Michigan Association of Community Mental Health Boards

FALL 2016

Connections
for communities that care

IT IS WHAT WE DO

Danis Russell, Genesee Health System, Flint, Michigan

Unless you have not read a paper, or watched the news, or ignored the internet for the last 7 months, everyone has heard about the Flint Water Crisis. If you live in Genesee County it is all you hear. If you live in Flint, it has become the never ending crisis of your life.

The basic facts are pretty simple. In April of 2014, the city of Flint switched its water source from Detroit to the Flint River. Anti-corrosives were not added to the water, lead leached out of the system into the drinking water, and anybody who drank water from the system drank water contaminated with lead for the next 17 months, until October 2015. Lead is a neurotoxin—poisonous to humans and animals if ingested—that accumulates in soft tissue and the bones. It can damage the nervous system, causes brain and blood disorders and can irreparably damage most major systems of the body. It is especially damaging to young (0-6 years of age) developing brains and organs, anyone with a compromised immune system, and the elderly. It can only be detected in the blood up to 28 days after the initial ingestion, and then it leaches into the body. The effects of lead poisoning may not show up for years.

Basic facts. Pretty simple. Each one of those simple facts has its own story and history, and all are far from simple. How this happened, why this happened, and who is responsible are debated, analyzed, and studied everyday by lots of groups and individuals. The "truth" of the facts is always debated and controversial. The truth will always be debated, and will always be questioned. What is absolutely true is that 100,000 people—about 8,000 of them under the age of 6—drank, cooked with, and bathed in water contaminated with unknown concentrations of lead daily for 17 months, and some for longer periods. This has drastically changed their lives and, for some of the youngest victims, the effects will be with them for the rest of their lives.

Genesee Health System (Genesee County Community Mental Health) has been in the Flint community for over

50 years in the same main location: two minutes from the middle of down town. (Yes, we all drank the lead contaminated water.) As an organization, we got involved very early in the crisis response and recovery efforts. Some of the first responders from the Substance Abuse and Mental Health Services Administration (SAMHSA), the United States Public Health Services Commissioned Corps (uniformed health staff under the direction of the Surgeon General), the Office of the Assistant Secretary of Health (HHS) and others contacted me. What followed, and what continues to present day, is a small group of GHS staff who basically have two jobs: their real job, and their Flint Water Crisis job.

We got involved early on with setting up community groups, facilitating events, providing free counseling and support in the community, and were asked to be part of most major planning initiatives.

We have collaborated with everyone, tried to help wherever we could, and have rarely said no to requests for help, participation, and money when needed. So, basically, we acted like a CMH. We have received praise and recognition from some—modesty aside—pretty lofty circles.

I have had the opportunity to have coffee, tea, drinks, lunch, and "quick chats" with people that *(Continued on page 2)*

It Is What We Do (*from page 1)*

I never imagined in my wildest dreams I would ever meet. To be honest, more than once I had the thought in my mind that the person sitting across the table was going to look at me, shake their head and say something like, "I just realized you run a CMH. What am I doing talking to you?" But that has not happened. Yet.

I think the praise and attention we have received is possibly due to some circumstances specific to Flint, and one very important universal truth. GHS is large, and we have been active in the community for many years. I personally have been here for a fairly long time, and have tried to get included in activities and issues where CMH was not always invited (we all know about that). We have a good reputation, and are known to support many other health and social causes in the community.

But, the universal truth that I think is the foundation of all of this—we are a CMH. We changed our name, but we never forget that community is still the first word in that name. I probably have to say that I think we have done a great job, and a lot of that is due to great leadership (my annual eval is coming up), but the reality is I think we did what most of the CMHs in the state would have done.

When others were scrambling to figure out a plan, we did what we do: provided support, counseling, consultation, facilitation. We all have done this every day since we were formed. Every CMH in the state has a group of individuals who would volunteer without a thought for long hours, angry meetings, and criticism for things out of their control if their community was in crisis. We did. You would. It is what community mental health is all about.

We have received lots of help from many different organizations and people. Many of you have sent money, water, uplifting messages, and offers of support. Thank you.

This crisis is going to continue; it will continue for a long time. The toll this has taken on the city, on the residents, and on the youngest and most vulnerable members of the population probably won't truly be known for years. Whatever the end result, it will be devastating. Flint has received lots of national attention from celebrities, sports teams, and national groups. Some of it has been helpful and sincere. Some, maybe not so much. As the attention fades, and the new cause of the day, month, or year emerges, it will no longer be as cool to donate water or do a fund raiser, but the crisis will still be here. So will GHS. Not so famous, unheralded, unappreciated social workers, psychologists, nurses, and all the staff will still be here to help deal with the long term effects. We will do this without fail. We all would. It is what we do.

Thank you.

Danis Russell, MA, MBA, is the CEO of Genesee Health System

One More Thing We Do

Tom Watkins, President and CEO
Detroit Wayne Mental Health Authority

Four months ago, Detroit Wayne Mental Health Authority (DWMHA) began training first responders throughout Wayne County, on the distribution of Naloxone (also sold under the brand name Narcan) to stop opioid overdoses. To date (June 30th), approximately 500 kits have been distributed to first responders throughout Wayne County. Two lives have been saved to date, one of which was caught on dash cam when Michigan State Police Trooper Ben Sonstrom saved a man from an overdose earlier this month. Naloxone binds to the body's opioid receptors, blocking the effects of opioids. When administered during the correct time frame during an overdose, this treatment can be life-saving, enabling people to get the longer-term treatment they need and deserve. Naloxone is an ideal treatment because individuals can neither get high on it nor abuse it, and it has no effect on individuals without opioids in their system. When first responders use the kits, DWMHA replaces them free of charge.

http://www.detroitnews.com/story/news/local/detroit-city/2016/06/25/state-police-save-lives-using-opioid-antidote/86372928/

https://www.facebook.com/DWMHA

https://twitter.com/dwmha

THANK YOU—We don't say it enough!

What you are reading would not be possible without a lot of time and effort being expended by many people. These authors make us better by offering different ways to look at ideas and attack tough issues. We try to credit those primarily responsible but many of these individuals would be quick to add that their contribution is the product of many souls. Once again, their voices reveal public behavioral health to be an amazing movement in Michigan! Their diverse perspectives educate us, bring us together, stimulate discourse, and advocate for individuals with mental illness, substance use disorders and developmental disabilities; and others who find themselves living in the margins of our communities, laced with stigma. In a time when media often captures our attention with fear and anger, what our writers are providing reflects the "better angels of our nature". When you see them, tell them, "thank you."

Keys to Forging a Healthy and Vibrant System:

Unity, Diversity, Advocacy

ROBERT SHEEHAN, CEO, Michigan Association of Community Mental Health Boards

Over the past several months, in headlines, newscasts, and radio interviews, as well as in the halls of the Capitol, on the Capitol lawn, in living rooms, offices, and clinics across the state, the future of Michigan's publicly sponsored behavioral health and intellectual/developmental disability services (BHIDD) system has been discussed and debated.

As I have written in the past, I, and many who watch our system have been impressed with the ability of all of the system's stakeholders to focus on what is essential while working to pursue opportunities, thwart threats, and draw order from chaos. The "essential" to which this system remains focused is its essential function, that of fostering a high quality of life for those served by the state's public BHIDD system—over 300,000 per year—through the use of evidence-based and promising practices; guided by person and family-centered community-based approaches.

In addition to this ability to focus on the essentials in the face of this swirling political environment, several other qualities of the BHIDD community, demonstrated through this most recent round of political, fiscal, and clinical discourse, have stood out over the last few months.

"This is what democracy looks like."

The first quality is unity. The response of the BHIDD community to Section 298 of the Governor's proposed FY 2017 budget for the Michigan Department of Health and Human Services was rapid and unified. Led by the persons served by the system—and joined by the family members of those persons, community partners of the system, advocates, clinicians, and concerned taxpayers—the response to Section 298 was, in the words of an advocacy colleague, "as unified and sudden as I have ever seen." This unity of purpose in the face of the threat to the public safety net posed by Section 298 led to the withdrawal of the original language and the formation of a workgroup, made up of a diverse set of stakeholders, to begin to take the next steps in the redesign and refinement of the state's publicly sponsored healthcare system, both its physical health and behavioral health/intellectual/developmental disability systems. As one member of this workgroup pointed out to me, "This is what democracy looks like."

The second quality is diversity. While diversity can work against unity if not handled well, the diversity of views represented across the BHIDD community led to a very strong political force. In venues across the state, stakeholders of the BHIDD community were able to coalesce around their common values and interests while not losing their passion nor clarity of their vision for the future. The ability to form such a coalition, not formally called together, but acting as independent parties linked via a common cause, was key to this spring's legislative victories and will form the basis for future efforts designed to improve Michigan's public healthcare system while fostering the common good.

The third quality is advocacy. While the BHIDD system's stakeholders—the persons served by the system, their families, advocates, and community partners—were forthright in their advocacy on behalf of the public system, these same stakeholders were equally forthright in reminding the system that much remains to be done. This advocacy—the advocacy aimed at ensuring that the system lives up to its values and the core concepts around which it was formed —is essential to the health, vibrancy, and evolution of the system. We, as providers and payers within the system welcome such advocacy and will continue to be in very active and change-oriented dialogue with those whom we serve and those who advocate with and on behalf of them.

It is in combining all three of these traits—unity, diversity, and advocacy—that the BHIDD community has been able to remind policy makers and the citizens of this state of the core values that drive Michigan's BHIDD community, of the power of the voices of the hundreds of thousands of Michigan residents served by the public system, and of the fact that the health and vibrancy of the state's public BHIDD system is promoted by the critiques of this system provided by those served by the system, and the state's well organized advocacy community.

The Association looks to the challenges ahead, with clear eyed resolve, courage, and hope. This Association and its members, alongside the hundreds of thousands of stakeholders and partners, will, in the months and years to come, tackle these and many other opportunities and threats through our continued commitment to unity, diversity, and advocacy.

INVESTING IN MENTAL HEALTH: *Dollars Well Spent*

George T. Darany, State Representative,15th District, Dearborn

Soon after Governor Snyder's 2016-17 budget was introduced, many of my constituents contacted my office to express their concerns about contentious boilerplate language in Section 298, and to discuss the many negative consequences that would arise as a result. Thankfully, we no longer have to worry about boilerplate 298, as the language has since been redacted; however, this issue reflects a troubling pattern that I have seen in Lansing throughout my time in office. For the past decade, mental health care has not been treated as a legislative priority, which means we have neglected the approximately 348,000 adults and 112,000 children in Michigan living with serious mental health conditions.

In the current system, public mental health entities provide specialty services not offered by traditional Medicaid Health Plans (MHP). These services include case management, community inclusion, employment, housing, jail services, and transportation. The recent proposal aimed to transfer state funding for Medicaid behavioral health services from public plans—or Prepaid Inpatient Health Plans—to for-profit MHPs. Many healthcare professionals argue that MHPs have higher administrative costs and allocate less to community services that directly benefit patients. Changing the current system could threaten to disrupt existing relationships between patients and their doctors, as most MHPs mandate that patients can only receive care from health care providers that are listed in the plan or network.

When the *Healthy Michigan Plan* was enacted in 2013, the Legislature re-directed general fund dollars away from healthcare providers, assuming that the federal government would pick up the slack. When this did not occur, county public health providers were forced to cut down on services offered to families who are covered by neither Medicaid nor commercial insurance. A few of these valuable services include reintegration services, education and awareness efforts, residential services, and case management. A recent report from The National Association for Mental Illness singles out this policy as one of the most damaging hits to mental health funding in the country.

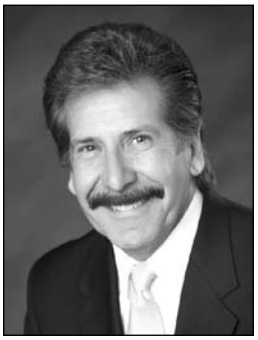
This issue hits close to home for me. I have seen the weight of mental illness physically consume friends and family members. Therefore, I see no reason why mental and behavioral health services should take a backseat to physical conditions in our healthcare system.

Furthermore, it is time for us to start talking about the connection between mental health and addiction. Addictive substances make chemical changes to the brain, with many of the same side effects as mental illness. The United States Department of Health and Human Services recently awarded $3.4 million in additional federal funding to battle opioid addiction in Michigan. Over the past year, the number of deaths caused by a drug overdose rose by 14% in Michigan, resulting in over 1,700 deaths. Numerous communities have suffered from increased use of heroin and misuse of prescription drugs, including my own. The number of drug related arrests in Dearborn has doubled since 2011, a quarter of which involved prescription painkillers; in 2015, the Dearborn Police Department responded to nearly 250 drug overdoses.

It saddens me to see my hometown of Dearborn lose so many individuals due to the lack of preventative action. It is crucial that we work together to combat the stigma that accompanies substance abuse, addiction, and mental illness so that affected individuals can receive the help they need. I will continue to advocate for preventative measures and school-based mental health services, renewed funding for direct services in the community and increased collaboration between inpatient and outpatient mental health care.

Mental illness, if left untreated, can serve as a significant obstacle to daily life—in school, at work, or at home. As legislators, it is our responsibility to protect the well-being of our constituents and reaffirm our commitment to mental health care in Michigan. I applaud the recent efforts of Lieutenant Governor Brian Calley for leading a work group on mental health care in Michigan, and I hope this will be a preliminary step toward a rigorous focus on mental health care in future state legislation.

Modernization in the Delivery of Michigan's Public Mental Health Services



Elmer L. Cerano, Executive Director

Michigan Protection and Advocacy Service, Inc.

Not long ago, I was at a meeting where a pretty hot discussion ensued and accusations were leveled stating, "You advocates" (meaning me) advocated for sheltered workshops and now you are advocating for their closure!"

I was advised, "Elmer, if you want to be successful, do the things you do well...and do more of them."

I thought about this advice for a minute and responded, "That should be good advice, but I am certain that is exactly what Kodak was also told."

Kodak made great film, and they had their competitors who made equally good or better film, but for years, Kodak held its own in an increasingly competitive market. Unfortunately for Kodak, some wise guy developed digital cameras—no film, no trips to the Cunningham Drug Store to get the film developed, no processing fees, no waiting and no additional costs. Kodak is now nearly invisible.

Kodak, like so many of us, refused to recognize that change is inevitable. Progress continues to move forward and no matter how we try to slow the pace of change, resist it or even ignore it, our efforts will inevitably fail.

The challenge for us is not to do more of what we do well; the challenge is to lead the change well.

Currently, Michigan's service delivery system for people with mental illness (MI), substance use disorder (SUD) and intellectual and developmental disabilities (I/DD) is undergoing significant changes that will have an impact on the lives of people with disabilities and their families far into the future. The system redesigns currently being discussed will impact generations of people with disabilities who are not yet born.

So, *our* responsibility of doing it right is enormous and extremely humbling.

I am of the generation who remembers the beginning of the deinstitutionalization movement. In our early 1970s naive wisdom, we thought that by simply building smaller institutions we would solve the problems associated with warehousing, mistreatment, dehumanizing services and abuse of people with disabilities. We convinced ourselves that even a 36 bed, former convent, would be a perfect place to put people with intellectual disabilities who were "ready" to be moved out of the horrid conditions of the 1,000 bed State run institutions such as Plymouth, Coldwater, and Lapeer. We never even thought to ask the opinion of the people upon whose lives we were intruding.

To be brutally honest, our rationale for a compromised definition of "community" for people with disabilities was based on costs, administrative convenience and historic inertia. It was not based on a true understanding of full community inclusion. Many of the supports and services we artificially defined as "community inclusion" would never be tolerated for people without disabilities.

Of course, since many of the institutional residents had been institutionalized since infancy, they did not have a point of reference from which to form an opinion as to a different or better lifestyle. For too many of these individuals, the institutional walls were all that was known to them as "home."

In 2009, when Michigan's last State institution finally closed, the residents and their families were asked, "Where do you want to live and what supports do you need to live successfully in the community?"

It was such a simple and reasonable approach. Why did it take us so long to understand that it was never the residents who were not ready to leave the institutions, it was us who were not prepared to deliver the supports people needed. In retrospect, we could have accomplished deinstitutionalization in alphabetical order rather than using a false "presumption of readiness" for people to have the opportunity to live less restrictive and more joyful lives.

Although there were strong advocates in the 1970s like Dohn Hoyle, and the late Ben Censoni, who insisted that the most severely involved populations have the first opportunity to leave the institutions, many of us incorrectly assumed that a process of incremental change was wiser. While some of us were busy building smaller institutions, others of us were concentrating on creating new digital cameras.

The world continues to change around us, and like it or not, the pace of change is accelerating.

The Game Changers

Managing change is always difficult and it is even more difficult when the advocates that had brought about change over the past forty years are now challenged to modernize their own forty-year-old-ideas of progress.

(See Modernization *on page 6)*

Modernization *(from page 5)*

Right now, there is an alignment of several major game changers that has provided us with a unique opportunity to move Michigan to the next generation of "deinstitutionalization."

Against the backdrop of the following game changers, perhaps a new way of thinking is possible and for the first time within reach, if we allow ourselves to think differently.

- The Home and Community Based Services Final Rule (HCBS)
- The Work Innovation and Opportunities Act (WIOA)
- The Americans with Disabilities Act (ADA)
- The Olmstead Decision
- Medicaid expansion
- The Affordable Care Act
- More inclusive definitions of "medical necessity"
- Rapidly advancing research and technology
- Inclusive education, etc

As challenging as it is, we must recognize that smaller institutions, group homes, "intentional communities" (segregated housing developments), sheltered workshops, day activity centers, segregated special education schools and classrooms, and all of the modern thinking of the 1970s, 80s and 90s must give way to basic values of:

- Person Centered /Family Centered Planning
- Self-Determination
- Full, uncompromising and honest community inclusion

The infamous Section 298 boilerplate language in the Governor's originally proposed 2017 budget –

Perhaps unintended, but the Governor's boilerplate language in his proposed 2017 budget (Section 298) started a discussion that many of us had been fearfully anticipating.

The effort to move all of the funding for the public mental health system through the private health care companies, gave rise to real fears that the services and supports needed to help people with disabilities live healthy and meaningful lives in the community would be funneled through an uncompromising medical approach. Community integration opportunities would be required to pass through a filter of medical necessity and return on investment profit margins.

Michigan Protection and Advocacy Service (MPAS), along with other disability advocates, not only viewed Section 298 as a real threat to the deinstitutionalization progress made over the past 40 years, we also saw it as a unique opportunity to move Michigan forward. To do this however, the forward thinking leadership of the Michigan Community Mental Health Boards Association, the Prepaid Inpatient Health Plans, and the Michigan Department of Health and Human Services, needed to up their games.

The Advocates insisted that while the current public mental health service delivery system must remain a *public* system, it too must modernize and become more efficient in how it responds to the vastly different and continually changing needs of the people it serves.

In January 2014 when the Federal Centers for Medicare and Medicaid Services (CMS) issued final rules clarifying eligibility for Home and Community Based Services (HCBS) Medicaid funding, all states were required to submit a transition plan by January 16, 2015. The States then had to demonstrate how they planned to comply with and implement their approved plan by March 2019.

"After decades of advocating for community based services and supports for people with disabilities, it became painfully clear here in Michigan, and around the nation, that there were varying definitions of what is meant by 'community'," said Kate Pew Wolters, Past President of the MPAS Board of Directors. "This historic lack of a clear definition of 'community' has allowed the creation of housing options for people with disabilities that looked suspiciously like the institutions that we sought to dismantle."

Throughout the country, there have been new developments of gated communities, special farms and residential villages specifically built for people with disabilities. Although well-intentioned, it appears clear that the new CMS rules will prohibit the use of Federal dollars from funding what is newer construction, but never-the-less, a traditional institutional approach to responding to the complex and changing needs of people with disabilities. The Federal laws and guidelines are clear—Federal dollars cannot be used for residential and non-residential programs that segregate people because of their disability.

MPAS supports the CMS rules in creating new opportunities for people with disabilities to be fully included in the fabric of American society and our interest reflects our willingness to assist the public mental health service delivery system in the difficult tasks of correctly managing the important changes imbedded in the converging opportunities. Michigan's HCBS Plan and the State's plan to implement the Workforce Innovation and Opportunities Act (WIOA) must hold true to the values of self determination and full "community" inclusion as defined by the general population.

One can hardly argue with the wording or the intent of the final CMS rules if implemented with honesty and integrity. It is how Michigan will successfully implement the rule that is the critical question. MPAS encourages the State of Michigan to move quickly and decisively to implement the final CMS rules with an *(Concluded on page 15)*

Mindfulness – The Opening Door

Robert Mcluckie, Connections Editorial Staff

This discussion of mindfulness contains material from the work and the experience of many people. In our community mental health practice the use of mindfulness techniques is rooted in evidence-based practice. Methods used to support consumers of services are proven to be effective through empirical research. Fortunately, we are also beneficiaries of a vast literature on mindfulness and meditation that arises from ancient folklore, contemporary self-help writers, yoga and meditation teachers, spiritual leaders, and lay practitioners. Often empirical research has borne out claims that were first articulated in very early folklore and parable, and later reinvigorated within popular culture. For this article I've drawn from all of this material.

A main focus of *Connections* is to share the experience of individuals who have used supportive services to help them in building and maintaining a meaningful life. They will speak here. It is their experience that is the reason for our work and the reward of our labors. May we always listen to them with mindful compassion.

A Definition of Mindfulness

Mindfulness is the practice of purposely focusing ones attention on the present moment and accepting "what is" here now without judgment. Mindfulness is clear awareness of immediate experience without distraction: fully aware/ here/ now.

Mindfulness can focus on what is happening externally or internally. One can be mindful of one's thoughts, feelings, breathing (a common relaxation technique), or one's body sensations. I can be fully aware of the sound of wind in the trees, the discussion I am participating in, my movements and actions as I rake the leaves, wash the dishes, and the temperature and feel of water as I swim. Mindfulness is to "Be Here Now" with full attention.

You're being mindful when:

- You eat dessert and notice every flavor you are tasting, instead of eating the dessert while having a conversation and looking around the room to see who you know.
- Having gotten free of your anxiety or self-consciousness, you dance to music and experience every note, instead of wondering if you look graceful or foolish.
- Thinking about someone you love or someone you dislike, you pay attention to exactly what your love or your dislike feels like. You're not caught up in justifying the love or hate to yourself; you're just diving into the experience, with full awareness that you're diving in.
- You walk through a park, you actually walk through the park. What does that mean? It means you let yourself "show up" in the park. You walk through the park aware of your feelings about the park, or your thoughts about the park, or how the park looks, or the sensation of each foot striking the pavement. This is different than taking a walk in the park and not "showing up," walking through the park while you are distracted by thoughts of what you'll have for lunch, or the feelings towards a friend with whom you just argued, or worries about how you're going to pay this month's bills.

The History of Mindfulness

The cultivation of mindfulness has roots in Buddhism about 2,500 years ago. Most religions include some type of prayer or meditation technique that helps shift our thoughts away from our usual preoccupations toward appreciation of the moment and a larger perspective on life.

Jon Kabat-Zinn, founder and former director of the Stress Reduction Clinic at the University of Massachusetts Medical Center, helped bring the practice of mindfulness meditation into mainstream medicine and demonstrated that practicing mindfulness can bring improvements in physical and psychological symptoms as well as positive changes in attitudes and behaviors.

> *"...mindfulness and meditation are in wide use as methods for enhancing participation in all phases of life."*

Today, mindfulness and meditation are in wide use as methods for enhancing participation in all phases of life. We in the community mental health profession encounter the practice of mindfulness most often through services utilizing dialectical behavior therapy (DBT). DBT uses a training approach so individuals may learn new skillful behaviors to replace ineffective and destructive behaviors. It teaches four sets of behavioral skills, the first set is mindfulness.

The Practice and Benefits of Mindfulness

Mindfulness is a skill. It must be learned. Like a sport or playing a musical instrument, we practice to become skilled, then we "practice" to maintain skill and to enjoy and benefit from the activity. Mindfulness practice often begins with learning to meditate. The purpose of meditation is to quiet the mind

(See Mindfulness page 8)

from its tendency toward constant activity. Meditators often refer to the normal state of mind as the "monkey mind." It flits here and there continually. If you've ever tried to meditate, you know how difficult it is to quiet the mind. Through meditation we learn to tame the monkey; to quiet the mind.

The first goal of mindfulness practice is to be able to focus the mind at will and to be able to hold that focus. This opens the ability to see our internal and external environment more clearly and more deeply. This ability then can lead to deeper appreciation, understanding and insight.

The final goal is "to live life mindfully." Those who practice mindfulness cite many benefits including less suffering, greater fulfillment, self-knowledge, and self-acceptance. The ability to change patterns in behavior and thought is cited as a central benefit, as is the development of a spirit of acceptance, loving-kindness, and a commitment to helpfulness. The most common benefit to those engaged in dedicated practice is a change in consciousness sometimes described as "tranquil awareness" or "calm abiding" in a restful state. These are individual experiences and clearly subjective, but reports of these benefits are common.

Empirical research verifies many benefits of mindfulness. The Harvard Medical School reports that mindfulness-based interventions have helped reduce physical and psychological symptoms in people facing a wide variety of challenges. Mindfulness-based cognitive behavioral therapy, and dialectical behavior therapy are well established treatment methods.

What's Your Experience?

We thank those who've shared accounts of their experiences with mindfulness practice.

Charles

I live a pretty active life. It's like, I'm always busy. I want to help people so I never say "no." I had so much going on I felt like I couldn't stop to relax. I was a workaholic. It was getting to a point where I thought I was going to go over the edge. You know, like a nervous breakdown or just go off the deep end. A good friend talked to me about it and pushed me to take up meditation. He's a meditator. I really respect him and trusted him, so I started meditating myself. At first it was real hard. *Real hard!* I made excuses that I didn't have the time; I'll do it later; something else is more important. But I kept trying. I kept at it for months. I'd focus on my breath and label my thoughts and emotions like you are supposed to. Eventually I started noticing how I could feel space between my thoughts and feelings, like there was more room inside. I could feel my thoughts and feelings start to come up, then they'd be here all the way. I'd see them as something I could look at; just look. Eventually they would fade away. This really helped me get a handle on things because I learned I could see this way in everyday life. This is mindfulness. You can look calmly at things rather than just feeling like everything is coming at you. I started to say "no" when I'd feel the urge to get busy-busy-busy or take up a new project. I would pause and say, "What do you really want here?" I slowed down. Now I feel a lot better every day. Not so rushed or nervous. You may think this is no big deal, but for me it is! I feel in charge of my life versus being always pushed around by things. Mindfulness is a good way to sort things out and a good way to live too. I'll always do it.

Mary

It is amazing how stress can affect you mentally and physically. I wouldn't have believed it if it had not happened to me. I was 43 when it caught up with me.

Most of my life I've suffered with anxiety and stress, but I just carried on. My drive to achieve meant that I didn't listen to my body. I worked my way up through management becoming an executive. I was studying for an MBA while working full-time. I was very stressed. I wasn't sleeping and my asthma got worse. I experienced headaches that lasted days, and severe eczema. Even with my body telling me so clearly to slow down, I kept on pushing. I began to experience weakness and seizures. My body had finally got my attention. I saw a neurologist.

I was diagnosed with psychogenic seizures. During a therapy session something from my past came to light and I was diagnosed with Post Traumatic Stress Disorder. After all of this I became ill with depression.

I was introduced to Mindfulness as part of my treatment. I was surprised at how I could actually slow down my thinking to the point where I could see stress coming. I've learned that I can meet any circumstance with calm. Everything can be greeted as an opportunity to practice mindfulness. I've learned how to accept and calmly work with difficulties rather than panicking or reacting in destructive ways. I use mindfulness practices every day. Sure, I still get anxious and stressed, but now I handle it with confidence and it's getting easier. My depression has reduced so that I'm not in treatment.

Mindfulness is like an opening door; it has truly changed my life. I enjoy a wider range of things and I enjoy them in a deeper way. I listen to my body and pace myself. From practicing mindfulness I am now kind to myself which was very difficult before. I didn't believe it when told mindfulness would improve my concentration and patience, but it has. I actually finish things now rather than moving onto something else and achieve a lot more with less effort. I wish that I had been taught mindfulness techniques as a young woman I might not have become ill. *(Continued on next page)*

Jeanne

I've been meditating and practicing mindfulness for about a year and a half. I've seen the benefits. I am a happier person and I feel much more relaxed and in control. Does mindfulness work? Yes! My husband and I were having significant difficulties several months ago. Our marriage was in trouble. We went to see a counselor. My husband brought up several traits of mine that he found very difficult. I had heard these from him many times before at home and I always would get angry, and defend myself, and yell or cry. In counselling I thought I'd try to stay calm, so I listened to him. I used mindfulness to listen deeply and to hear the emotion in his words instead of flying into anger. Wow, was I surprised! Instead of just reacting, I listened deeply and heard a whisper of love and concern there in his comments. He wasn't just accusing me. I found I was able to open up and discuss his concerns with him. I was thinking with wisdom from my practice of mindfulness. I said within myself, "I love this man. I will be calm and listen mindfully." I learned a lot about myself in those sessions. Some of it wasn't pretty, but as the meditation slogan goes, "Maintain a joyful mind"… Because you are practicing… Life can be hard, but you have tools… You can go through the difficulties… Be glad because you will learn a better way…You will grow! I'm so grateful for the practice of mindfulness.

How Mindfulness Is Revolutionizing Mental Health Care

The National Institute of Mental Health (NIMH)—the largest scientific organization in the world dedicated to research on mental illness—is getting serious about investigating mindfulness as a complementary treatment for a range of mental health conditions. More than 350 million people globally suffer from depression, and 1 in 13 people around the world have been diagnosed with an anxiety disorder. Overall, the World Health Organization estimates that roughly 450 million people suffer from some form of mental or neurological disorder, and that roughly 1 in 4 people will be affected at some point in their lives.

Evidence of the efficacy of mindfulness-based treatments continues to grow. There are now nearly 500 scientific studies on mindfulness/meditation and the brain in the National Institute of Health's PubMed database.

Research has shown mindfulness to increase activity in brain areas associated with attention and emotion regulation. Mindfulness also facilitates neuroplasticity—the creation of new connections and neural pathways in the brain. Meta-cognitive learning (learning to watch your own mind and to be introspective in that sense) has an impact on brain pathways long-term. This knowledge about the neurology of mindfulness could one day lead to improved clinical treatments.

The beneficial effects of mindfulness also extend to non-clinical populations. Anyone can benefit from learning to cultivate a focused, non-judgmental awareness on the present moment, particularly in our busy modern lifestyles that are often characterized by stress, sleep deprivation, multitasking and digital distractions.

(*Huffington Post*, January 23, 2015)

Mindfulness Techniques

There is more than one way to practice mindfulness, but the goal of any mindfulness technique is to achieve a state of alert, focused relaxation by deliberately paying attention to thoughts and sensations without judgment. This allows the mind to refocus on the present moment. All mindfulness techniques are a form of meditation.

Basic mindfulness meditation – Sit quietly and focus on your natural breathing or on a word or "mantra" that you repeat silently. Allow thoughts to come and go without judgment and return to your focus on breath or mantra.

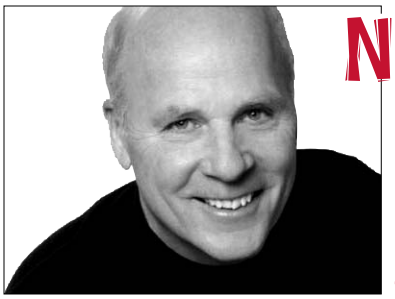
Body sensations – Notice subtle body sensations such as an itch or tingling without judgment and let them pass. Notice each part of your body in succession from head to toe.

Sensory – Notice sights, sounds, smells, tastes, and touches. Name them "sight," "sound," "smell," "taste," or "touch" without judgment and let them go.

Emotions – Allow emotions to be present without judgment. Practice a steady and relaxed naming of emotions: "joy," "anger," "frustration." Accept the presence of the emotions without judgment and let them go.

Urge surfing – Cope with cravings (for addictive substances or behaviors) and allow them to pass. Notice how your body feels as the craving enters. Replace the wish for the craving to go away with the certain knowledge that it will subside.

Out and About – Generating mindfulness becomes easier as we practice. Sometimes we will simply drop into a state of tranquil awareness (mindfulness) without conscious effort. This is good news! It means our base frame of mind is becoming one of non judgmental peaceful witnessing. Practice mindfulness when you are out and about in your world. Practice mindfulness while walking, eating, shopping, gathering with friends, etc. It's good for you!



Never Enough

Michael Burke

It is true that in life things don't often turn out as we plan. My situation was different. Things had turned out better than planned. I was married to my high school sweetheart and we had been blessed with two perfect daughters. We were married ten years before our children were born so we were in a great place, both financially and emotionally.

My professional life surpassed my wildest expectations. I loved being a lawyer and had one of the most successful practices in the county. My peers had voted me in as president of the local bar association. My spare time was filled with volunteering for agencies such as the County United Way Board, and the Board of Brighton Hospital. Most satisfying, was time spent chairing three successful school millage proposals in my community.

This, however, is just part of my story. The rest of the story deals with my struggles with addiction and the trading of one addiction for another. My name is Michael Burke and I have been in recovery from alcoholism for thirty-eight years.

As a young man I discovered that alcohol worked for me. It made me feel confident in myself. I was always a "controlled" drinker, a person raised in a family where one was expected to be able to "hold his liquor." In the beginning that was easy for me. I had an incredibly high tolerance to alcohol, able to drink large amounts without appearing to be affected.

As the years passed, my drinking started to change. My tolerance to alcohol decreased. The control over alcohol that I had enjoyed no longer existed. Thanks to the guidance of my wife, family and friends I entered a thirty day inpatient rehab facility in 1978 and I have not had a drink since. I had no problem accepting the fact that I was powerless over alcohol and that my life had become unmanageable. I even bought into the theory of cross-addiction as it related to other substances. I fully accepted that drugs, prescription or non-prescription, could return me to that world of addiction I never wanted to be a part of again. I knew I would never take recreational drugs after my education at Brighton Hospital. I also knew that if I needed a prescription narcotic drug it would only be taken under strict medical supervision. What I failed to accept was a warning given during a lecture at Brighton Hospital about a process addiction.

The lecture was given by Doctor Russell Smith, a world renowned speaker on alcoholism. He told the patients who were congregated in the chapel that his greatest fear for us was that we would leave our addiction at the steps of Brighton Hospital and walk down the street and trade it for another addiction. This is how he stated it to the patients, "You people must understand that if you can drink it, if you can smoke it, if you can snort it, if you can inject it, if you can roll it (referring to dice and gambling), you are the ones who can become addicted to it. Stay away from it."

That was in 1978, but in so many ways it feels like it was just last week. I chose to follow all the advice given by Dr. Smith except the part about gambling. As a result of that decision, I spent my 23rd, 24th and 25th years of sobriety in Jackson Prison. I am a compulsive gambler. It would take about 20 years for me to cross the line from social to compulsive gambler. It all began with a harmless trip to Las Vegas.

My wife and I usually took a yearly trip to Vegas, the Bahamas, or some other gambling destination. I loved acting the part of the high roller. Rides in limos, suites, fine dining and shows were offered as "comps" at the casino. There is a price to be paid for comps, and the cost can be substantial. There is a great line in the movie *Casino* about gamblers: "The more they gamble, the more they lose, and in the end we get it all." To get the comps you have to gamble. From the very beginning I was not honest about my gambling. If I lost money, I just didn't tell my wife. It was a form of financial infidelity. I knew that if I told her I usually lost a large sum of money on our trips we would never go back. We only went out west once a year back then. My law practice was good enough that the losses on my yearly trip could easily be absorbed. The foundation of every addiction is built upon lies. I was beginning to build the foundation of my gambling addiction on those very first trips.

What most people do not understand about compulsive gambling, or addiction in general, is that in the beginning it works. It was never about the money, so winning and losing did not matter. It was the rush I lived for. It reminded me of the rush I got in my early days of drinking. The money only allowed me to gamble for a longer period of time. I was unaware that I was losing control of my gambling until it was too late. The chains of addiction are too weak to be felt until they are too strong to be broken. By the time I was able to comprehend what was going on I had become addicted.

My life changed in 1994 with the opening of Casino Windsor. Many gambling studies have been done based on the proximity of a casino to the gambler. One of those studies showed that problems associated with compulsive gambling doubled within a fifty to sixty mile radius of a casino. Casino Windsor was 58 miles from Howell. In the beginning I would go over to Windsor and spend $300 a day. I never told anybody I was going to the casino.

Gambling is called the hidden addiction. I was very good at hiding the fact that I was gambling. Because of my practice, I could always say I had some place to be that would require me to be gone for a few hours. Over the next few years my gambling became worse. I was now at the stage of compulsive gambling referred to as "chasing." I was spending more time at the casino and of course losing more money. All I wanted to do was to win back the money that I had been losing. I promised God that if I could just win my money back I would never gamble again.

I finally found myself in a financial dilemma where I owed a lot of money and needed funds to support my addiction. Two out of three compulsive gamblers will commit an illegal act to get money with which to gamble or to take care of problems created by their gambling. My solution was to borrow money from my clients' trust accounts. I had convinced myself that I was not stealing that money but simply borrowing it until I could replace it. That day was the beginning of the end. There could be no turning back.

"I had to come home and tell my wife and two daughters everything…The pain that I saw in my family's eyes that day will live with me until the day I die."

The two greatest dangers facing a problem gambler are proximity to the gambling venue and access to funds. I had both. I was less than an hour drive to the casino and had access to my clients' trust accounts. In a few short years my once perfect life was destroyed. The first time I took money out of that trust account I knew it was only a matter of time before everything collapsed around me. I have come to discover that this is somewhat of a common ending for many compulsive gamblers—total devastation.

For me it all ended on March 30th, 2001. That day I went to the State Bar of Michigan and turned myself in for taking funds out of my clients' trust accounts for my personal use. I left there and went over to the Michigan Attorney General's Office and admitted what I had done. After that I had to come home and tell my wife and two daughters everything. They had no idea what was going on. The pain that I saw in my family's eyes that day will live with me until the day I die. I probably understand addiction better than most people. But even that knowledge does little to abate the self-loathing and disgust I carry because of what I did to my family on that day.

Two months later I was sentenced to serve three to ten years in Jackson State Prison and ordered to repay my victims the sum of 1.6 million dollars.

I was absolutely terrified every day I was in prison. But I soon learned that when a person is suddenly placed in a position like this that he must decide what he is going to do from that point on. I decided that I was going to get better physically, emotionally and spiritually. I did that in the next three years with the help of my family. My family sent me every book and article they could find on compulsive gambling. That knowledge, combined with my own experience helped me to become an expert in the field of compulsive gambling.

Today I travel around the United States speaking to groups about trading addictions and compulsive gambling. My book, *Never Enough: One Lawyers True Story of How He Gambled His Career Away*, has been published by the American Bar Association. The book explains my rapid descent into the abyss known as compulsive gambling. The proceeds from the books go to my victims.

Over the years I have come to learn that a large percentage of compulsive gamblers come from a substance abuse background; usually alcoholism.

Many of the people in this population are able to effectively deal with their substance abuse with the help of a good recovery program and then end up trading their substance abuse addiction for a compulsive gambling addiction. Addiction is addiction is addiction. I have travelled the country talking with compulsive gamblers. The majority have told me that they come from a substance abuse background. Some disclosed that they drank and gambled at the same time. The majority stated that they first had successfully dealt with a substance abuse problem and later developed a compulsive gambling problem when they were in recovery. These people told me that gambling did all the same things for them that substance abuse did for them. The major difference was how much easier gambling is to hide. There are no outward manifestations. The first time that a gambling addiction may become apparent to a family member or friend is when the gambler loses a job, when the gambler's home is foreclosed, when there is a divorce, when criminal charges are filed or when suicide is attempted.

If you are a person in recovery or come from a family history of addiction, my simple advice to you is, *do not gamble*. If you have friends in recovery who are gambling, please advise them not to gamble. Any amount of money they may win is *Never Enough* to justify the total devastation that awaits them further down the road.

Michael Burke lives in Howell, Michigan where he practiced law for 25 years. You can contact him at:
burkemichaelj@yahoo.com.

Burke's book, *Never Enough: One Lawyer's True Story of How He Gambled His Career Away,* has been published by the American Bar Association. Proceeds from the book go to his victims. He travels the country speaking to groups on the topic of trading addictions and compulsive gambling.

The **Bedrock** of My Mental Health

Greg Adams, Lenawee Community Health Authority Board Member

My name is Greg Adams, and I am a board member at Lenawee Community Mental Health Authority (LCMHA). For over ten years I received treatment and counseling from LCMHA for bipolar disorder. During that time period, in an effort to work on my physical and mental fitness, I competed in triathalons, several marathons and shorter distance road races, and culminating with completing an Ironman competition. For me, exercise is a form of therapy whether it is a swim, bike, or a run.

A few years ago I decided to train for an Ironman. After completing the race, I remember thinking that maybe I could use my story to help others—to promote how improved your mental health can become through increased physical fitness. I approached a friend at LCMHA. I was quite shy about it, half thinking the idea was nonsense and that nothing would come of it. I couldn't have been more wrong. Since that day, I've shared my story with and given presentations to many support and civic groups, written articles for the LCMHA newsletter, and was eventually asked to serve on the LCMHA Board. For this article I will share my journey.

An Ironman consists of a 2.4 mile swim, followed by 112 mile bike ride, and ending with a 26.2 mile run. I finished the total distance in 14 hours and 8 minutes. People ask me, "Wow, what was it like?" I usually just smile and say, "It was a long day." I struggle to sum up the event. How do you describe a 14 hour race? I truly can't comprehend what I did, and honestly, the hardest part was training for the distance.

Being bipolar is not something I focus on or let limit me, but it does loom over me and my training. I absolutely need to work out to stay healthy, both physically and mentally. I consider it to be a part of my prescription drug program, and it's truly the cheapest form of therapy I can find. I get workouts weekly from a coach, and every day I do what is "prescribed." Doing a swim, bike or run every day (or often a double workout) provides me with several benefits: a sense of accomplishment as I work toward a goal, a "mental high," confidence and swagger, a fit body and an outlet for my anxiety and paranoia, i.e. my mental health issues.

I have also battled with obesity. Prior to getting serious about my health I weighed 250 pounds. For the past twelve years I've kept the pounds off and maintained a much healthier body weight at about 160. A driving force for me to maintain my fitness regime is to not allow myself to get that heavy ever again.

Truthfully, my fitness and working out is the bedrock of my mental health. I embrace living in the now and not looking ahead—you aren't doing an Ironman today, you're doing a workout today that will help you to do an Ironman. My philosophy is, "If you follow the plan, you will get there." And I apply that to all facets of my life. Why worry about something you can't control and that isn't a worry in the current moment? Each workout you do is a step up the ladder *and* will build you up to be stronger overall—both physically and mentally.

That is not to say I haven't failed. If I miss a workout, that can easily multiply, and it takes a toll on my mental health. I begin to question myself. I become withdrawn. I gain weight. I lose fitness. I become depressed. My life falls apart. Part of why I exercise is because I fear what would happen to me if I didn't. So I get outside to exercise whether the temperature is 0 degrees or 100 degrees, because it helps me keep my mental state in check. I absolutely need a routine, and exercising helps provide an anchor for each day. Otherwise I might drift, it's who I am.

Prior to tackling the Ironman, I had competed in six marathons, and two dozen half marathons, triathalons, and 100-mile bike rides. However, an Ironman is well beyond any of those events; I knew doing it would require hyper focus and more dedication than I ever put forth before.

I had to accept training for an Ironman to be like a part time job. During my peak weeks I trained well over 20 hours a week. My weekends were also training focused. On Saturdays I would start swimming or biking at sunrise, completing a five-plus hour workout. I'd then get up Sunday and do a double digit mile run. The event itself was like a celebration of all of the dedication and hard work I'd put into my training.

I'm so blessed to have an amazing support system. My sister and father were my support crew on race day. The race was held in Sandusky, Ohio and started with the 2.4 mile swim. It took me one hour to finish, and I placed in the top four percent.

Next up was the 112 mile bike ride. The sun was now rising. It was windy. It rained *(See* **Bedrock** *on page 15)*

Combating Stigma of children's mental illness

Crystal Coleman, Director, Clinical Services, The Children's Center, Detroit

Throughout Michigan Community Mental Health System of care we are always looking at ways to *reduce barriers to treatment*. It is one of those topics that never gets old. We have established practices, policies, protocols, and quality and compliance standards from the local—and stretching to the federal level—in our efforts to get individuals to our front door. We require and ensure that appointments are scheduled within 14 days or sooner, hoping that this will increase the likelihood for families showing up. We offer evening, walk in, and weekend hours for the convenience of our families. We assist with transportation. We ensure that our staff and offices are warm and welcoming. I'm certain that each agency has developed various creative ways to open their doors to our communities. Despite all of these efforts across continua, we continue to find a need to reduce barriers to treatment. Why is that?

The National Alliance of Mental Illness (NAMI) holds that 20% of youth ages 13 to 18 live with a mental health condition and that suicide is the 2nd leading cause of death in youth ages 15–24. NAMI also shows that the average amount of time from onset of symptoms to intervention is 8–10 years. That leaves our children and youth at a grave disadvantage which of course holds the potential to translate into further disadvantages in adulthood.

The 2015 *Kids Count in Michigan Data Book* shows that in 2014 there was a 31% increase (from 2006 to 2012) of confirmed child victims of abuse and neglect. It also shows an increase in teen (ages 15-19) death rates as a result of homicide (12 per 10,000) or suicide (10 per 10,000). The prevalence of mental illness, alarming and increasing rates of suicide, child abuse and neglect, as well as trauma related to violence and crime, suggests that our community is filled with children and families who could benefit from services.

If we are offering individuals an opportunity to change and improve significant challenges to their lives and support in making those changes, then why are they not knocking down our doors? Perhaps the major hurdle to tackle comes well before an appointment is offered.

The true barrier that must be overcome in order to create the opportunity for someone to walk through our doors is stigma. The Children's Center, just as other community mental health agencies have done, has decided that in order to reach the individuals who do not willfully walk into the doors of our agency, we must offer services to children and families in settings that are a natural part of their lives.

Our Community Based Partnerships program has partnered with Detroit Public Schools, Community Schools, Education Achievement Authority, Detroit Charter Schools, Children's Hospital of Michigan Specialty Clinic, and Detroit Community Health Connection. Even in these settings, we have learned that being physically present is not enough. While this accessibility increases student's ability to engage with a school based therapist, being within these settings has not significantly decreased teachers and administrators labeling of children and placing consequences before treatment. It also has not increased parent's participation in understanding and managing their child's symptoms and behaviors. Additionally, mainstream entertainment and news media often portrays individuals with mental illness in such negative light that it leads to fear and judgement and avoidance and shame rather than understanding and empathy for individuals experiencing these symptoms.

In order to reduce stigma related to mental illness, we must:

(1) Change the way that society, our community, talks about, views, and experiences mental illness by dispelling the myths that media perpetuates by providing the community with true, proven data and facts on a wide spectrum.

(2) Help individuals understand that both mental health and mental illness occur on a spectrum and educate community members on early signs and symptoms of mental illness so that children can begin to receive early assessment, intervention, and services.

(3) Maintain the systems that have been put into place to allow convenient access to treatment and services once individuals have made the decision to seek treatment.

In the coming years, The Children's Center looks forward to shifting our focus from reducing physical barriers to accessing mental health services to increasing the community's and our partners' education, awareness and understanding of mental illness and combating stigma. Join us and take the NAMI pledge to be "Stigma*free*" at www.nami.org

A Mother Called Karen

By Karen Cole, Mother of David

In the Spring 2010 issue of Connections*, we printed an article written by Karen Cole, devoted mother to David—born with a developmental disability—titled* Karen & David (you can re-read/download that moving article and poem on the MACMHB website by clicking on "Resources," selecting "Connections," on the drop-down menu, and then the "Spring 2010 issue." The article appears on page 6).

In June of this year, nearly six years after we first learned a little about David and his mother, Karen Cole wrote to Editor Clint Galloway to tell him that David had passed away. That email reads, in part:

"To Clint Galloway, Editor:

"In that issue [Spring 2010] you published an article titled *Karen & David* telling the story of my journey with my son, David.

"David and I journeyed together for almost sixty-three years when David died on February 25, 2016. I have been looking at photographs related to our journey as well as reviewing written material. This evening, through tears, I again read *Karen & David.*

"We held a "Celebration of Life" for David on his birthday, April 16, 2016. I shed no tears during that tribute because a number of persons presented their stories of interactions with David, in which many spoke of his wit, kindness and courage. It fed my spirit to recognize that professional persons, as well as others, came to know David as I knew him and did not think of or refer to him in clinical fashion but as the person they were privileged to know.

"He was disabled for approximately six weeks with a diagnosis of congestive heart failure. He received excellent care during his hospital admissions, and at age ninety, I was fortunate to daily drive from Algonac to St. Johns in Detroit to be with him. I was fortunate to be with him in St. Johns River District Hospital in St. Clair at the moment when sepsis claimed his life. Again, his courage was noted by those who cared for his needs during the journey of his illness.

– "Karen Cole, blessed to have been the mother of 'A Man Called David.'"

Following is a piece Karen wrote in April 2014 which she has chosen to share with us. Her powerful writing reveals the love and understanding of the relationship she has had with David— complete, and with the thorns as well as the blooms.

Thank you, Karen for again allowing us to step into the life that you and David shared. Karen Cole shows us what it means to be mindful and present.

A MAN CALLED DAVID

During the month of April, David had to deal with a pressure sore on his braced leg. This limited his upright movement with the walker for approximately two weeks.

Although he is confined to the wheelchair for the majority of his day, it was recommended that in order to retain his sense of balance he should move short distances with a walker. The physician explained that when one views the environment from a static position at all times, one loses the ability to adapt to varying positions.

David does not have the energy necessary to walk with the walker for other than short distances, such as from a car into a building, or moving about within the confines of a house. He becomes short of breath.

David was anxious when his bruised leg made it necessary to postpone appointments that would require his upright movement. One appointment was the monthly hair cut in Algonac followed by a day-long visit to my home. But I told him that I would come to his house and with help, we could transfer to my van and go to Tim Horton's to pick up coffee and then sit by the Blue Water Bridge in Pt. Huron.

David thought about that offer for a moment and then said: "Could we go to St. Clair?" I said, "Yes we can." Another moment and then he asked: "Could we go to McDonald's in Marine City?" I replied, "Yes." A pause, "Could we go to McDonald's in Algonac?" "Yes." A wonderful example of David's tactful manner. He wanted to go to Algonac.

On Saturday, April 19th, what was to be his regular Algonac visit, I fixed a bag with a large dinner tray, towels, hand wipes and a plastic container to hold the all too flexible McDonald's chocolate shake container. We would be spending our time together in the car. He mentioned "going to your house" in a very subtle fashion, which is his nature, and I explained that I would drive by but that, because of stairs, we could not go in. He was obviously pleased to see the house. We drove on to McDonalds.

David ordered "a Big Mac, Regular Fries, Chocolate Shake and Apple Pie." Because David is a fan of clocks, I suggested, when we left McDonald's drive-in, that I could park in downtown CVS lot with a view of Talmer Bank digital clock as well as a view of the river.

We found the perfect corner spot with an unimpeded view of the clock, the park and the river. David was excited and so pleased. I experienced his presence—as though we were one. He was filled with joy and contentment; fully present in every moment. I have no doubt that our mutual respect and unconditional love for each other created this beautifully serene experience of Oneness.

–Karen, mother of David, April 19, 2014

Modernization *(from page 6)*

unwavering commitment to deliver on the promise of better options for people with disabilities and their families.

For those of you who might not be familiar with the "Final Rule" here are a few of the aspects that will require our best thinking on how to move from where we are, to where we need to be:

- Each individual has privacy in their sleeping or living unit
- Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time
- Individuals are able to have visitors of their choosing at any time
- The setting is physically accessible to the individual.
- Any modification of the additional conditions must be supported by a specific assessed need and justified in the person-centered plan

Home and Community Based settings do not include:

- Nursing facilities
- Institution for mental diseases
- Intermediate care facility for individuals with intellectual disabilities
- Hospitals
- Any other locations that have qualities of an institutional setting, as determined by the Secretary
- Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution
- Any setting that is or any other setting that has the effect of isolating individuals receiving Medicaid HCBS will be presumed to be a setting that has the qualities of an institution

CMS rules that alone will prohibit HCBS funding include:

- Settings designed specifically for people with disabilities
- Settings primarily or exclusively for people with disabilities and on-site staff provide many of their services
- Settings that isolate, or where people in the setting have limited interaction with the broader community.
- Settings that are co-located and operationally related to one provider

In conclusion

Like the deinstitutionalization movement of the past, there will again be resistance to progressive movements to integrate people with disabilities into the general community. Some opposition will come from the community at large, others will emanate from people with disabilities and their families who fear a repeat of past failed promises for community inclusion, safety and needed supports.

These fears and concerns must be respected as we are again faced with the conflicts between personal preference and the purpose for which public dollars can be used. The inevitable conflict will surface, time and time again, where personal choice overrides a community inclusion philosophy. We cannot shy away from facing these very real and emotionally charged questions with respect and understanding.

As hard as the challenges are, and as difficult as the discussions will be, we have a duty and a responsibility to current and future generations of people with disabilities, that public policy and funding will be used to assure people with disabilities—and their families—access to the supports and services they need to live successfully as an integral part in the fabric of American society.

Bedrock *(from page 12)*

for over an hour. I was on the bike for over 7 hours—pedal, pedal, pedaling. I got off the bike feeling good. I had done four 100-mile rides in my training, and several over 80. I think my sister was surprised by how happy I was as I came for the run!

I did a nine-minute run, then one-minute walk for the marathon and things were going well. Halfway into the run I was still smiling. Having done such extensive training had toughened me mentally. But around the 20th mile, my stomach stopped processing fluids and food, and I could not keep anything down. So for the last 90 minutes of the race I took nothing in—after having been on the course for over 12 hours. The Ironman finished in the parking lot of Cedar Point Amusement Park, and as I made the turn onto the causeway and saw the lights of the rides in the distance—and the finish—wow! I had started the odyssey at 7:00 am, and it was now approaching 11:00 pm. My finish time was right where I expected it to be. I had followed my plan and achieved success!

Since the race I've continued to grow and challenge myself, instead of thinking I was limited by being bipolar. Joining the CMH board and speaking to groups and giving hour long presentations was not something I ever saw myself doing. The Ironman was a physical accomplishment, and everything I've done since has been just as rewarding.

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

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A Parable of Practicing Acceptance

A hundred and fifty years ago there lived a woman named Sono, whose devotion and purity of heart were respected far and wide. One day a fellow Buddhist, having made a long trip to see her, asked Sono, "What can I do to put my heart at rest?" She replied, "Every morning and every evening, and whenever anything happens to you, keep on saying, 'Thanks for everything. I have no complaint whatsoever.' "

The man did as he was instructed, for a whole year, but his heart was still not at peace. He returned to Sono, crestfallen, and lamented, "I've said your prayer over and over, and yet nothing in my life has changed; I'm still the same selfish person as before. What should I do now?"

Sono promptly replied, "Thanks for everything. I have no complaint whatsoever." On hearing these words, the man's understanding opened. He returned home with a great joy.

– From Zenkei Shibayama Roshi's *A Flower Does Not Talk*

RECOMMENDED READING...

Childhood Disrupted: How Your Biography Becomes Your Biology, and How You Can Heal

Donna Jackson Nakazawa, Author

For clinicians who work daily with Adverse Childhood Experiences (ACEs), you will find nothing new here. But for the vast majority of the rest of us, here is the evidence that may only resonate within your intuitive self. We now know that our biography becomes our biology. "The emotional trauma we suffer as children not only shapes our emotional lives as adults, it also affects our physical health, longevity, and overall well-being. Scientists now know on a biochemical level exactly how parents' chronic fights, divorce, death in the family, being bullied or hazed, and growing up with a hypercritical, alcoholic, or mentally ill parent can leave permanent, physical 'fingerprints' on our brains."

–Amazon.com

For those of you who would like a summary essay that Nakazawa wrote for Aeon, follow this link:

https://aeon.co/essays/how-bad-experiences-in-childhood-lead-to-adult-illness