Connections

for communities that care

MI HEALTH LINK — *Detroit Wayne Mental Health Authority Blazing a Path*

Tom Watkins, President and CEO, DWMHA

This has not only been a busy second year for the Detroit Wayne Mental Health Authority (DWMHA), but an exciting time for community mental health and this region. DWMHA has been able to put forth effective systematic policies and effect change in the mental healthcare system that is being recognized as consumer and community-focused, data-driven and evidenced based. It is these same efforts that have allowed DWMHA to re-evaluate and make necessary improvements to our system of care.

In 2014, DWMHA was one of four Prepaid Inpatient Health Plans (PIHPs) selected to participate in the Dual-Eligible Demonstration Project, MI Health Link. The MI Health Link Program is a Center for Medicare and Medicaid Services (CMS), and Michigan Department of Health and Human Services (MDHHS) Demonstration Program for Integrated Care for Medicare and Medicaid Beneficiaries which began February, 2015.

The MI Health Link Program was designed to test an innovative payment and service delivery model to alleviate fragmentation and improve coordination of services for Medicare-Medicaid enrollees, enhance quality of care and life, and reduce costs for both MDHHS and the federal government. The MI Health Link Program is administered through Health Plans, called Integrated Care Organizations (ICOs), that were required to either directly, through subcontracts or through partnership with local Prepaid Inpatient Health Plan (PIHP), provide for all Medicare and Medicaid behavioral health covered services. CMS and MDHHS expects this model of integrated care and

financing to improve quality of care, reduce health disparities, meet both health and functional needs, and improve transitions among care settings of MI Health Link enrollees. MDHHS's plan ultimately brings together health plans with PIHPs/CMHSPs that have a strong history of effectively managing the care and supports for persons with mental illness, intellectual and developmental disabilities, and substance use disorders. As with any change, this Demonstration Project has many challenges.

Following months of collaborative meetings with MDHHS, ICOs, PIHPs and community stakeholders the MI Health Program was implemented in phases:

Phase I of the program started February, 2015 in Region 1–North Care PIHP with ICO UP Health Plan; Region 4–Southwest Behavioral Health PIHP with ICOs Meridian Health Plan and Aetna Better Health.

Phase II of the program started May, 2015 in Region 7–Detroit Wayne Mental Health PIHP and Region 9–Macomb Community Mental Health PIHP with ICOs Aetna Better Health, AmeriHealth of Michigan, Fidelis/Centene Securecare, HAP Midwest Health Plan and Molina Healthcare. MDHHS's plan ultimately brought together health plans with PIHPs that have a strong history of effectively managing the care and supports for persons with mental illness, intellectual and developmental disabilities and substance use disorders.

Challenges

The MI Health Link Program is aligned with the future direction of the Triple Aim: improving the patient experience of care (including quality and satisfaction), improving the health of population, and reducing the per capita cost of health care. The following scenarios will describe the benefits of this program for people with mental illness, and intellectual developmental disabilities and substance use disorders. As with many

Impressively Focusing on the Essential While Balancing Competing Opportunities and Threats: *A Letter from the MACMHB CEO*

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

I and many who watch our system—the public behavioral health and intellectual/developmental disabilities services (BHIDD) system—are impressed with the ability of all of the system's stakeholders to focus on what is essential while working to pursue opportunities and thwart threats. This letter from the CEO is built around deconstructing this sentence.

The system's stakeholders include the consumers and families of consumers served by the system, Community Mental Health Service Programs (CMHSPs), Prepaid Inpatient Health Plans (PIHPs), Michigan Department of Health and Human Services (MDHHS), private providers, statewide and local advocacy groups, and community partners representing the full array of human needs. These stakeholders represent all of the populations served by this system: adults with mental illness; children and adolescents with emotional disturbance; children, adolescents, and adults with intellectual/developmental disabilities; and a range of approaches, disciplines, and viewpoints. All of these parties have a stake in the health and vitality of this system.

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 400,000 per year—through the use of evidence-based and promising practices, guided by person-centered community-based approaches.

The opportunities and threats faced by our system are numerous, with some holding the potential to foster the growth and strengthening of this system and those served by the system; some posing harm to the system and those served by it. It is not always easy to discern whether an event in the system's environment to which we are called to respond is an opportunity or a threat.

Some of the opportunities and threats currently before our system include:

- The complex work designing the system's approach to the requirements of the changing federal Home and Community Based Services (HCBS) rules—changes that will foster greater freedom, and choice for consumers.

- Readiness assessments and the changes spurred by these assessments, as required of CMHs and providers mov-ing toward becoming Certified Community Behavioral Healthcare Centers (CCBHC).

- The system changes that will foster the integration of physical healthcare and behavioral healthcare/intellectual/developmental disability services as outlined in the Section 1115 Medicaid Waiver. The application for this waiver was recently issued for public review and comment, by MDHHS. The application, revised to address the issues identified during this public comment period, will then be forwarded to the federal Centers for Medicare and Medicaid (CMS) for review, negotiation, and, it is hoped, approval.

- The January 2016 expansion of the state's Medicaid Autism services benefit to persons up to the age of 21, from the previous limit of 5 years of age.

- The dialogue within and outside of the system regarding the development of bold approaches to ensure that Medicaid enrollees receive services and supports which are person-centered and community-based (central to the state's public CMH/PIHP/provider system for decades), and integrated across many facets of the lives of these Medicaid enrollees: behavioral healthcare/intellectual/developmental disability services, physical healthcare, housing, employment, and education.

This latter effort—the development of bold approaches to the structure and function of the public BHIDD system—must reflect:

- A vision informed by rich dialogue involving the stakeholders to the system

- A commitment to holding to the system's core principles and proven practices

- The courage to retain and strengthen what is working and fixing what does not work

- The discipline to avoid quick fix proposals and suspect claims of cost savings

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 tackle these and many other opportunities and threats, while ensuring that we keep our "eye on the prize," not losing sight of what is essential—fostering a high quality of life for those served by the state's public BHIDD system through the use of evidence-based and promising practices, guided by person-centered community-based approaches. ▪

Certified Community Behavioral Health Clinics

ERIC KURTZ, MA, Contract Consultant
State of Michigan CCBHC Project Director
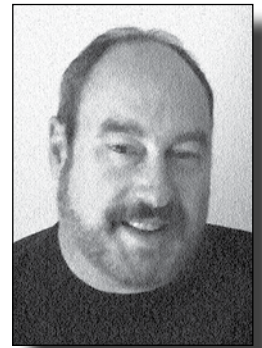
In one of the most significant steps forward in community mental health funding in decades, President Obama signed into law a demonstration project of U.S. Senator Debbie Stabenow's (D-MI) *Excellence in Mental Health Act*. Senator Stabenow's bipartisan legislation, introduced with Senator Roy Blunt (R-MO), expands access to community mental health services and strengthens the quality of care provided for those living with mental illness. The Excellence Act is intended to increase Americans' access to community mental health and substance use treatment services while improving Medicaid reimbursement for these services. When fully implemented, the Excellence Act will infuse over one billion dollars into the behavioral health system, making it the biggest federal investment in mental health and addiction services in generations.

As stated by Senator Blunt, "One in four adult Americans has a behavioral health issue that is both diagnosable and treatable and ensuring that they have access to the mental health services they need is vital to strengthening our communities and keeping Americans safe."

Senators Stabenow and Blunt first introduced the Excellence in Mental Health Act in February 2013 to put community mental health centers on an equal footing with other health centers by improving quality standards and fully funding community services and offering patients increased services like 24-hour crisis psychiatric care, counseling, and integrated services (physical and behavioral healthcare) for mental illness. The law is supported by over 50 mental health organizations, veterans' organizations and law enforcement organizations.

As part of the demonstration program, Michigan, along with 24 other states, was able to apply for and receive funding for a one year planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This planning grant is to be used to certify CCBHCs in Michigan and to apply to be one of eight states to receive a two year demonstration grant that will be awarded by January 1, 2017. From a service prospective, CCBHCs will provide intensive person-centered, multidisciplinary, evidence-based screening, assessment, diagnostic, treatment, and prevention services. Although Michigan has been a leader nationally in person-centered, multidisciplinary care, this initiative intends to address the needs of individuals in urban and rural communities, with particular focus on those with health disparities. As outlined in the planning grant application, when we look at the prevalence of mental health issues in Michigan (it is high), and compare it to the available sources these individuals have to access care, we rank 41st out of 50 states for adults and 44th for children.

Rates of depressive episodes in the past year are 10.2% in Michigan compared to the national average of 9.9%, and rates of suicidal thoughts among adults are a full percentage point higher than the national average (4.5% versus 3.9%). Illicit drug use among adolescents, dependence among individuals 12 and older, binge drinking, alcohol dependence, and heavy alcohol use are all higher than national averages.

To address these access and care coordination issues, the Excellence Act will require CCBHCs to provide services, regardless of severity, to adults and children with behavioral health and/or substance use disorders (preferably within the same setting) with staff that are culturally and linguistically trained to meet the service of the clinic's population. Certification requirements include access to and availability of service on a 24 hour per day basis (including crisis intervention, mobile and onsite), and to serve all consumers regardless of ability to pay. In addition to access to care requirements, care coordination is a lynch pin of the CCBHC statute. This includes the coordination of physical healthcare, veterans' service needs, children in foster care, and providing care in conjunction with juvenile and criminal justice agencies including Assisted Outpatient Treatment.

Although Michigan would like to see these initiatives and program requirements be part of a statewide certification process in the future (since the current award is only a planning grant to apply for the two year demonstration program without the assurance of continued funding), Michigan indicated it would certify up to 10 clinics. Michigan's planning grant application can be found on the MDHHS website, www.michigan.gov/mdhhs (click on the tabs to advance pages):

Keeping Michigan Healthy • Behavioral Health and Developmental Disabilities • Mental Health • "Spotlight," and go down to MI-CCBHC Project Narrative.

Current planning activities include expansion of our CCBHC Steering Committee, implementation of a formal stakeholder engagement process, the development of a Request for Information from interested CCBHCs and the development of technical assistance and support for potential CCBHC clinics.

For additional information, you may contact Eric Kurtz at Kurtze@Michigan.gov.

INFLUENCE: *Addressing Health Disparities*

Julie Schillim, MA, LLP, LPC,
Associate Director of Community Support Services, Newaygo Community Mental Health

The Addressing Health Disparities Leadership (AHD) Program is offered through the National Council for Behavioral Health (NCBH) as a ten month program for middle managers from mental health and substance abuse organizations. The structure of the program consists of three "in person" meetings in Portland, Oregon; Orlando, Florida; and Washington, D.C. (2014-2015), webinars, individualized coaching, and peer support calls. The goal of the health disparities leadership program involves developing the leadership and management skills needed to address disparities as well as general professional development. The AHD program provides a link between the ongoing concerns with health disparities and leaders within communities across the country hoping to help address these disparities. I was honored from the moment I was notified of my selection to participate, and as of August, 2015, and I am now honored to be one of the Addressing Health Disparities Alumni.

The leading question in one of the first activities was, "When did you first know you were a leader?" Varying answers ensued from participants: "When I was a teen...when I was a child...when I received my first leadership position..." The group was comprised of twenty-five impressive, articulate, ambitious, and energized diverse middle managers from across the country. The group eagerly discussed their personal narratives, opinions, perspectives, and thoughts. The environment was safe; one in which amazing people wanted to hear what you had to say, valued differences, and asked questions. It was an educational, empowering, and inspiring experience. The AHD program truly inspires the spirit with a desire to make a difference at the forefront of behavioral healthcare delivery. Further, it provides a wealth of knowledge delivered by faculty who specialize in areas such as leadership, health disparities, middle management, organizational development, and professional development. A key to the success of this program is the learning that takes place between peers. At every meeting, all participants fully participate in the process and learn from each other. It was for this reason that the first part of the program emphasized developing a general and shared understanding of what "addressing health disparities" means.

Addressing health disparities is not a new issue in the health care community. The Department of Health and Human Services has addressed health concerns within its *Healthy People* reports since 1979. In 1979 the Surgeon General's Report, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention* was established. Following the 1979 report came *Healthy People 1990: Promoting Health/Preventing Disease, Objectives for the Nation*; *Healthy People 2000: National Health Promotion and Disease Prevention Objectives;* and *Healthy People 2010: Objectives for Improving Health.* The current *Healthy People,* developed by the Federal Interagency Workgroup in collaboration with the U.S. Department of Health and Human Services, other federal agencies, public stakeholders, and an advisory committee, is *Healthy People 2020.* In the last twenty plus years, a central goal has been to address health disparities. In *Healthy People 2000*, the goal was to reduce these disparities, and in 2010 the goal was to eliminate them. Currently, for 2020, the goal is not only to eliminate health disparities but also to create health equity and improve the overall health of the nation.

Definitions of health disparities have varied. *Healthy People 2020* defines a health disparity as a particular type of health difference that is closely linked with social, economic, and / or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, age; mental health, cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

The Centers for Disease Control, meanwhile, defines health disparities as, "preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations." The CDC further describes populations as defined by "race and ethnicity, gender, education or income, disability, geographic location (e.g. rural or urban), or sexual orientation." Thus, inequality of resources—social, political, economic, environmental, and environmental effects, poverty, environmental threats, access to care, education, and individual/behavioral factors—all influence health disparities. Health equity, by contrast, is the opposite of a health disparity: it is health equality among all people.

Health equity and eliminating health disparities involves addressing disease, illness, and health care services as well as other factors (determinants of health) that influence health outcomes of the population. These determinants include variables such as education, nutrition, housing, transportation,

culturally competent providers, health insurance, and safe water and air. SAMHSA acknowledges the importance of behavioral health disparities among populations that include, "racial and ethnic groups, LGBT individuals, people with disabilities, girls, and transition age youth, and young adults." Further, many subgroups struggle with higher rates of disorders related to mental health and substance use, increased rates of suicide, poverty, domestic violence, trauma, and increased involvement in foster care and the legal system. As a result, these groups have historically often struggled with access to services, poor service use, and inadequate behavioral health outcomes. In an effort to address these disparities, SAMHSA has included them within its strategic initiative.

In our final "in person meeting," we spent time specifically discussing health disparities as they relate to race and ethnicity. Linda Rosenberg, President and CEO of the National Council for Behavioral Health, joined this discussion and spoke eloquently about health disparities and the real impact facing minorities as a result of them. As a participant, I was impressed with her ability to respond to the questions asked during the meeting, which she followed with an article, "Is The Problem Cultural Incompetence or Racism?" (Rosenberg, 2015). She underscored a few of the staggering statistics regarding these disparities, encouraged practitioners to address institutional bias and improve our cultural competence, and expressed support for "Black Lives Matter."

In addition to discussing health disparities, the AHD program spent time discussing leadership overall, including such topics as processing system changes, change management, and managing conflict. The workshop also included professional development activities and discussions, with topics such as taking time to understand personal strengths and weaknesses, processing vulnerability, and identifying a vision for professional growth.

As a middle manager, I am in the unique position to influence and motivate others. Being in the middle can be viewed as an opportunity. The passion and desire that drives my involvement in the mental health field can be minimized by the day-to-day struggles of crisis, process, policy, data entry, and paperwork. These day-to-day struggles are important and there is often a greater purpose behind them. It is, however, still important to continue doing those things beyond the day-to-day agendas—those things in the job that move the field forward, changing it in ways that care for consumers on a human level, support the workforce at a deeper level, and influence others to support the elimination of health disparities. This seems like a feat for a middle manager, but if we all get caught up in

merely the day-to-day struggles, who will make a difference?

As part of the Health Disparities leadership program I was required to complete a "stretch project," which was designed to push the middle manager/participant's leadership in an area that he or she chose to promote change. I worked with the executive team at Newaygo Community Mental Health (NCMH) to determine where to devote my energy. At the time, NCMH had some strengths in the area of trauma informed care. However, a formalized structure for a trauma-informed system of care was not yet established. The rural community we serve, we believed, would benefit from the development of such a system.

My desire for change and my passion for a trauma informed system of care was a topic of discussion during an early coaching session with my AHD Coach, Suganya Sockalingam, Ph.D., who so eloquently spoke to me about cultural changes like trauma-informed systems of care. She acknowledged that cultural change takes time and encouraged me to make a more "realistic" work plan.

> **"We all have the capacity to inspire and empower others, but we must first be willing to devote ourselves to our personal growth and development as leaders."**
>
> *—Discovering Your Authentic Leadership,* George, Sims, McLean, and Mayer (2007)

The modified work plan created after this discussion was more feasible than the initial plan, considering all of the additional competing changes happening concurrently. The new plan also encouraged other members from our champion team to become involved, as she also suggested. Doing this made the project a team approach and not just my "stretch project". The process was not without obstacles, though I believe that our stumbling gave us opportunities to creatively grow, moving forward.

The seven domains of trauma informed care include the following domains:
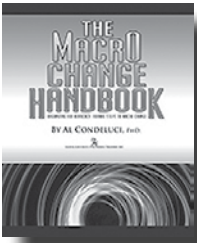
(1) screening and assessment

(2) consumer-driven care and services

(3) trauma informed and educated workforce

(4) trauma-informed, evidenced-based, and emerging best practices

(5) safe and secure environments

(6) community outreach and partnership building;

(7) ongoing performance improvement (National Council for Behavioral Health, 2015).

The trauma informed team chose to start with building a trauma informed and educated workforce (domain 3) as well as increasing trauma-informed, evidenced-based, and emerging best practices (domain 4). For example, we completed an agency-wide "Trauma-Informed Care 101" training that was

The Macro Change Handbook –

Organizing for Advocacy: Formal Steps to Macro Change

By **Al Condeluci, Ph.D.**, 2015, Lash & Associates Publishing/Training, Inc.

"To Create a New Reality..."   Reviewed by Robert M. McLuckie

Al Condeluci has been a disability rights advocate and catalyst for building inclusive communities since the early 1970s. My first experience with him was hearing his plenary session at a MACMHB conference many years ago. It was clear that Al Condeluci was the real deal: a true advocate who worked hard in a variety of modes to support better lives for people living with disabilities. I read his books and papers posted on his web page. I sought out opportunities to hear him speak numerous times. On one occasion I volunteered to pick him up at the airport and drive him to a conference event. The up-close conversation confirmed a warm, passionate, committed man, informed and seasoned by his own deep experience; someone who vigorously lives his message. Al Condeluci's passion is rooted, and his wisdom forged, in his day-by-day work to create communities that care. When he speaks, I listen.

In the Preface, Condeluci explains: "My passion for advocacy and culture change probably started when, as a young child, I found myself defending my cousin Carol. Many times she was teased because of her Down syndrome, and these experiences bothered me. I couldn't understand why people, both kids and adults, could be so cruel." With passion fueled by this personal, emotionally charged experience, Al built a career as an advocate, leader and teacher. *The Macro Change Handbook* is his 8th book in a series focusing on community advocacy and change. The introduction, states, "I have worked hard to make this book succinct, efficient and easy to use...I know all of these concepts and strategies are grounded in solid academic and experiential theory."

Just 75 pages, the *Macro Change Handbook* is a focused, clear, thorough, and an eminently useful summary of what Dr. Condeluci has learned as an advocate and agent of change. The book's power lies in its lean, no frills, to-the-point presentation and the credibility of its author. This is power coaching from a master.

The Macro Change Handbook begins with an examination of the types, levels and challenges of advocacy. Macro Change is "getting the world to change to accommodate the individual." Certainly, individuals must adapt, learn and change to meet the demands of living in society. But in some situations, this "micro" individual change may not be possible or might even be an unfair burden to the individual. These situations call for another direction—to change the culture, environment or situation around the person to be more accommodating.

The book quickly moves into very meaty and efficiently blunt discussion of the dimensions of the change process and the factors that lead to resistance to change. The middle chapters explore the concept of power, the basic principles of formal macro change, and collective advocacy, or organizing others. The steps and stages of advocacy are described with clarity and key strategies and tools for change are presented. This is a "how to get there" discussion. The dynamics of power and the ways and means of the use of power are given some very frank, and very timely, straight-talk. Dr. Condeluci states quite simply that understanding these elements is essential if we are "to create a new reality," which is the objective of all advocacy activity. The Objective: "To Create a New Reality." This is fundamental material, not just for those in human services, but for any person or group that seeks meaningful change in our local, state or national community. This book serves a very broad audience indeed.

Advocacy is serious business! The final chapter, "Street Smarts," offers Condeluci's reflections and insights. He opens this section with Hemingway's caution to "Never confuse movement with action." Even though Al rather humbly refers to this material as "other elements you will need to keep you focused and successful," Street Smarts is essential information. In fact, this is listening to a highly accomplished guide impart essential wisdom gained from a lifetime of experience; simply priceless.

The appendix offers "Focus Questions" to help clarify and articulate the issue one has targeted for advocacy and to focus in on action. This smart questioning is the sort of wise process that keeps one anchored in present realities: clear-eyed and on track.

Reading *The Macro Change Handbook – Organizing for Advocacy* is likely to trigger much affirmative head nodding. You will recognize you're being given the keys to a vehicle that will help you get to where you want to go. It's a reliable road map to use all along the way.

Take this moment now. Go to:

http://www.lapublishing.com/search.php?mode=search&page=1

Buy the book. It will inspire and energize you. ▪

Robert M. McLuckie

Everyone Has a Story to Tell ....

Debra Johnson, M.S., Executive Director, St. Clair County Community Mental Health

There was never a truer statement than the old maxim "everyone has a story to tell." Since January 2008, individuals supported by St. Clair County Community Mental Health (SCCCMH) have had an opportunity to tell their stories by participating in a SCCCMH sponsored writing program.

The writing program was introduced following a review of studies suggesting that writing is a healthy outlet by which people can express themselves while reducing stress, managing anxiety, and coping with depression. This is because the act of writing allows an author to introspectively make new connections, see new significances, and forge new understandings about his or her life, all of which are inherently therapeutic.

Additionally, the creative nature of writing mirrors many of the key components of recovery. Writing brings hope because creativity implies a new and better future. Writing teaches people how to make choices, because writing involves making countless logical choices. Writing helps teach responsibility, because the writer alone makes choices and is responsible for the outcome. Writing helps empower people because writers produce brand new things by organizing their own talents and resources. And writing connects writers to the larger community because they offer their work to their audience as gifts of insight and beauty; it allows writers who use SCCCMH services to foster healthy relationships with community members built on creativity and mutual respect. Finally, the confidence and insights authors gain by writing often spills out into their everyday life.

The writing classes at SCCCMH are suitable for individuals with all levels of experience, providing new writers the confidence to explore their creativity and put their unique voice out into the world. Since the writing program's inception in 2008, it has evolved from a primary focus on biographical writing, which emphasized the writers' personal experiences, to classes that include additional forms of writing, such as journaling, poetry, short stories, plays, scripts, and songs. This evolution was driven by the desire to open up possibilities for individuals who were not comfortable discussing their mental health recovery or personal histories in a non-fiction format to nonetheless experience the benefits of writing. By fictionalizing their stories, these additional types of writing allow individuals emotional distance, while still allowing them to write about issues important to them.

A second class exists for more experienced writers, which offers a deeper perspective, inspiration, and perhaps a renewed determination to delve further into their craft. Most of the people attending this class have individual long-term projects, such as writing a novel or a collection of poetry. When students have completed their writing project, SCCCMH staff facilitates their publication through Amazon's Create Space, an on-demand publishing company. This allows students to make their work available in book and e-book form to interested friends, family, and the general public. This tangible result of hard work and dedication is an important component in maintaining their resolve to complete their project.

Writer James Sawden

A typical class begins with two or three students volunteering to read work they have completed since the last class. The class then discusses their writing, both for form and content. While students are encouraged to share their writing it is never a requirement of the class. Following open reading, a 20 to 30 minute instruction and class participation period follows. During this time the instructor explains a new writing concept, for example, Japanese haiku. The class would then complete one or several haikus, working as a group. Following this, each individual attempts
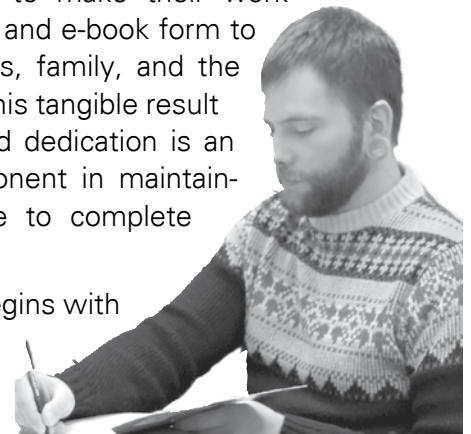
to write a haiku of their own. Students would then be encouraged to work on haikus during the week and bring back some fresh work for the next week. This process is followed for every concept or specific type of writing.

To be successful, the writing class must be friendly, supportive, and fun. For this to occur, it is vital that the instructor be flexible. Sometimes individuals will not respond to the particular type of writing being covered and alternative writing projects must always be available. Students should never feel obligated to write on any topic or in any particular form. They should be free to make those decisions for themselves. The instructor must also consider that every class will have individuals with different skill sets and intellectual abilities. The topics and explanations must be accessible to everyone.

Author Sharon Remington

The intensity of the shared personal stories and writings of individuals receiving mental health services sends a powerful message of hope and inspiration to their friends, family, and the community. The writings connect the writers—who share a diversity of struggles and recovery—to readers, through their unique style and shared goal of healing, transformation, and hope. The resulting dialogue helps to create conversations about mental illness and recovery in the community, challenging the stigma and discrimination surrounding mental health.

For several years, the central anti-stigma message of the project came through "Inside Out," an annual journal of creative writing which was augmented by art work from SCCCMH's art program. Everyone contributing to the journal and all SCCCMH employees received a copy. The journal was distributed free to local bookstores and coffee shops. Currently, writings of individual students, as well as a compendium of student writing, are made available via on-demand publishing.

Additionally, work of individuals participating in the writing program are featured in SCCCMH's annual Art of Recovery Celebration, which every March features works of art, writing, and a play or movie, cre-

ated by individuals participating in our art, drama, and writing programs. This event, as well as additional community projects involving our creative arts classes, aim to get people talking about mental health and help end the stigma often experienced by people with mental health problems.

Just as writing can be a powerful anti-stigma tool in the community, it can also combat self-stigmatizing thoughts. The introspection and confidence writing provides authors serves to fight self-stigma and the accompanying problems of low self-esteem and self-efficacy, which dissuades individuals from pursuing the kind of opportunities that are fundamental to achieving their life goals.

For mental health providers who may have hesitated to offer art programs such as drawing, painting, drama, and dance, due to a lack of resources, writing is an ideal entry point to the arts because it provides a low barrier to entry. Other than an instructor or facilitator, all someone needs to participate is a pencil and piece of paper. Unlike art, which requires special drawing pencils and paper, or canvas and paints, virtually anyone who wants to write has the tools at their disposal. It is also an activity open to people with physical challenges which might preclude drama and dance.

A writing program ideally supplements evidence-based recovery programs. By telling their stories, individuals advance in their recovery and help end the stigma associated with mental illness.

Writer Mary Powers

Three Haikus

Love to have and hold
Joining two hearts alone
Now time to reflect

Beside the red barn
The chickens running around
Then day becomes night

Bread and wine are fine
The main course is delicious
The candle blows out

— Kim Lewinski

Breaking Through

I try to break through
and see the part of myself
that I like.
It's a roller coaster of emotions.
Screaming,
I'm at the top of a big tall tower
in the dark,
bumping into everything in my path,
trying to get out of there
and back on solid ground.
Trying to break through
it's like an everlasting asthma attack.

— Melissa Robison

The World

The dark side of the sword
Its jagged edges are sharp
The colors of the world
Are black and white
The world is cold and clammy
The earth is dry and dusty
The sand has turned into glass
The sky's a hornet's nest

— Amy Odle

Why the Arts are Vital to Recovery From Mental Illness

In my personal experience with my own mental illness, I have found that being involved in artistic adventures has been a large part of my recovery. I have been involved with the visual arts program, the writing program, and the drama program at St. Clair County Community Mental Health.

As someone who has gone through college as a visual arts major, I can tell you that the visual arts program at SCCCMH is incredibly helpful to help me continue to learn how to express myself. I can't always put into words what I think or feel but I can use my artistic skills to speak.

For me, the writing program was something that was just a "let's try it out" kind of thing. I had written for fun and written journals before, but never anything I had shared with anyone else. With the writing class, not only have I gotten over my fear of sharing my thoughts, I have also written my first novel. Writing has opened up my ability to communicate in a different way and given me another avenue to be heard.

My involvement with the drama group, the CMH Players, has been in a behind-the-scenes capacity. I have worked on one film as the cinematographer and editor, and I will be doing so in an upcoming film as well. Being able to interact with the actors and director in a professional environment, as I was trained in college to do, has been rewarding. It gives me hope that someday I will be able to talk to people in an honest, straightforward way without fear taking hold of me.

All in all, I have found the arts program here at SCCCMH to be a vital part of my recovery from my mental illnesses. I have overcome many obstacles by finding new and different ways to interact with the world. If it can work for me it can work for anyone.

— Alexandra Livesay

Dance Movement Therapy and the Golden Years

Sarah Zichi, M.S., Registered Dance/Movement Therapist
Activities Coordinator, SarahCare Adult Day Care Center

I have recently started work at an adult day care facility in Grand Rapids where I am using my training as a Dance/Movement Therapist to help create and facilitate days filled with enriching and nurturing activities for our participants to engage in before going home to their loved ones.

I feel lucky. My co-workers and supervisor were generous enough to let me integrate Dance/Movement Therapy (DMT) into our schedule of activities immediately. At first DMT was seen as a form of physical exercise, and while physical activity is a by-product of this group activity, it is not the primary goal. To think of Dance/Movement Therapy as just another form of exercise is missing the intent of the professional field. The American Dance Therapy Association (ADTA) has described the profession as "a behavioral health modality that combines physical activity, social support, creativity and emotional expression." The primary goal of DMT has been to stretch the participants both mentally and physically. The majority of my group members have been diagnosed with either dementia or Alzheimer's, illnesses that confuse and muddle the past and present together. Dance/Movement Therapy focuses on the "here and now" and enables group members to clearly know where they are within their bodies and relationships, if only for the hour they are participating in the group.

I use a less traditional method in facilitating dance therapy groups. Many dance/movement therapists choose to use a "free form philosophy," in which they have the participants introduce new movements into the group using mostly non-verbal communication. While this can be a very effective methodology, if I were to use it we would probably be sitting around looking at each other for 45 minutes because I am frequently met with "I don't know how to dance," or "We just finished lunch! It is time for a nap." Instead, I introduce structure into the sessions. First, it allows participants to know what to expect, and secondly it takes pressure off of them to "perform". We start our sessions with a full body warm-up, and then we warm-up our minds by playing a name game, where we either try to name all of the group members that day, or we just share our name and answer a question about ourselves, a favorite thing about our current season, if we cheer for Michigan or Michigan State, our favorite kind of pie, something simple that enables us to know one another a little better. Once we move on from that we start dancing. I have a multitude of props that I use to help facilitate movement, such as scarves, ribbons, a parachute

and an octoband. I'll put on music from the 50's or 60's and we will all sing along and hopefully some movement starts to happen. One thing that I've noticed happen is that movement is contagious. There are a few participants who I can always count on to follow along with the directions, and once they really start getting into the dancing, others will join in! We usually dance to about three or four songs: it could be free movements, following the leader or making up a dance of our own. Once we are done with the movement part of our session we end with a guided meditation and cool down. The end of the group is used as a time for reflection and resolution. We start with deep breathing and from there I will suggest thinking about a color, or a "happy place" or we just focus our attention on our breathing pattern. The key is to keep it simple! There are many guided meditations that could be presented, but it can be hard to follow complicated meditations for even the healthiest of minds, so I keep endings simple.

Having shared background information on the sessions, I have two stories I would like to share about the impact DMT has had on participants.

On one rainy afternoon, there was more resistance than usual at the beginning of the session, so I asked the group what they wanted to do for Dance Therapy that day. Most said they wanted to take a nap but there were a few people that said they wanted to see me dance. As a Dance Therapist I was taught that sessions are not supposed to be about me, so when they told me that's what they wanted I was very hesitant to honor their request. Instead, I decided that I would dance for them, but with a catch. I created a new game I called "Stump the Dancer". The group would shout out different styles of dance or specific dance moves for me to do, and if I knew what they were asking me I would show them, but if I didn't know, they had to either get up and show me the movement or describe the movement to me to teach me how it went. I was given polka, waltz, foxtrot, tap dance and some specific ballet steps. I was never actually stumped by them but every few requests I would act as if they had in fact stumped me and then they had to show or explain the movements. This went on for some time; once they had exhausted their list of dances it was their turn to show me their moves! I put on "Rockin Robin" and had them dance the entire song. At first some were self-conscious, but others started dancing right away. The movements became contagious, and by the end of the song we were all dancing and singing. Most of the participants forgot that I told them they only had to dance for one song, so when the next song start-

ed they all continued moving to the music, and expressing the emotions of the song through their movements. About half way through the song fatigue set in and the movements became smaller and slower until it completely stopped. I praised them for their wonderful dance moves and suggested we combine our talents. We decided that we should come up with our own special dance! First we chose our song, "Unchained Melody," and then we came up with our movements. I asked for suggestions about what our movements would be and whenever someone gave a suggestion we added it into our dance. We ended up with about five different movements that we did sequentially throughout the entire song. We were working on strengthening our short term memory, and by the third time we repeated the song the group was relying on each other to remember the dance and I was able to stop dancing and just provide encouragement with only a few cues for the next movement. This session surprised everyone involved. It surprised me because the group was willing to be so creative and playful when at the beginning all of them were resistant to even dancing with me. It also surprised the group because they had forgotten their own abilities. So much of dementia care is focused on what is lost that participants can get stuck in negative thinking patterns, but during this particular activity we focused on what everyone *could* do, including me. The transference of watching me dance empowered and inspired the group when it was their turn to dance and create. At the end of the group I asked how they were feeling, but without their saying anything I could tell they were proud of what they had done and they had fun while doing it too!

The second story is not about a group, but a relationship that developed between a participant and me. As I was settling into a new job, learning all about the different participants, there was one gentleman that came almost every day and just wandered around the center, seemingly unable to participate in the scheduled activities. He was non-verbal and the staff would just let him do his own thing, maybe saying "hi" when he walked by. One day when I was trying to talk to him, another staff member came up and basically told me that he was a lost cause and that I was not going to get any more out of him. I personally do not believe anyone is a lost cause; sometimes it just takes a different approach to reach them.

One of the first things we learn as a Dance/Movement Therapist is the art of mirroring. The basic principle of mirroring is matching movements and meanings of another person. This is an excellent way to build a relationship with non-verbal individuals because it shows willingness to understand and builds a foundation of trust. Soon after I was told I did not need to try, I started mirroring this man's movements and noises. He was very ridged and always had his arms bent at a ninety degree angle with his hands locked in fists. As he walked, his knees were locked, making his stride

a shuffle, a sharp rocking movement with every step. In his upper body he had visible twitches unrelated to his walking. He would communicate by whistling and when he did speak it was barely audible. I never tried to change his behavior; instead I changed what I was doing. Whenever he would walk past me I would stop what I was doing and mirror his movements and the noises he made and we would have a "conversation." It did not take long before he was coming up to me more frequently and started saying, "hi," and smiling. A week later he was giving me fist bumps and answering questions about how he was feeling and if he needed to go to the bathroom. Others began to take notice, specifically his wife. One day when she came to pick him up she commented about the friendship we had formed, and that he seemed happier when she picked him up. She attributed it to the relationship we had developed. When you give participants encouragement and positive attention, significant improvements can occur, even in an elderly individual with dementia.

Dance/Movement Therapy is an under utilized psycho-therapeutic modality in the State of Michigan. Part of the reason is because there are very few dance/movement therapists in the state, but perhaps the greatest impediment is a lack of awareness about DMT. I know the impact of the work that I do. As more information about the field becomes available, I am confident that DMT will become a staple in all mental health practices.

"Dance/movement therapy is primarily about forging a healing relationship where movement and dance are the media, just as words are the medium in verbal psychotherapy. We pay honor when we dance with people with dementia, when we relate to them in an embodied way, when we attempt to understand their nonverbal communication. When we dance with them, we invite them to be in their bodies, to savor the sensations and experience of vitality, now, in their last days, while they still have bodies."

 –Donna Newman-Bluestein

For a nine minute demonstration and explanation of dance movement therapy, copy and paste this link in your browser. You will see other videos along the right side of the You Tube page showing additional videos:

https://www.youtube.com/watch?v=TYF9_zKDrc8

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Camp Connect – Connecting Children on the Autism Spectrum and the Community

Melissa Lee, Social Marketing Coordinator, Saginaw County Community Mental Health Authority

Many children spend their summers playing with friends, exploring their surroundings and more often than not, getting their hands dirty. However, for children with a diagnosis on the autism spectrum and their families, summers aren't always so carefree. Children on the autism spectrum typically display symptoms that include impaired communication ability, impaired social interaction, restricted or repetitive interests, and sensory stimulation challenges. Because of these symptoms, finding adequate care and engaging activities for children experiencing them can be challenging for families.

The Autism Spectrum Disorders Services team at Saginaw County Community Mental Health Authority (SCCMHA) recognized the need for an outlet in the community specifically designed for children diagnosed on the autism spectrum and their families, a convenient location where the children could learn and play, and where families knew that their children had the care they needed. After hours of research, planning and collaboration, SCCMHA Camp Connect launched its inaugural session on July 13th, 2015.

For four weeks, SCCMHA Autism Spectrum Disorders Services staff, in partnership with Saginaw YMCA staff, actively engaged with children 18 months to 6 years of age with an autism diagnosis being served by SCCMHA. Camp Connect ran Mondays through Thursdays at the Saginaw YMCA from 10 AM until 2 PM and was the first in the region to offer a specialized day camp program for children under six years of age.

"Early intervention is a key component in any mental health and developmental treatment plan," explained SCCMHA Occupational Therapist Scott Staszak. "We felt it was important for this camp to be open to young children in our community with an autism diagnosis to help them achieve better outcomes for themselves and their families. The earlier they are actively engaged and exposed to social norms in meaningful ways, the better chances there are for long-term progress in their treatment."

Camp Connect included specialized play-based activities that promoted gross and fine motor skills, socialization, and leisure, all of which have a fundamental developmental element. Through these structured activities, camp attendees were engaged in ways that not only held their interest, but developed important skills for their continued growth and development. In total, 29 children and their families participated in the four week program at Saginaw YMCA, which included a support group for the parents and caregivers every Wednesday morning that was also a first to be provided in a camp program setting for the region.

"I really enjoyed watching the children at camp interacting with one another and just having fun," said Heather Beson, SCCMHA Autism Spectrum Disorders Department Supervisor. "It was also rewarding to know that parents had a place to send their children during the day and felt comfortable doing so with us."

The SCCMHA transportation department even participated in the fun camp atmosphere as well, decorating their busses and engaging with camp participants when they picked them up in the mornings and dropped them off at the end of the day. "The Transportation Department team went out of their way to make this an all-around enjoyable experience for the kids," Beson said. "Their support, help and enthusiasm was above and beyond anything we could have hoped for and it was just an added element of enjoyment for the children who participated. The kids love riding those busses and looked forward to seeing their Transportation friends every day. You couldn't get a support team better than that if you tried."

Another major component and measure of success for Camp Connect was community exposure and inclusion, achieved through partnership with Saginaw YMCA. Staff wanted camp participants to be a part of the community and have some of the same experiences that children who participate in traditional summer camp programs do. By partnering with Saginaw YMCA staff and hosting the camp at their facility, the only real visible difference between Camp Connect and traditional YMCA youth camps that were operating during the same time were the color of the T-shirts the kids wore.

"We could have easily organized this camp to run at one of our SCCMHA facilities," Staszak said. "But that wasn't the direction we knew the camp needed to go to make an impact. Not only did we expose camp participants to the amazing community around them, but I think we made a huge impact on the stigma and misunderstanding surrounding mental health and autism. YMCA staff had the chance to spend quality time with camp participants and learn that they are just like the other kids that come through their programs. They want to make friends and learn and have fun; they just might need some extra support in achieving that. And the community got to see a group of kids being kids, experiencing life with no labels."

At the end of Camp Connect's inaugural four-week run, staff

hosted a celebration at the Saginaw YMCA for camp participants and their families, featuring magician Cameron Zvara, balloon animals, bounce houses and a variety of other fun activities, cotton candy and treats, and barbeque by *That Guy's BBQ*.

"We couldn't have asked for a better first run at a program like this, or a better celebration of everyone who participated in Camp Connect and made it such a success," said Beson. "We definitely learned some things and will be making some adjustments for the next time around, but I'm so very pleased with how everything turned out and the kids really seemed to enjoy their time which is why we did this in the first place."

Parents and caregivers were equally impressed with the success of the camp, and were thrilled to have a safe, engaging atmosphere for their children in the community. "The camp staff had to be doing something right because I saw a great change in my son's attitude when he came home," one parent said. "It seemed like he really had fun at camp." And when asked what they thought the best part of Camp Connect was, another parent responded simply, "Him [child] being happy."

SCCMHA Autism Spectrum Disorders Services staff has already begun preparations for the second session of Camp Connect, expected to run during summer 2016. For more information on the SCCMHA Autism Spectrum Disorders Department, Camp Connect, and how you might be able to participate, contact SCCMHA Autism Program Supervisor Heather Beson at hbeson@sccmha.org. ▉▉

INFLUENCE *(From page 5)*

well received by staff, as evidenced by post training surveys. This training has been incorporated into our training standards for new staff.

We also found that many other domains have been changed by our efforts in some specific domains. For example, increased training influences the screening and assessment process. We have also spent time discussing small steps to change other areas as well. Additionally, we have devoted time to activities and discussion on stress, burnout, compassion fatigue, and secondary trauma in supervision, as well as ways to promote staff care. This included activities such as "staff care week." We have also worked on making the environment more trauma informed with improvements in our waiting room area.

Overall, there was progress made from the initial Organizational Self-Assessment (OSA) in March of 2015 to the second OSA, completed in August of 2015. We will complete another OSA at the end of January 2016 to take note of our overall progress. This process has occurred gradually and strategically so it does not seem to be abrupt. In conjunction with the health disparities program and the work plan we developed, our participation in the *Trauma Informed Learning Community* through the National Council provided our agency with the support we needed for vital training and resources.

Even though we have made tremendous progress in our efforts to develop a trauma informed system of care, we still have a long way to go. Indeed, a trauma informed system of care is not something that you arrive at—it is an ongoing process. We have more recently, for example, been working on ways in which to increase consumer involvement (i.e., committee involvement) and education in the community (i.e., discussion outlets, and a social media workgroup).

This ongoing process spills into many other areas of discussion that impact the health disparities of our community's rural population. It is my hope that we continue to explore ways to improve our cultural and linguistic competency as well as meet our community outreach needs in a trauma informed way. Personally and professionally, the faculty, National Council Staff (Mohini Venkatesh, MPH Vice President of Practice Improvement and Adam Swanson, Senior Policy Associate), and other AHD participants (including alumni) have had a significant influence on me and, as intended, taught me ▉▉ tremendous amount about health disparities and leadership.

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new programs and partnerships, the start-up period included several challenges, a learning curve and many lessons learned. Bringing two distinct cultures together (Medicare and Medicaid) to provide integrated health care benefits to enrollees has been the common goal with future promising outcomes. The ICOs are getting a glimpse into the vast work of the CMHSPs that provide care, supports and community living services to the population of persons we serve with behavioral health concerns. PIHPs/CMHSPs are able to work more closely with the ICO to get the physical health needs of consumers met. The PIHPs, along with the ICOs have taken the leadership role and are making this program a success for the consumers that we jointly serve.

The scenarios below demonstrate that integrating the management of Medicare and Medicaid benefits through a single entity (i.e. PIHP/ICO) has positive health outcomes for the consumer. In addition, these scenarios demonstrate that integrated care delivery (physical health providers and behavioral health providers) results in the achievement of the Triple Aim. As the PIHP for Region 7, Detroit/Wayne County, we provide services to over 100,000 consumers annually. Detroit Wayne Mental Health Authority (DWMHA) is committed to creating the infrastructure for providers to deliver integrated health care.

❖ SUD providers serve consumers who are hard to reach and often don't want to be reached, but do want their Methadone. As a result of the MI Health Link Program, the PIHP Care Coordinator and the SUD providers have been proactive in connecting with the ICO, even before the Level I Assessment has been sent, with consent of the enrollee. The PIHP Care Coordinator is assisting the ICO Care Coordinator in completing all required assessments, team meetings and the Integrated Individual Care and Supports Plan. As a result of this collaboration, several SUD enrollees are starting to get physical health needs addressed such as dental care and other chronic illnesses through the ICO and ultimately with the physical health provider.

❖ Consumer "J.T."—Admitted to psychiatric unit three times back-to-back within a 45 day period in July, 2015. Consumer did not engage easily with PIHP Care Coordinator on the first visit. By the second visit, he understood that the PIHP Care Coordinator was going to be part of his care team. By the third visit, he was able to identify his needs and get resolution to some of them while agreeing to work on others. No admission since September, 2015.

❖ Consumer "R.S."—Three admissions back-to-back within days— one after one week, and another after two weeks for a total of five admissions in August, 2015. Small victories have been seen. The time between hospitalizations is getting longer, in part due to the collabora-

tion between the ICO Care Coordinator, the PIHP Care Coordinator and the Behavioral Health Provider developing an Integrated Care and Supports Plan with the consumer to keep him safe in a community setting. PIHP Care Coordinator met with the consumer twice during the initial admissions; it became apparent that meeting with him and hospital social worker was not sufficient. PIHP Care Coordinator facilitated a meeting between the consumer's parents, behavioral health supports coordinator, psychologist, director of adult services, specialized residential providers, ICO Care Coordinator, and ICO Medical Director. Intervention included steps that related to housing, increased staff time, medication compliance, family support, behavior plan training for residential staff and potential additional social opportunities that might improve consumer's quality of life. As a result of these interventions, instead of the consumer rotating in and out of hospital within one to three days, the consumer has not been hospitalized during a four week span at the time of this article.

In an effort to assist others, DWMHA has provided below a link to its presentation for the implementation of the MI Health Link Program:

http://www.dwmha.com/Portals/0/Documents/Providers/MI-HealthLink/MI%20Health%20Link%20Presentation%20for%20MACMHB.pdf

Integrated Healthcare Initiatives

By combining medical care with behavioral health services, DWMHA addresses the spectrum of problems that a consumer might bring to the health care provider, whether it is in a primary care or mental health setting. Integrated Health Care is a systematic holistic approach to the overall care of an individual, coordinating services for physical health, mental health, substance use disorders and developmental disabilities.

> Clearly there remains much work to do and lessons to learn on this important Demonstration Project. Equally clear is the fact that integrating and coordinating care will produce better outcomes for the people we are charged to serve.

Integrated care is central to improving the overall health of consumers of mental health and substance use disorder services and produces the best health outcomes for people with complex healthcare needs. People with mental illness and addiction disorders have an earlier rate of mortality than the general population, higher rates of chronic life-threatening health disorders and conditions such as type II diabetes, heart disease, obesity, and hypertension. Through integration of primary and mental health care, the benefits include improved access to care, reduced morbidity; and reduced life threatening and chronic conditions, better monitoring, reduced stigma and fewer medication complications.

Detroit Wayne Mental Health Authority has made a commit-

ment to creating a culture and infrastructure for integrated health care delivery for our consumers who have severe mental illness, intellectual and developmental disabilities and substance use disorders. DWMHA has standardized its integrated processes and assessments. This was done through the creation of a Streamlined Access Screening Questionnaire to reduce redundancy of questions and consumer time on the phone, the standardization of the integrated Bio-Psychosocial Assessment Pre-Plan and Individual Plan of Service, and through training providers on the standard assessment for level of care.

DWMHA established successful data sharing relationships with sixty-three per cent (63%) of all the Medicaid Health Plans in Wayne County. The purpose of the Data Sharing Care Coordination Project is to identify consumers of DWMHA who are also members of Medicaid Health Plans, and share utilization and cost data of these common individuals. Through this effort, DWMHA is developing a process of sharing information on common individuals in an effort to better manage their health care utilization, cut unnecessary costs and improve integration.

DWMHA has led the charge for the development of MI Care Connect. MI Care Connect is a health information exchange that will manage the behavioral health consent electronically, allow for the display of appropriate Care Connect 360 data and appropriate assessment and care plan data for the purposes of highly effective care coordination to improve the health outcomes of DWMHA consumers. The data in MI Care Connect will enhance the integration of behavioral and physical health data throughout the tri-county region.

Together, Chief Operating Officer Jeffrey Delay, and Director of Integrated Healthcare Initiatives Audrey Smith have championed our efforts in Wayne County. We have learned a great deal from the other members of the CMH system that are part of this Demonstration Project – Macomb County CMH Services *(John Kinch, Executive Director/Renee LaVigne, MI Health Link Administrator)*, NorthCare Network *(William Slavin, Executive Director/Diane Bennett, MI Health Link Administrator)* and Southwest MI Behavioral Health *(Bradley Casemore, CEO/Patrick Visser, MI Health Link Administrator)*.

Caution

Clearly there remains much work to do and lessons to learn on this important Demonstration Project. Equally clear is the fact that integrating and coordinating care will produce better outcomes for the people we are charged to serve.

However, no one should jump to the conclusion and suggest that ending the CMH carveout and allowing the Health Plans to manage the public mental health benefit automatically "integrates care." There is nothing in the data to suggest that ending the carveout in itself will integrate care. Michigan has developed a robust public community mental health service delivery model that has been enhanced and refined since its inception a half century ago. Policy makers must proceed with caution, assuring decisions are informed by data and clinical evidence to assure CHANGE = PROGRESS for some of Michigan's most vulnerable citizens.

As we progress into the future, we aim to be evaluated by the strides we have made, the hurdles we have overcome and, more importantly, the positive impact we have had on society and the people we serve. We will continue to strive for a quality standard we would want for those we love.

By any measure, the Detroit Wayne Mental Health Authority has grown into a stronger organization today as we enter our third year as an Authority. By working cooperatively with our State Department of Health and Human Services colleagues, legislators, providers, community stakeholders, advocate groups—and most importantly, listening to the needs of the people we serve—we will continue to grow and succeed together!

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. Follow Watkins on twitter @tdwatkins88.

Thank You to Tom Watkins from *Connections*

We are grateful to Tom Watkins for his contributions to these pages and for the overall difference he has made over the years, but we are even more enthused by his positive impact on the DWMHA, as exemplified in this article.

Watkins has served the citizens of Michigan as a former Department of Mental Health Director and State Superintendent of Schools, and is viewed as a visionary leader who is able to work across the political aisle to add value and make a difference in the lives of vulnerable people. Collaboration is a sorely needed skill in what has become an increasingly partisan environment.

Lt. Governor Brian Calley, a consistent and strong human services advocate stated, "Under Watkins, the Detroit Wayne Mental Health Authority has provided strong leadership during the present healthcare transition, ensuring that our most vulnerable citizens receive the care, support and services they need to live productive lives in their communities. DWMHA is an essential partner to the State of Michigan."

Yet, Watkins is quick to share credit with his exceptional team by stating, "It is through our outstanding staff and community partners that we are able not only to react to change, but to lead it and assure it is not simply about change, but progress."

Robert Sheehan, CEO of the Michigan Association of Community Mental Health Boards, applauds the achievements of the DWMH Authority under Watkins saying, "They have one of the leading behavioral health leadership teams in the nation; what has been accomplished by the DWMHA since becoming an Authority, is nothing short of remarkable."

— *Clint Galloway, Editor*

Coming Together

Clint Galloway, Editor

I want to thank all the authors who have contributed to this issue! Your articles exemplify the vision and purpose captured in the title we chose nine years ago, **Connections for Communities that Care.** *Connections* is a storybook about ways of coming together for individual and community well-being, and what you have before you is another issue in that series. Some stories are about what we do well, while others envision how we can do better. What is amazing is how frequently the stories echo the theme of connecting, integrating, addressing disparities, accessibility, relationships, transportation, employment, and many others. These are a few of the essential threads in weaving the fabric of community.

Perhaps the explanation for *Connections*' endurance is that Nature has a bias for weaving us together. It is "The Universe Story." Every life needs caring, but not all needs are equal—some are severe and persistent rendering us more vulnerable in that universal pursuit of happiness. *Connections* remains dedicated to articulating what needs to be present in our communities so that healing is readily accessible for the whole person. How can we come together to create these centers? What kind of management structures, services and issues do we need to address that will serve the whole person? What kind of connections beg to be created? Do we not all desire a place where we can go for Integral Care? I was pleased when I received the articles written for this issue. They provide markers for quality Integral Care. That was the vision that conceived *Connections* nine years ago and continues to illuminate the path going forward.