behaviors is imagination. The story-line that is floating around about the person is a major part of the problem. What's needed is a new story.[1]

My practice is based upon a simple idea: difficult behaviors result from unmet needs. In a sense, difficult behaviors are messages which can tell us important things about a person and the quality of his or her life. People with difficult behaviors are often missing:

- Meaningful relationships
- A sense of safety and well-being
- Power
- Things to look forward to
- A sense of value and self-worth
- Relevant skills and knowledge

These needs are usually minimized or ignored in educational or human services settings. As a result, individuals may become:

- Relationship resistant
- Chronic rule-breakers
- Helpless and insecure
- Depressed and isolated

Supporting a person with difficult behaviors requires us to get to know the person as a complicated human being influenced by a complex personal history. While it is tempting to look for a quick fix, which usually means attacking the person and his or her behavior, suppressing behavior without understanding something about the life he or she is living is disrespectful and counterproductive. Difficult behaviors are a reflection of unmet needs. They are "meaning-full." Our challenge is to find out what the person needs so that we can be more supportive.

Our best efforts to support someone who engages in difficult behaviors will fall to pieces if the people who are asked to provide the support are not supported. Whether you are a friend, a parent, or a paid caregiver, there is a relationship between your needs and the needs of the person you are supporting. In my experience, a person's supporters often need:

- Supporfrom friends, family members and colleagues
- A sense of safety and well-being
- Power
- Interesting and difficult routines
- A sense of value and self-worth
- Relevant skills and knowledge

These needs are usually ignored by educational and human services organizations. People inside and outside of these organizations often feel that their needs are being ignored by an insensitive and uncaring bureaucracy. As a result, they often resort to their own difficult behaviors. An individual may become:

- Resistant to new ideas and support
- Cynical and rebellious
- Overly controlling and punishing
- Depressed and isolated

While it is tempting to blame caregivers for failing to "deal" with a person's difficult behaviors, I believe that the vast majority of people working in human services are interested in helping not hurting. But helping is difficult when your own needs are being ignored. It is a central contention of my practice that many human services workers are under-supported; some must contend each and every day with fear-provoking management practices that discourage quality, productivity, and creativity. When people do not feel supported—when they feel afraid—they have a difficult time being supportive. Thus, it is critical that any

(Continued on page 15)

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[1] *I will be forever grateful to Tom Kohler, Coordinator of the Chatham-Savannah Citizen Advocacy, for describing my work as "finding new stories." Tom does the work as well as anyone. To be so described by the likes of him is as good as it gets.*

SENIOR REACH®—*Innovative Help and Caring in Action*

Senior Reach®, a nationally recognized evidence-based program through the National Registry of Evidence-Based Programs and Practices (NREPP), provides outreach and education, behavioral health treatment, care management and other needed community-based services to adults aged 60 and older who are isolated, frail, or in need of support. This community-based, collaborative program identifies older adults who may need emotional support and/or connection to community services, but are not seeking services on their own behalf. Created in 2005 in Colorado through a multi-agency partnership to better serve older adults, Senior Reach® has achieved proven clinical outcomes that include reductions in depression, anxiety, social isolation, and increased overall recovery.

In December, 2015, the Health Endowment Fund notified MACMHB that they had been awarded a two year grant totaling $ 4.2M to fund the initiative. Twelve identified sites in the Michigan began providing an impressive array of services in May, 2016. By December, 2016, the 12 sites provided Senior Reach® training for 6,942 community partners, received 691 referrals from those partners, completed 653 intakes from those referrals, and engaged 512 seniors in services. Senior Reach® sites will receive MHEF financing through March, 2017. Sustainability and program service evaluation will be the major foci of the second year of operations.

For those interested in learning more about Senior Reach®, an article by Michael Vizena appears in the "MACMHB 2016 Annual Report" and is available for reading online or download at www.macmhb.org. More information on the national program is available at www.seniorreach.org.

The balance of this article—the human side of the story—reports on actual services being delivered to individuals in Michigan through Senior Reach® funding.

Northern Lakes Senior Reach *(Northern Lakes Community Mental Health, a suburban site serving six counties, including Grand Traverse, Leelanau, Missaukee, Wexford, Crawford and Roscommon.)*

Maureen

When Maureen returned to her home town of Traverse City one and a half years ago, she encountered a number of unforeseen difficulties. Affordable, temporary housing was hard to come by while she waited for an apartment to become available at a local senior living community. Having suffered three heart attacks in 2015, she found herself feeling not only displaced but also overwhelmed with unpaid medical bills, doctor's appointments, and transportation barriers. She had seen ads for Senior Reach® in various, local publications and decided to call. Maureen recalled, "I felt like I was laboring under a heavy load alone. I needed the help and I knew it." Maureen shared that her familiarity with the administering agency of the program (Northern Lakes Community Mental Health) gave her "great confidence" that the staff possessed the expertise to counsel and advocate for her. She reports that the Senior Reach® care manager and clinician provided her with both support and "practical help," such as making phone calls, sorting out medical paperwork, and connecting her with available community resources. She views the staff as "not just 'listeners," but also 'doers' who have *really* helped."

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STEP *(Services to Enhance Potential in Wayne County)* received a referral from The Senior Alliance (TSA) after they had received several frantic phone calls from a woman [*the couple in this story preferred to remain anonymous*] in tears desperately trying to get assistance for her spouse. Her spouse had relapsed with drinking and was no longer taking his psychotropic medications. He also was opening different bank accounts to try to hide money from his wife. TSA had tried to assist the woman as best they could but did not know where to even begin with the many layers of issues.

When Ellen Mariscal, STEP behavioral clinician, first met this client she was a nervous wreck. She was contemplating leaving her husband because he was making risky financial decisions without her knowledge. She originally just wanted Senior Reach® to provide services to her husband; however he refused. Ellen encouraged her to let Senior Reach® try to provide services to her because she was in need of a lot of support and information on resources. Eventually she agreed.

Jennifer Onwenu stepped in to assist the woman with transportation resources so she could get to her medical appointments since her husband was still drinking. Jennifer also provided her information on legal resources. Ellen began to provide behavioral health services to the woman to work on stress management, coping skills, and education of substance abuse disorders. Eventually, her husband agreed to meet with Ellen, Jennifer, and his wife. At this point he had hit rock bottom. He had lost his job due to his alcoholism and was finally recognizing how much his depression had worsened.

Jennifer was able to provide him information on unemployment benefits and how to enroll in Medicare benefits. Ellen began to work with both him and the spouse together in weekly couples sessions. Initially there were a lot of ups and downs. Ellen helped them to review their options (substance abuse treatment, separation, divorce. etc) and helped mediate many conflicts related to the spouse's drinking and mental illness. Most importantly, Ellen helped them to strengthen their communication skills between each other and begin to rebuild trust.

In the end, both the woman and her husband decided to stay together. The husband eventually agreed to have his medications adjusted so his depression improved. He also agreed to enter a substance abuse treatment program and as of April, had been sober for almost a month. The woman is now happy to have support from her husband and is providing him support in his recovery in return.

Had it not been for STEP's strong relationship with The Senior Alliance and their trust in the Senior Reach® program this couple would not have been identified. They do not have any children and had lost touch with their friends and siblings over the years. Senior Reach® provided them the support they needed to make it through this difficult time with their relationship still intact.

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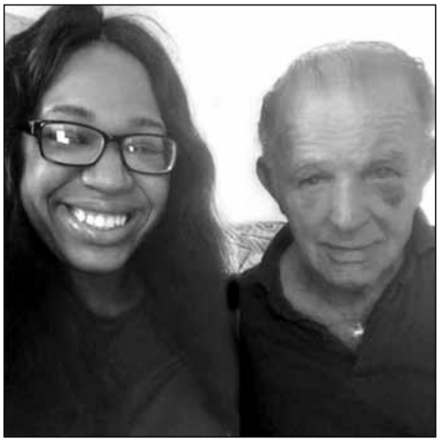
STEP (Services to Enhance Potential, Wayne County)

Jennifer Onwenu, MSW is a care manager for STEP, a partner with the Northeast Guidance Center's Senior Reach® program located in Detroit, MI.

Recently Jack Ray Oelke, a 73 year-old homeless man, who had been living in a tent in a park, was referred by a community partner to Jennifer after he had been asked to leave. During the assessment Jennifer found that he could not read or write and had fallen on hard times after his wife of 20 years left him and refinanced the home without his knowledge. As an elderly carpenter who had been living on a fixed income he unfortunately lost his home. Illnesses, hospitalization, and debt drove him to being homeless.

The first meeting and assessment allowed Jennifer to sign Jack up for health benefits with Michigan Department of Health and Human Services (MDHHS); he had been hospitalized a week before and wanted his back medical bills paid and coverage for the future. They also began looking for potential housing. Jack's desire was to remain in the downriver area where he had previously resided and was familiar. The following week Jack met with a coordinator at Flat Rock Towers and as a result he was able to get into an apartment. It is a fixed income apartment with utilities included so Jack will be able to afford rent. She is still working with the service coordinator to obtain clothing, dishes, and furniture and food items.



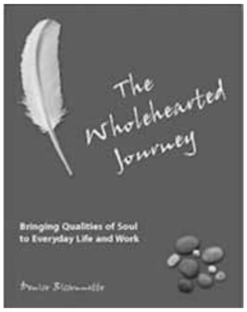
Jennifer Onwenu and Jack Ray Oelke

Through Jennifer's social work expertise and the collaboration and partnership with a human service organization, in addition to the Senior Reach pledge to "make a positive impact on any senior who is referred to the program", Jack's health and social support needs have been met and he no longer falls into the "underserved" older adult category.

According to Jack, "My life has changed one hundred percent since I met Jennifer and she got me involved with the Senior Reach program. I would encourage any older person who has a need to get in touch with and use the Senior Reach program. They don't look down on you; they treat you like a human being."

A Gift for Those Who Give **A book review by Robert McLuckie**

The Book: ***The Wholehearted Journey:*** *Bringing Qualities of Soul to Everyday Life and Work*
Author: **Denise Bissonnette**
Publisher: **Diversity World, Santa Cruz, California**



Direct Support is the most personal of professions. Our support for this workforce must include celebration and nurturing of the inner personal development of each Direct Support Professional, as well as support for the blossoming of compassion and wisdom in each individual worker. It seems to me that this is the mission of Denise Bissonnette's *The Wholehearted Journey: Bringing Qualities of Soul to Everyday Life and Work.*

Denise introduces the book:

This is a book of poetry, parables, and creative ponderings. It is a book of insights gleaned and distilled from the work of hundreds of writers, philosophers and fellow pilgrims throughout the ages. It is full to the brim with important questions and practical suggestions for putting our purposes and principles into practice. It is a call to arms for spirited and soulful living, both in work and in the larger context of our lives. *The Wholehearted Journey* is an invitation to dive deeply into the waters of self-exploration and to come out refreshed and renewed; eager to express our gifts, share our joy and give birth to our dreams. This book is about bringing our whole heart to the altar of everyday life.

Denise was a direct support worker who has become a respected author and conference presenter. In her own words:

"I am a job developer and a career coach who loves the field so much that I can't help but speak about it. That's what I think most qualifies me to do what I do – the sheer passion and utter respect I feel for this profession and the important work we do.

"Just out of college, I had the privilege of working with people in a variety of settings, from social service agencies to adult education programs, people who came with a wide range of barriers, but who also brought a vast spectrum of assets and strengths. They included refugees and immigrants, ex-offenders, youth, welfare recipients, and persons with disabilities. What I came to quickly learn is that each person came with their own story, their particular problems and their unique potential. These individuals and the employers I worked with over those years were my greatest teachers. Like most, I learned to do job development by the seat of my pants – an education I would not trade for anything in the world."

Reading *The Wholehearted Journey* feels like going on a personal retreat. Each chapter focuses on a quality of soulful living and offers an easy guided tutorial for applying it to everyday life and work. It is aimed at nothing less than personal transformation. But this lofty ambition is anchored in views of simple, everyday life and the things…the gifts…we so often overlook. What gives the book its very genuine power is exactly this: it points at the ordinary in a way that enables us to see it with new eyes. The commonplace becomes profound and I, the reader, feel a spirit of happy lightness in realizing that I have seen the beauty that has always been close at hand. This book is a gift to the heart.

Each chapter is rich with poetry, anecdotes, wisdom quotes, and plain straight talk. In the introduction, Denise reveals, "Early in its creation, it struck me that I was writing this book first and foremost for myself, because above all, this writing is a bold and honest expression of how I ache to live." As we read, we sense this very deep sincerity. We feel as if we're spending an evening with a dear friend who experiences the same soulful searching questions that we know well."

The 20 chapters cover essential themes:

I Dedicate This Day: *Bringing the Sacred into the Everyday*
Unlived Dreams and Rising Bread: *Shaping Fresh Hope From New Dreams*
Arriving: *Embracing the Unknown*
Nurture Your Nature: *Celebrating Your Gifts*
Rekindle the Flame: *Restoring Purpose and Passion*
The Masquerade: *Befriending Yourself and Others*
New Wings: *Moving Through Fear*
Lessons from the Apple Tree: *Accepting Change*

Meadowlarks: *Renewing the Joy of Giving*
The Puppeteer: *Pulling Your Own Strings*
The Beauty of Today: *Seizing the Day*
The Journey to Belong: *Employing Your Inner Compass*
On Second Thought: *Harnessing Perspective*
At the Feet of the World: *Becoming More Teachable*
A Heart Contained: *Choosing Joy*
I Want to Live in Color: *Living Wholeheartedly*
Not One Alike: *Valuing Your Part in the Whole*
Rhythm: *Cultivating Balance in Life and Work*
Veil of Wonder: *Seeing Through New Eyes*
A Pilgrim's Plea: *Remaining True to the Soul*

What really makes this book life changing is the “To Ponder and Practice” section in each chapter. Here the reader is invited to reflect on one’s personal experience of life and to make notes that may lead to a richer, genuine existence.

Those Who Give

Some years ago I attended a conference designed for direct support professionals. One session entitled “What Keeps You Going?” was clear acknowledgement that direct support work is very difficult at a deeply personal level. The title and opening remarks acknowledged that burnout was the most significant risk to both the direct support worker and the quality of support given.

His shy, but impassioned insistence, “I always get far more than I give,” rang out as a theme of the session.

After a brief presentation, audience members were invited to stand and speak about what “keeps you going” on the job day-to-day. Many spoke. They offered a variety of personal approaches to self-renewal and reinvigoration—some very creative. Remarkably, each one who stood spoke of the profound meaningfulness that the work brought to their personal experience of life. Each one spoke of the real love they experienced so often—the giving and receiving of feeling beyond affection. Some shed tears. One gentleman described his discovery of a “deep well of compassion” at the center of the work. His shy, but impassioned insistence “I always get far more than I give,” rang out as a theme of the session.

Our recognition of the great worth and essential role of Direct Support Professionals is embodied in our strong advocacy for appropriate wages and benefits, training to develop skills and enable advancement and our support for their true identity as “professionals”. We know that empathy, compassion, and open-hearted embrace of the joy of helping are essential ingredients in the direct support provided within our services. I very strongly believe that these and other traits of depth of character, must be very actively encouraged, developed, protected, and intentionally nurtured through our direct and sincere effort, and not simply sought or assumed as desired qualities.

Why Give This Book as a Gift to Our Direct Support Professionals?

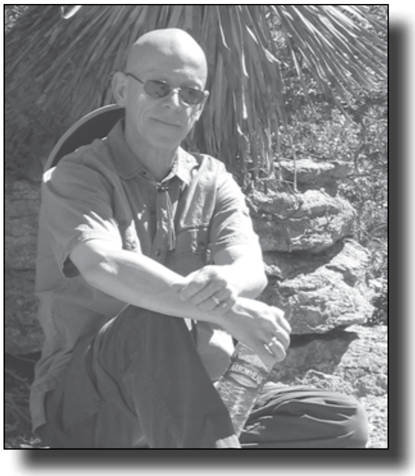
We should extend *The Wholehearted Journey* as a gift to our direct support professionals; each has taken a job that offers low wages and little fame, but puts him or her square in the center of life’s very rich and difficult drama. They are called to help, support, care for, laugh and cry with, and nurture those who are the most vulnerable among us. We owe them our deepest regard. For those who will listen, *The Wholehearted Journey* will open the path to a deep, compassionate, joyful experience of living and giving.

The Wholehearted Journey can support the growth of wisdom and help each one to move well beyond a theme of “just keep going,” to a place of thriving masterfully in a profession where compassion and wisdom are basic requirements of the job. And of course, *The Wholehearted Journey* is highly recommended for the rest of us as well! Enjoy the journey!

“I don't want to exist as if in some mindless entanglement in a meaningless world. I want to work myself like a silken thread in a web to which I belong.

– Denise Bissonnette

The Wholehearted Journey: *Bringing Qualities of Soul to Everyday Life and Work* may be purchased at: denisebissonnette.com, or at Amazon.com (used), as well as on Kindle. ▪



Robert McLuckie pictured here near his home in Arizona

Integration *(from page 4)*

common. This has helped to provide higher quality care that benefits all people; more importantly, integrated treatment has improved the lives of people who may not be able to advocate for themselves and/or have more significant, chronic health care needs. Regardless of how integrated and collaborative health care becomes, the role of advocacy and advocates remains critical to ensure all of the SDOH drivers that impact overall health are considered. Some individuals are fortunate to have informal but strong advocates (e.g. parents, caregivers, friends, etc.) that help bridge the formal health care system with an understanding of the larger needs and interests. Many individuals in the Community Mental Health system do not have this level of informal or effective advocacy. Therefore the role of the supports coordinator or case manager is even more vital to ensuring that necessary care is provided, home and community supports are viable and the person remains central to the Person-Centered Plan.

The Michigan Landscape for Behavioral Health Services

Currently, the control of the State of Michigan's $2.4 billion Medicaid behavioral health system budget is under debate. In January 2016, Michigan's proposed budget for 2017 included an effort to restructure the delivery and payment model of the Medicaid physical health and behavioral health services for persons receiving services. The initial report, which was the outcome of nine months of meetings with various groups and advocates, has 91 recommendations. The Michigan Association of Community Mental Health Boards (MACMHB) agreed with the recommendations but proposed that people receiving services through CMH still have choice where they receive their (CMH) care. MACMHB is advocating that funding should stay in the communities managed by the existing CMH structure.

The Michigan Association of Health Plans (MAHP), which is the trade association for all of the health plans that provide services to Medicaid beneficiaries in the state, believes the report is incomplete, because the state's mandate is that the workgroup propose a road map for effective and efficient integrated health care. The Michigan Association of Health Plans believes integration should start at the top of the funding chain under a managed care system administered through the HMOs.

In April 2016, the Michigan Association of Community Mental Health Board Center for Healthcare Research and Innovation conducted a study of healthcare integration initiatives led by Michigan's Community Mental Health Services Programs, the state's public Prepaid Inpatient Health Plans, and providers with the Community Mental Health system. The study examined various efforts aimed at integrating health care services. It found more than 750 healthcare integration efforts were operating within the state, many occurring in co-location settings, with the integration of electronic health records and the identification of high utilizers of the system. However, our efforts need to go well beyond integration of care and focus not only upon services but rather building lives.

Conclusion

There are thousands of Michigan citizens with significant disabilities, including IDD, that have relied on their trusted physicians and specialists for years. As discussions proceed in Michigan around the "how, who, and what" of integrated health care, any redesign in the state's healthcare should not disrupt those key health care relationships between individuals in the CMH system and their established providers. Integrated service models should:

- Maintain Person-Centered planning and Self-determination arrangements
- Include Supports Coordination and Independent Facilitation of the Person-Centered Plan
- Understand that there are many factors that will impact an individual's overall health status, and that they have to be woven into the overall treatment approach
- Allow for additional physician time and remuneration
- Provide accommodations for various communication methods used by people with IDD
- Promote increased wages to recruit and retain competent caregivers
- Work from a mind-set that IDD is permanent with chronic conditions, and modern medicine cannot "fix or cure" IDD; therefore, supports and follow up may need to be continuous and ongoing
- Recognize that persons with IDD are living longer and subject to health issues related to aging, requiring viable plans to "age in place"

It is strongly recommended that the above considerations for persons with IDD be a critical part of the planning of the integration of physical and behavioral health. ■

We would like to recognize Jim Dehem, CEO and Sarah Bannon of Lakeview Consultants for their contributions to this article.

New Stories

(Continued from page 9)

effort to support an individual include support for the person's supporters. To paraphrase early childhood educator Jean Clarke, a person's needs are best met by people whose needs are met.

In a nutshell

It is simplistic to treat a person's behavior without understanding something about the life that he or she lives. It is equally simplistic to develop interventions that do not take into consideration the needs of a person's caregivers. The challenge is and always will be to build support for the person and the people who care. When I work with people and their teams, I help them to focus on the development of support plans that include seven quality of life indicators:

1. Health and well-being
2. Relationships
3. Fun and joy (things to look forward to)
4. Power and choice
5. A Sense of Value
6. Skills and Knowledge
7. Support for the person's supporters

If you're too tired to read one more word (and the people busiest providing support usually are), I encourage you to get some sleep. I leave you with these four simple ideas:

- Difficult behaviors result from unmet needs.
- Finding out what a person needs is the first step in helping the person, and the person's supporters, to change.
- Attempts to "fix" the person may be misdirected. It is often the "system" that needs fixing.
- Taking care of yourself is one of the most important things you can do. If you can't take care of yourself, it will be very difficult to care ***about*** someone else.

Learn more about David Pitonyak at www.dimagine.com

mhNOW believes cities can be catalysts for meaningful mental health impact.

Why cities? Cities—with their inherent networks, density, creativity and entrepreneurial capacity—bear the highest burden of mental health but also have the highest potential to achieve meaningful mental health impact.

ENGAGEMENT

Existing city services, community organizations, and civil society have established networks and the ability to work together in new ways on preventative approaches to address the long-term cost of mental illness at its source and to reach and empower every citizen.

ENERGY

Youth organizations can be inspired and youth movements activated across cities to destigmatize mental health to create an enduring culture of tolerance and understanding.

EFFICIENCY

City governments, now more so than national governments, can advance new innovations and thinking quickly, and are closely tied to local businesses, investors, and other resources.

EXPLORATION

Cities are homes to research centers and institutions of higher education. In this golden era of neuroscience, where discoveries are constantly demystifying secrets of the brain, research collaborations, studies, and clinical trials are more important than ever.

Check it out @: http://www.mhnow.net/

On 6/23/2016 Huffington Post published a follow-up article on the Flint Water Crisis entitled: "Partnerships Are Critical to Keeping Promises in Flint," *in which MHNow was identified as a partner. The collaboration happening in Flint exemplifies the strategy advocated by MHNow. www.huffingtonpost.com/undefined*

MACMHB
426 S WALNUT
LANSING MI 48933
Telephone: 517-374-6848
www.macmhb.org

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CELEBRATING 50 YEARS – REFINING OUR VISION FOR THE FUTURE

At the fall conference in Traverse City we will be celebrating the 50th anniversary of the Michigan Association of Community Mental Health Boards. That is the theme of the next issue of Connections which we anticipate being available prior to the conference. Let this be an opportunity to dream the future!

Yes, an understanding of how we got here is important; much of that history was captured in the Fall 2013 issue of *Connections* when we celebrated the 50th anniversary of the Community Mental Health Act that provided a pathway for the development of community based services. In the cover article of that issue Linda Rosenberg, President & CEO of the National Council for Behavioral Health, reminded us that this "was the last piece of legislation President John F. Kennedy signed before his assassination. He encouraged a bold new approach to mental health and developmental disabilities, one in which the "cold mercy of custodial care would be replaced by the open warmth of community."

The principle expressed in that poignant phrase remains as appropriate and powerful today as it was when uttered 54 years ago. Although there is much in our past to celebrate, countless individuals will tell you we have a long way to go to completely dislodge the experience of *cold mercy*, replacing it with *open warmth*. The further we have come, the more we realize the journey is endless.

Many of the contributors to the Fall 2013 issue had not only witnessed but played an integral role in making the changes that have created the amazing service delivery landscape we have today. We invite you to go back and read their stories to better understand how we go here. However, the unfolding story of shaping a future characterized by open warmth, a sense of belonging and being engaged in meaningful relationships has many chapters yet to be written. Everyone reading this has a role to play; together we are shaping the future. We encourage you to send us your dreams for the future (email us at cghermitage@gmail.com) so we can share them in *Connections for Communities that Care*.

- What would you like our social landscape to look like in another 10, 25 or even 50 years?
- What needs to change?
- What are the most important principles and values that will guide us?
- What are the obstacles to making those changes?
- How can we overcome them?
- What are the first steps?

Share your dreams with the rest of us so we can work together making them a reality, that's how we got here.