CMHA
Community Mental Health Association of Michigan

Connections
for communities that care

SPRING 2018

INCORPORATING COMMUNITY INTO OUR MODEL OF WELL-BEING AND ILLNESS

Ron Manderscheid, PhD, Exec Director, NACBHDD and NARMH

Thirty-five years ago, we discovered that well-being and illness are not the two ends of a single continuum. This insight came from the 1946 Preamble to the Constitution of the World Health Organization, which states: "Health is a complete state of physical, mental, and social wellbeing, and not merely the absence of disease" (emphasis mine). Thus, the two dimensions, "well-being" and "illness," became our framework for guiding work on recovery.

Stated in simple terms, to achieve recovery it is essential to make progress on the illness dimension through traditional biopsychosocial interventions. It is also essential to make progress on the well-being dimension through, self-help, self-directed care, social support, and peer support. Both types of care are required.

This two-dimensional array is also the basis of modern population health management. A moment's reflection will assure you that use of these two dimensions generates four population subgroups, each with different well-being and illness needs. It is only in the past three to five years that we have begun to capitalize on this insight to guide population health management.

But we now realize that this model is incomplete. To move forward, we need to add a third dimension: community, which unfortunately was neglected in our earlier work. During the past decade, we have learned that the healthcare system only accounts for 10% to 20% of our health status. Fully 80% to 90% of our health status is due to what happens to us in our communities.

A few examples can be used to reinforce this point. One's ZIP code is very predictive of how long one will live. Our communities determine what social and physical health determinants impinge upon us. They also determine what traumas we will experience at what stage of our lives. Thus, communities have great impact upon our well-being, our illnesses, and ultimately, our happiness as well.

When we include community as the third element of our model, this dimension can range from very salutary effects on well-being at one end to very detrimental effects on the other. The clear implication for us in behavioral health is that we need to begin to engage in community interventions to promote these positive effects and mitigate the negative ones.

Initial steps are being taken to bring these public health strategies into behavioral healthcare and to bring behavioral health strategies into public health. This past fall the American Public Health Association hosted a symposium on this topic at the Carter Center in Atlanta. A summary of this effort will be available shortly.

In future commentaries, I will explore further the ways that the community dimension impacts upon our well-being and our illness.

It is amazing that we neglected this critical dimension for so long. ■

This article originally appeared January 11, 2018 on Behavioral.net.

Envisioning the Future: Part II

Clint Galloway, Editor

Response to the invitation to share your vision for the future of healthcare required us to publish two issues; this is the second issue that constitutes a 50th anniversary celebration of what is now known as the Community Mental Health Association of Michigan.

As you read these articles, it becomes apparent that change is a dominant theme. The Greek philosopher, Heraclitus, spoke the truth, "You can't step in the same river twice." With so many details to navigate, I've found it helpful to step back, take a deep breath, and try to grasp the big picture. Is it possible to identify an orienting generalization that will enable us to not only better understand what has been happening, but more importantly, to guide us in framing the future?

Our world has been inexorably moving away from understanding and thereby organizing itself hierarchically, with levels clearly delineated, to an organic perspective that focuses on how we are all interconnected. Hierarchies are concerned with who has power and is in control with position being critical. It was the default model when we were organized in tribes. Their development created silos (think fortresses and castles), boundaries, and walls. When we are organized in hierarchies, change is predominately a matter of struggle and conquest, a scary business! When we began to build organizations for commerce, we often utilized the methods that served us well in establishing empires. Who is in charge? The primary emphases became administrating, managing, and directing. This has been changing for some time.

The emerging orientation is focused on the myriad of connections that constitute being whole. This is good news for those engaged in healthcare because being 'whole' is the original meaning of 'health'. This shift in thinking began in the 18th century in the period historians refer to as the "enlightenment". New ways of understanding our world were introduced that challenged the explanations of the hierarchical authorities. We began to examine the world for ourselves, equipped with the tools of reason and spurned by the passion of empathy. It was the dawn of the sciences in education and democracies in political systems. (I warned you this was a big picture!) Discoveries began to accumulate and as they did, we became healthier, doubling our life expectancy in the last century! It was an organic orientation that was undaunted by the complexities and messiness of interconnectedness. Yes, democracy is a messy business and it's infecting all organized systems, including healthcare. The attributes of listening, learning, and collaborating are replacing our obsession with power and control. We need to chill, especially those who hold the reins! Understanding and supporting the efficacy of relationships is paramount. Change becomes a matter of learning how to authentically work together with mutual respect and cooperation. Connecting horizontally is the future. The process of integration looks very different through an organic lens than it does from a hierarchical perspective. The orienting generalization of an organic perspective that emphasizes connections and relationships is essential for improving the health and well-being of individuals, communities, nations, and the world. Indeed, we will not acquire full health until all these dimensions are included. How will we accomplish that?

The articles in these two issues provide some real clues. Think of our work like that of polishing a diamond that contains innumerable facets, together revealing the heart and soul of what constitutes health.

Haveman reminds us that the winds of change continue and show no sign of abatement. He ends with a quote: "Coming together is a beginning, staying together is progress, and working together is success." Jim has a stellar history in Michigan's public mental health system. This is third time he has shared his insights in Connections. (Summer 2013 and Fall 2014)

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THE WINDS CONTINUE TO CHANGE

Jim Haveman, Director, Department of Mental Health [Retired],
Michigan Community Mental Health Director for Governor's John Engler and Rick Snyder

I have been writing about change in the Community Mental Health System since 1984. I have been reviewing the various articles I wrote recently, and if you reflect on them, you be the judge if I have been right more than I have been wrong.

I have respected and been part of the Community Mental Health movement most of my career. I have worked with the champions who have paid their dues and given of their time for the people we serve. If you look back at the past 50 years of the CMH Board Association, you know who you are and you know who the champions are. One just has to review the list of those who have been recognized by the Board Association over the decades. We owe these "people pillars" so much gratitude.

I worry that those working in the system today don't fully understand the past and the journey we have been on to be where we are today. The CMH movement has always evolved through time and adapted to new services and eliminated old practices. But today it seems to be stuck and spinning its wheels as to what direction to go.

It was only in 1980 that the Unification Committee was appointed by the Department of Mental Health to bridge the policy and funding from large institutions to communities. It was the vehicle that jump started the real community mental health movement in Michigan. At the same time, we were working as CMH Directors to merge the Directors Association and the Board Members Association into one entity which is now the Community Mental Health Association of Michigan. In the early 80s, most of the CMH boards had budgets of less than 3 million dollars.

In those days there was a mandated annual meeting sponsored by the Department of Mental Health with the two Associations. That was our time to share ideas and each proposal had to be formulated into motions. These were individually presented and were voted on by the CMH delegates from the various Boards. That was the only yearly opportunity to express ideas and concerns to the Department of Mental Health. My, how things have changed where communication is now a daily interaction between the Department of Health and Human Services and the Association, it's members and providers.

In 1991 when we were presenting the "Promise of Performance" that solidified the focus on person centered planning and community services to the Michigan House Appropriations Committee, I was really getting hammered. We were in a packed room and Hal Madden, a CMH Board champion was sitting behind me. He kept whispering in a loud voice,"Don't let them get to you Jimmy!" I also have fond memories of the calm and pastoral voice of Rev. Rudy Kemppainen at unique times of change and conflict as the CMH Board Association went through its transformation.

The rewrite and passage of the Mental Health Code in 1995 was a miracle. When it was introduced on the floor of the House of Representatives, the Legislature had over 115 proposed amendments within the first hour. Shucks, we thought we had thought of everything when it was submitted and had every interest group represented in support. Wow, were we wrong!

It has been a great ride for all of us and I salute the CMHAM for its persistence and perseverance. The one consistent person in our journey over the past decades of the Association has been Chris Ward. I offer to her special thanks!

Clint Galloway, the outstanding member of the Ionia County Mental Health Board (renamed "The Right Door"), has been a champion over these decades. He has kept "Hope Alive" and has reminded us via his publications and words what the CMH enterprises are all about. His newsletters have kept critical thinking flowing, and he has challenged his readers to reach for the stars.

Clint recently sent me a note and asked me, "Stepping back from the current turmoil, what would you like our social landscape to look like in another 10, 25 or even 50 years?" So I took him up on his offer to share a few thoughts for each

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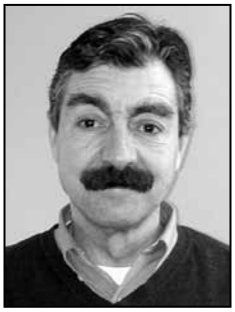
CMH Association and Its Members: *Forging a Third Way*

Robert Sheehan, CEO, Community Mental Health Association of Michigan



In the late summer of 2016, this Association's Executive Board adopted a set of principles for our healthcare transformation leadership efforts. This set of principles was built upon a clear-eyed assessment of the premises in the environment in which we all work – premises, outlined below, that have become clearer over the past several years:

1] Michigan's public mental health system is unique, along four dimensions, in that it is:

- a longstanding (20 years) publicly-managed and governed, provider-sponsored, risk-based managed care system
- that organizes a comprehensive, person-centered community-based system of traditional and non-traditional services and supports
- serving the full set of mental health populations (persons with SMI, SED, IDD, SUD), wile also
- serving as the state's statutorily-mandated mental health safety net.

2] Michigan's public mental health system has a long history of leading and actively fostering innovation. The current set of innovations led by this system, built around the theme of healthcare transformation and integration, number in the hundreds.

3] Michigan's public mental health system has a number of strong allies within the State Legislature and Executive Branch, within the advocacy community, and within homes, schools, workplaces, county courthouses, and communities across the state, giving it significant political power.

4] Even with the support of the system's allies, there are significant threats, in the political and healthcare landscape, to Michigan's public mental health system and those served by that system. Given the financial allure of Michigan's Medicaid mental health market, a number of private sector parties in the healthcare arena will use their considerable political and financial power to enter this market.

5] The innovation displayed by Michigan's public mental health system is matched by sweeping changes in the healthcare environment across the country, where a number of healthcare transformation initiatives are underway and emerging. These initiatives, including the trend toward integration of physical and mental health services, payers, providers, and benefits, are being played out in large-scale, state-by-state, in changes to Medicaid and commercial programs across the country. Additionally, a number of statutory, policy, and personnel changes at the state and federal level, over the next several years, will dramatically impact the development of these healthcare transformation initiatives.

Two bases for action drawn from these premises: The synthesis of these premises leads to two foundational concepts that provide this Association and its members with a bold direction:

1] Because neither the healthcare transformation momentum nor the expectations of our system's many stakeholders will stand still during the coming years, neither can our system. Because they will not wait for the dust to settle around the outcome of Michigan's Section 298 pilot process, nor for the decisions of nor leadership changes in the state and federal government, our system must continue and, in fact accelerate, our innovation in our practices, partnerships, and structures, with the same boldness and wisdom that has brought us this far.

2] A "third way" must be one of the core concepts to guide the work of the Association, its members, and allies relative to healthcare transformation initiatives. This "third way" uses a strong set of principles combined with pragmatism and a bias for action to building public-private partnerships and provider-payer partnerships to lead the state's healthcare transformation efforts, while strengthening Michigan's public mental health system.

The pursuit of this "third way" strategy is based on the recognition that it is a far superior approach to the two options often put forth as the only options for the future of Michigan's public mental health system – retaining the current structure of Michigan's publicly-sponsored mental health system or privatizing the core functions of the Michigan system. The third way will ensure that Michigan's public system remains strong and will grow stronger; continues to provide community-driven and community based, high quality, person-centered services and supports; continues to serve as a strong, reliable, and public community safety net; and continues to be at the cutting edge of healthcare and human services. ■

Editor's Note: This piece from Robert Sheehan was added to this edition of *Connections* as it was being readied for printing, to echo the theme of the Association's Spring Conference, *Collaboration and Innovation,* and to promote discussion of key strategic themes as they are also being discussed and debated by the Association's Executive Board and its members.

THE PROMISE OF SELF-DIRECTED CARE

Christopher Pinter, Chief Executive Officer Bay-Arenac Behavioral Health

The health care system in the United States is rapidly changing. As new developments in medical and pharmaceutical technology offer more opportunities to enhance and extend life, the traditional methods of managing, financing and delivering care also must adapt. For example, in the 1940s and 1950s, nearly all medical care was provided in a hospital or institutional setting; by the 1980s, most care provision had moved to an ambulatory or community-based setting such as a doctor's office, or later, a medical express clinic. These changes spurred innovation in outpatient medical technology and resulted in more health care being available to a larger percentage of the population.

An integral component of this transition to ambulatory-based health care delivery was the parallel evolution of health insurance. In its earliest phases, health insurance was designed as an assurance of income due to "loss of work days" from a medical illness, similar to worker's compensation. The key difference being that health insurance extended beyond income loss related to a work injury to include income lost due to almost any health condition. The health insurance model picked up momentum after the Great Depression proved that for many Americans, relying on private savings alone would be insufficient to compensate for the financial expenses related to an accident or serious medical condition. In addition, the wage controls instituted as part of the World War II mobilization effort made employer-based health insurance an attractive benefit to supplement frozen wages, particularly once the federal government provided a tax benefit to employers offering this coverage. In the interim, states began to enact enabling legislation for non-profit, prepayment programs such as Blue Cross and Blue Shield to offer insurance for hospital and physician-based services. The emerging importance of health insurance was further augmented with the passage of the Medicare and Medicaid Act of 1965, vastly expanding access to health care for the elderly and the financial role of the federal government.

> "The longer people live, the more health care resources they are likely to consume."

In the meantime, advances in medical technology and pharmacology were making many acute and chronic conditions more tolerable for consumers. This increased the life span in the United States for most persons over 25% between 1900 and 1982. This trend has remained relatively constant during the last 30 years and even increased further for persons over the age of 65. These increases in life expectancy and longevity are the primary factor often driving the periodic debates over the need to change the entitlement status of Medicare and Medicaid. It is simple mathematics: the longer people live, the more health care resources they are likely to consume.

As health insurers (both private and public) have had a larger role in the management of health care services, and medical technology has expanded the availability and type of ambulatory providers (i.e. specialists, pharmacies, labs, diagnostic centers, adaptive devices) – one essential member of this equation has often been overlooked: the consumer. This is primarily due to the fact that health care financing (demand), rather than individual consumer market choice, tends to drive health care delivery (supply). The gradual movement toward self-directed care seeks to fundamentally alter this dynamic.

The most essential element of the health care system is the consumer. The consumer decides when to access care, what types of conditions to address, what treatment strategies to pursue and ultimately, if care has had a successful outcome. In fact, even in a system dominated by large private and public payer systems, it is ultimately the individual consumer that provides the financial resources for care, either through out of pocket expenses, or collective private and/or public purchasing power. In addition, most mechanisms to manage the costs associated with health care involve one of the two following strategies: controlling the consumer's access to care and/or controlling the provider's ability to be reimbursed for

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FOR THOSE WHO ARE MOST VULNERABLE AMONG US

Robert McLuckie, Connections Editorial Board

Forty-five years ago I worked as an intern in the research department of one of Michigan's institutions. During my first week the director asked me to deliver a package to our Infant Stimulation team in Cottage 3. The receptionist directed me to the basement level, where I walked into to my first face-to-face encounter with people with devastating disabilities. The large tiled room smelled faintly of urine, but mostly of soap and disinfectant, and was filled with white steel cribs. Most folks were silently staring at the ceiling, and some were sleeping. Others were moaning, crying out, or rocking back and forth. I passed the packet to the project leader who invited me to walk about the room to meet those who "lived" there. I walked… paused…touched…stroked hair…held hands…and spoke to the people lying in those cribs. No one answered. I looked into their eyes, some vacant, others seemingly yearning to speak or somehow connect, but unable. I'd met the most vulnerable among us.

Years later, I supervised a Community Mental Health activity center, commissioned to serve adults who did not "fit" well into other services. Some were isolated due to behavioral problems of violence or self-injury. Others were living with mental illness diagnoses in addition to a substantial developmental disability. One young member of our group, Betty, lived with severe cerebral palsy. She was of normal intelligence but could not speak, control her body, or help herself in any way. Betty communicated by flailing her arms and vocalizing in sharp yells with different tones for yes, no, pleasure, pain. Strapped into her wheelchair, Betty participated in her own life only with complete assistance from others. Very often our most meaningful support was to simply hold her hand while she cried. My friend, Betty, was trapped in her own body and one of the most vulnerable among us.

Today, those in Cottage 3 have moved into community-based settings, and Michigan's community services array now offers a solid and broad platform to support vulnerable individuals in living active and meaningful lives. We've accomplished so much: we've moved from large segregated institutions and congregate care to person-centered self-directed services, home ownership, supported employment, self-advocacy, and access to a full array of lifestyle choices.

Our Next Frontier

Let's first recognize that Michigan's incredibly successful community service system is a services "industry." We work within organizational structures, contractual alliances, procedures, protocols, and regulations to manage a huge mechanism of coordinated care. Creating operational definitions to standardize and measure our most delicate products -- quality of life, meaningful lives, compassionate supports -- can bring dilution and drift, which happens in every industry. In one example, an organization mounted a broad effort to enhance community participation and inclusion in its residential services. A few months later, reports from front line managers were encouraging and I visited one residence said to be doing particularly well. As I entered, a group of folks were heading out the door. The staff member took the arm of one man and said "Not you, Paul. Not today. Your 'inclusion' is on Tuesday." Had the concept of membership in the community really become distilled to a ritual of scheduling and counting "inclusion events"? Perhaps, because our implementation strategies and quality assurance systems demand observable outcomes, this can become a focus on achieving somewhat bland indicators of success. A "circle of friends" comes to mean the number or social engagements or people who visit per month, rather than actual genuine, consequential, and lasting personal connections.

Looking forward, what will be our next frontier? None of us is an expert in how to create a life of meaning and joy, but we all know when it's happening and when it's not. If we have the will, we can use the structures of our service array to support a vibrant life for each individual served. Now that the base structure of our community services system is well established, let us commit to assisting each person to enjoy a life of deep fulfillment, personal meaning, and joy. Let this be our flagship, our star, our purpose.

Relationships are Primary

Dr. Beth Mount, a prominent national consultant and author in the developmental disabilities field, grew up in Atlanta during the 1960's Civil Rights Movement. She was deeply influenced by Martin Luther King Jr.'s call to remember that "we are all tied together in the single garment of destiny, caught in an inescapable network of mutuality." Dr. Mount is a passionate advocate for those who are most vulnerable among us and speaks in blunt terms: "I'll say it in the most straight-forward way I can: most of the people supported by our human services organizations are lonely – profoundly lonely. And most of what we do in human services is secondary to helping people form and maintain meaningful relationships. There, I've said it. The cat is out of the bag. I don't think our industry – and that's what it is, an industry – is paying enough attention to the impact of loneliness in the lives of people who experience disabilities. *Loneliness is* *the only real disability."* [1]

Relationships are the essence of our existence, the "food" of the human spirit. They are necessities, not luxuries. To make support for valued relationships anything less than a top priority is a form of violence against those we serve. Supporting those who are most vulnerable among us must include ensuring that each person experiences genuine, loving, trusting, and enduring relationships.

The Inner Life

Your life is not a problem to be solved but a gift to be opened. – Wayne Muller [2]

If the goal of our next frontier is to support meaning, fulfillment, and joy for those who are most vulnerable among us, we must understand that this means an unrelenting focus on the inner life of the person. This may seem obvious, but we often get caught up in the hectic routines of work life and settle for far less. We may be tempted to conclude that the most vulnerable among us have a very limited capacity for a healthy inner life. The common "wisdom" says there is a vertical scale of high to low ability with the more capable folks on the high end and those wrapped in our narrow expectations and sympathy on the low. But at any point on this scale there is a broad horizontal expanse wherein lies a vast store of possibility for each individual no matter where on the scale they fall – the possibility for rewarding experiences, adventures, personal enrichment, and fulfillment. In other words, there is plenty of room for living, even for those who are most vulnerable among us.

A wise person once said that we are not human doings, we are human beings. A healthy inner life is one of beingness, not doingness, and is not limited to only those of great capacity. Beingness is enthusiasm, zest for life, personal fulfillment, contentment in the here and now, excited anticipation for tomorrow, belly laughs, giggles, love, fascination, restful sleep after a busy day. Let us not equate self-worth with how well or how many things a person is "doing." Instead, let us support the person's right to simply be in this world in ways that bring them joy and personal contentment.

Daily Practice

The ability to be in the present moment is a major component of mental wellness. – Abraham Maslow

If you are a musician and you practice each day, your instrument will resonate with the skill you bring to it. If you are a meditator and you practice each day, the presence and mindfulness learned while sitting will carry you through the day. This is called daily practice. Our next frontier, when providing support for those who are most vulnerable among us, must include supporting daily practice. This means supporting habits that affirm self-identity and self-esteem and seek answers to the questions: Who am I? How am I unique? What do I love?

Daily practice must be a form of celebration of the ordinary moments. It requires that we slow down and treat each moment as important, not just something we rush through to get to the next thing. In honoring the ordinary, we come to experience the truth that the more one celebrates life, the more in life there is to celebrate. Some simply call this "being positive;" others call it our mysterious and delightful ability to create the life we seek.

Daily practice must embrace kindness through giving and receiving. In practicing kindness, the heart will become rooted in an unspoken sense of abundance. Reciprocity will become commonplace. When a gift of the self is given in kindness, kindness is returned. Giving and receiving favor common exchange, and relationships flourish.

Daily practice must bring individuals to know their unique personal gifts. We all have them. In practicing one's gifts, the sense of beingness expands. Gifts may be offered to the family with whom one lives, to one's neighborhood and community, to the Earth.

Daily practice must be joyful, loving, and gentle. No rushing to become or do something else. We simply settle in and practice being here now; present within each ordinary moment of life. This will reveal the inner strength and the power one possesses, but may not have known.

Afterword

Our next frontier in supporting those who are most vulnerable among us must include the daily practice of being present for what comes our way, and experiencing joy and wholeness in ordinary daily life. Our next frontier must be to assist each one to know the peace and joy of "I am here now."

The path of supporting those who are most vulnerable among us is rich and deep. Our opportunity is to create deep joy and meaning. How very wonderful indeed!

Live your life, sing your song. Not full of expectations.
Not for the ovations. But for the joy of it!
– Rasheed Ogunlaru ■

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[1] "Loneliness is The Only Real Disability," Beth Mount, *Toolbox for Change: Reclaiming Purpose, Joy, and Commitment in the Helping Profession*, David Pitonyak, 2009

[2] *How then shall We Live, Wayne Muller*, Bantam Books, 1996

REFLECTIONS FROM THE HEART OF WORKING IN FLINT

Elizabeth Burtch, Genesee Health System

Most people have heard of flight versus fight. I'm getting ready to talk about moving from crisis to recovery and I am having the biggest "flight" response ever. So if I bolt out of the room – just pretend it didn't happen. Right now my body is flooded with adrenaline and all sorts of other chemicals that are meant to help me fight off a bear. But there is no bear; why is my body flooded with these chemicals right now?

And why am I still standing here? If it is actual fight versus flight, how could this happen? My brain is imagining all sorts of scenarios right now. These imaginations and thoughts are causing feelings that are triggering my brain to release all sorts of survival chemicals.

The problem is, I'm not in *actual* danger, it just feels like I am. Even though my body is releasing all of these chemicals that makes me believe I'm in crisis, I am able to use the logic part of my brain right now. I am observing and acknowledging what's happening internally while I'm trying really hard to be purposeful with my breathing to counteract this "fake" trauma response. What would happen if a bear *actually* came into this room right now, I wouldn't be obsessing and ruminating over what I was going to say, or if I have something on my face, or if I picked the right outfit. In fact, it would be the opposite – I would react without thinking. I would run or hide or try to throw a chair. (Let's be honest, I'm going to let someone else handle that.) And what happens if I've had a run-in with this bear before? What happens if I have been faced with this bear over, and over, and over again, in my life? How do these circumstances change my reaction? Would I fight more efficiently? Or maybe run faster, knowing the odds were against me? Would I be paralyzed out of pure fear?

A few years ago, I was on my way back to the office from a home-visit in the middle of the day. It was right between the Court Street and Robert T Exit on 475 North. The van in front of me turned too sharply, flipped and landed on its side. I immediately pulled my car to the side of the road and called 911, got out of my car and ran to the van. There was a man who had also pulled over. Together, we were able to bust out the window and talk with the woman. I remember getting a towel from my car because her face was bleeding and calmly talking to her, knowing that she was injured and in shock. I talked with the police officers and briefly chatted with the gentleman who also stopped to help. I remember that he was a nurse and I made a joke about being the best first responder duo.

Then I got back to the office. As I walked in, my coworker looked at me and said, "Oh my gosh, you need to sit down! What's going on with you?" We sat down in my office and then it hit me. It all just hit me at once. It felt like a wave of numbness and panic at the same time. Certain parts were playing like a movie in my brain, over and over and over again. There were lots of gaps, too. I would try to distract myself, try not to think about it, but these images were invasive. And it seemed like the harder I pushed these thoughts away, the worse they got. I began to feel guilty that I was having this reaction. I wasn't the one in the accident. My car wasn't totaled. Why am I being like this? It's easy to see how this spirals out of control.

Luckily, all of my friends are therapists. More importantly, I have built trust with these people, some for many years. I felt safe talking about what had happened; I was able to say, "I am feeling so guilty. Here's what's going on." My friends responded with, "Of course you feel those things. Anyone who saw what you saw would have that reaction." Almost instantly my guilt slipped away. Once the guilt was gone, I talked over what had happened multiple times. (I'm clearly a verbal processer.) I was no longer having those invasive thoughts.

Guess what happens every time I drive by that spot? My stomach flips. Why? Supposedly I'm "over" it. I talked it out with amazing friends who care for me, I processed it, I did all of the things that I was supposed to do after something traumatic. That part of my brain that responded so seamlessly at the scene of the accident was able to do so because the logical part of my brain wasn't getting in the way. This "response" part of our brains is really good at storing memories while automatically pumping our bodies full of these survival chemicals. Remember, this isn't in the part of our brain that is making a mental grocery list; this is the part of our brain that is responsible for keeping us alive.

As to this awful feeling that sweeps over me every time I drive to work, I had a few options: I could take side streets and avoid that feeling. However, I made a conscious choice to not change my life around because of something awful that I had no control over. As much as I would like to think that taking side streets will ensure that I never witness another accident, it's just not reality. It's a false sense of security that my brain is making up in an attempt to keep me safe and avoid danger. I know what my body does when I drive by that spot, and I consciously take a deep breath to counteract that automatic response. My body is responding

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Daniel's Story: A Voice of the Unheard

Daniel K. Arnold

Hi, my name is Daniel Arnold, and I am a survivor of severe mental illness. I owe my recovery to Jesus, peer support, church support, faith, miracles, and a disciplined life. Many people are rooting for me and this helps a lot. It would be very difficult to stand alone. There are those who have gone before and those who will come after. We support one another. My Higher Power can move mountains.

I first went to a mental hospital in 1999 after coming out of jail and have been hospitalized/committed to a crisis unit maybe 20 times. I have seen stigma & setbacks and am a little reluctant to share my story at this moment.

I have come very far. Being off of psychotropic medication for over 100 days, I have defied the odds. My case is severe enough to be placed on court-ordered shots and oral medication. Still, I have bucked the system with a lot of oversight. My family, caseworker, psychiatrist, church family, mental health drop-in center, and friends are all aware of my decision. This controversial choice was met with opposition at first that grew to acceptance. It was a matter of faith for me and I would like to share it with you. My journey has been met with a lot of lost battles, but the war is not over. I believe I can be victorious.

In the last 100 days, I have continued to meet with mental health professionals and shared my story with my pastor, friends and family. I have been as transparent as possible with many people, not just to be accountable, but to inspire others.

My faith walk began in part with letting go of fear. I was told believing I was healed and letting go of psychotropic drugs would involve the police forcing hospitalization. I was informed by an individual that my non-compliance could land me in a miserable state hospital long-term. I had to be ready to put my freedom on the line for what I believed in. I had to be ready to take a stand that might not even be appropriate for an AFC Home. I had to be ready to give up everything.

My first inkling was to go into hiding. I contacted a pastor and asked him if I could hide out at his house from the police. When that door closed, I decided to communicate. Instead of living in fear, I weighed the costs. I would turn myself in and remain true to my convictions. That day I turned myself into Crisis Services at Community Mental Health of CEI. When they evaluated me, they surprised me. Crisis Services determined I was too healthy for the hospital and that the police order had not gone through yet. I was given discharge papers that night! The next morning I met with my case manager on the phone. She informed me that the police would not be coming and that I would need to check in with her weekly. Soon she changed meetings to twice a month and then once every three weeks. On the last appointment, she decided to schedule the next appointment two months in the future.

Part of my journey of recovery has involved staying engaged in the community even in the height of my disability. My philosophy is "Do something, no matter what." Everyone can volunteer behind the front desk at Justice in Mental Health Organization and I did just that!

I relayed messages, greeted people, and answered the phone for the organization at the front desk. This did not require any clearance at all and built my resume & references.

Over the course of years, while on disability, I have written books on mental health, spoken at conferences, written an article to Clubhouse International and coordinated open forums for mental health consumers with the police, the bus system, Michigan Disability Rights Coalition, and the Mayor.

I believe people should never quit no matter how debilitated they are. Everyone has something to offer! Step by step I have continued the journey to where I venture today. Life is not perfect. I have to strongly limit caffeine intake, be careful about sleep, and stay accountable with those around me. I love this life God has given me. I decided to apply at first to volunteer at church, and then apply for a job. I decided to apply for the job I wanted. I now work in a preschool. I now advocate for children and mental health consumers. I also serve on two consumer advisory councils for mental health. I am presenting February at the Michigan Association of Community Mental Health Boards Conference Workshop on "Alternative Coping Mechanisms in Mental Health."

Friday I advocated for child development educational programs at the Lansing Educational Transition Committee Meeting organized by Mayor-Elect Andy Schor. Monday I advocated for mental health services in the Lansing Neighborhoods & Public Safety Transition Meeting. Things are moving forward, but I take one day at a time. I value my health, family, friends, church, and God.

I want consumers to know they have rights and mental health professionals to know that their consumers have hope. I believe accountability is important, as well as receiving health services. I believe it is always good to stay engaged with the community and never give up! I have my own convictions and am glad

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MICHIGAN'S PUBLIC MENTAL HEALTH SYSTEM:

Committed to Innovation with Courage and Vision

Robert Sheehan, Chief Executive Officer
Community Mental Health Association of Michigan

As you know, over the past year, our Association has developed a bold and future oriented (some might call it a "post-298") strategy, designed to ensure the strength of Michigan's public mental health and the health of the individuals, families, and communities served by this system.

That strategy is based on several premises:

- ✧ The importance of a strong public mental health system, in Michigan, to the well-being of those who rely upon this system, their families, and communities served by this system
- ✧ The unique nature of Michigan's public mental health system (longstanding publicly-managed and governed, risk-based comprehensive community-based system, serving the full set of mental health populations that also serves as the state's mental health safety net)
- ✧ The national trend toward integration of physical and mental health services, payers, providers, and benefits; health care transformation; and payment reform played out in large-scale, state-by-state, changes to Medicaid programs across the country
- ✧ The diversity, from state to state, of the integration efforts being applied to Medicaid programs across the country
- ✧ The political and financial power of a number of private and public sector parties in the healthcare arena – political power that is exercised within individual states, such as Michigan, and nationally
- ✧ The political power of Michigan's public mental health system and its allies – power across advocacy, political, clinical, community, and public support dimensions

Based on these premises, the strategy that this association has been pursuing, over the past two years, has involved the development of a working knowledge, by the Association's members and allies, of innovative integrated care structures and practices, occurring across the country – providing a rich source of guidance as Michigan continues its healthcare transformation efforts.

This effort continues the long tradition of Michigan's public mental health system, of continually developing innovations that put it at the leading edge of the field of the movement.

This tradition of innovation has been strong and continuous over the past fifty years. In fact, a review of the efforts of Michigan's public mental health system, within only one dimension of our work – healthcare and payment transformation – is stunning. Below is that review.

For two decades, the Association's members, under a Medicaid 1915 b and c waiver, have served as Michigan's Medicaid Specialty Services managed care system, with a risk-based capitated payment structure, moving from a fee-for-service system in 1998. As part of this capitated payment system, the public PIHPs and CMHs must meet outcome and quality standards as measured along a number of dimensions and must develop and implement several Quality Assurance Performance Improvement Processes each year. Over the past two years, the contract between the State of Michigan and the Association's members has included performance incentive payments for the successful implementation of collaborative and integration efforts between the state's public mental health and physical health system. This places Michigan's public mental health system in the highest level of the value-based payments continuum.

Additionally, the Association, and its members, have been engaged and will continue to be engaged in the promotion of a number of alternative payment and healthcare system transformation initiatives over the past two decades, including:

- Association's members are actively involved in and co-leading State Innovation Model (SIM) efforts.
- Association's members are grantees of SAMHSA's Primary and Behavioral Health Care Integration initiative.
- The Association and its members were key in the development of Certified Community Behavioral Health Centers (CCBHC) readiness (Michigan is working with SAMHSA and members of the Michigan delegation to expand CCBHC beyond the initial set of states – an expansion that would include Michigan).

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Burtch *(from page 8)*

to my brain imagining that car accident. I can recognize and choose to respond in a way that puts me back in control.

If I did not have the caring coworker who stopped me in the hallway, who noticed something "off", who sat with me, who gave me permission to cancel my appointment later that day; If I did not have my friends on the other side of the phone to give me the support I needed, what would have happened? It's very possible that this one event, without the support and care of people who love me, would have landed me in a situation where this spot of road plagued me with fear. Maybe this anxiety would have turned into a fear of expressways, a fear of driving, a fear of leaving my house. This could have had a massive impact on my life. It could control me. And what if it happened again? How would I cope? How would I react?

Sometimes, the same awful bear comes at us over, and over, and over again until it feels totally out of our control. It feels like there is no response that can keep us safe. It feels like we have no one; we are on our own. This is especially true for children and vulnerable individuals who rely on others for their safety. This repeated trauma can rewire our brain. We begin to adapt to these bear attacks. Maybe we stay at a heightened state, ready to respond. Maybe we shut down. We isolate. We try to numb. We seek "pretend" comfort. It's too much. And these all makes sense. Our brain is trying to protect us. This bear has taught us to not trust – anyone, including ourselves. We have 'learned' that life happens TO us and that we have no say. So we numb. We've 'learned' that other people are not helpful and do not keep us safe. To make things more complicated, this part of our brain remembers experiences that we can't put words to because it is too traumatic, or the event occurred before we had language.

As babies and infants, we cannot survive without a caregiver. We are totally helpless. If we can't connect with that caregiver our life is literally on the line. So, in exchange for all of the exhaustion and sleepless nights, babies give us a little smile or coo now and again that lets us know we're doing a good job, and when we smile back, it gives them reassurance that we are invested. These tiny, brief moments are beginning to wire that baby's brain for trust in relationships. These moments that are our first "potential" bear attacks have a lasting impact on all of us. The more bear attacks and the less connection we have, the more likely we are to up the ante and avoid all of these awful feelings. And this can be devastating. We will do anything to avoid uncomfortable memories and feelings. We turn to substances, we turn to suicide and we turn away from anything that would help us. We are afraid. We are consumed with shame, the idea that *we* are not worthy of anything except those bear attacks. Our brain has contaminated our lens of how we see the world; we see danger lurking around every corner. We avoid meaningful relationships because they are painful.

There is no disputing the fact that there is a massive and devastating opioid crisis in our country, and in our backyards. There is no disputing our obesity rates or prescription drug usage. These facts suggest to us that people *aren't* getting what they need to address trauma and every day stressors. It seems like people are turning away from people, and turning to a substance. Of course this is a quick remedy to an awful feeling. But I don't believe that people jump right into drugs or alcohol. More likely, there was an attempt to connect that was met with shame or blame – over, and over, and over again.

So, let's think about this; how do people generally respond to crisis and trauma? How do we respond to seeing someone in pain? It's easy to respond unfavorably when faced with other people's trauma. It's easy to place blame, which is really a shallow defense mechanism that perpetuates trauma and disconnect. Think about what people say about Flint; "Why don't they just move?" The blame for suffering is now transferred to the victim and we are off the hook.

How do comments like that make us feel? What does it mean to hear that there is something we could have done to avoid something awful that we have experienced? What does this feel like for people who have felt so much disconnect in their lives? It reinforces the message that they are unworthy. It causes those wires in our brain to become more and more difficult to undo.

I am not talking only about individuals who are living with a severe mental illness or who are struggling with drug addiction. I am talking about all of us – all of us who have witnessed the pain and suffering of people we love and care about as well as those of us who have felt helpless and hopeless; desperate for help and answers. We cannot talk about hope and recovery and not talk about us, the care givers. All of us have a story to tell. We have both stories of bear attacks and stories of hope. We have stories of love and hate, of grief and joy. Our stories are the foundation of who we are; the way we see and interact with the world is through the lens of our own experiences. We all contribute, we all matter, and we are all a part of the story of healing. When someone in your life is going through crisis, what is your response? What about those individuals in our lives who seem to be in constant crisis, what is our response? When is the last time you asked yourself, "how am I doing?" When is the last time you answered honestly to a friend who asked you that same question? When is the last time you stepped back from helping everyone else and put

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Burtch *(from page 11)*

some of that energy into yourself? We need to understand our reactions in order to help others with theirs. You know, the whole oxygen mask thing in the airplane? Put yours on first.

We can't force people to see themselves the way that we see them. We can't force people to get help. And we certainly can't help people gain control of their own lives when we are feeling out of control ourselves. We cannot teach a skill we have not learned. So where do we start? We start by directing our energy into what we *can* do. Not what we can't do, not what everyone else has done wrong, not the mistakes that we have made in the past, and not pretending like we can see the future. In this moment right now, what *can* I do? How can we stay healthy ourselves when we are surrounded by crisis and trauma? We can be purposeful in our interactions and our relationships. We can understand and have empathy and also make positive choices for ourselves. Some of these choices are so difficult, especially with individuals who are living with mental illness or struggling with drugs or alcohol or who are in constant crisis. We sometimes get immersed in their crises, because we don't know how else to help. We think that by staying, we are helping, when in fact, many times we are enabling the person. When we set boundaries and limits, when we change how we have always responded, there will always be push back. It will be uncomfortable and painful for all involved. We can acknowledge and respect their reactions and also remember that we *did not cause* the crisis, nor will we fix it.

We can remind ourselves that it's okay to feel. It's okay to feel things we think we should be ashamed of. We are allowed to take time to walk through the swampy mess of feelings. We can practice control in our own lives, through self-awareness and setting boundaries. We can take care of ourselves. We can be gentle with ourselves when we mess up. We can be honest and courageous. *We* can seek help. We can choose to do something different today. Nothing changes if nothing changes.

This is incredibly difficult. It's a lifelong struggle for us helpers. We want to take away the pain immediately. We need to know this about ourselves, because trying to give a quick fix or take away the pain is the *opposite* of showing and guiding people to see their own autonomy and ability to take control. When we have established a connection with others we are teaching our brains that we can and *need* to trust other people. None of us can do this alone.

How do we create an opportunity for connection when there has been an overwhelming amount of disconnection? How could anyone possibly override this or make a difference? It turns out, trust is built in tiny moments. It's built when someone looks at us and smiles, when our friend remembers the birthdate of a loved one who has passed, when our partner offers to cook dinner because they see that we've had a rough week. These are all tiny moments that we can give to each other. Moment by moment, we can rewire each other's brains to embrace that connection, even if it feels scary and even if it is uncomfortable. We can keep an eye out for people and ask how they are doing – and really mean it. We can practice forgiveness and acceptance within ourselves. We can arm ourselves with training and resources and information. We can check in after something awful has happened. We can call, we can text and we can stop by. Sometimes people need more support and that's okay. We can encourage people to seek professional help, we can support them. It's about taking care of ourselves and those around us.

I have always believed that people can achieve and maintain recovery and I believe this about Flint. I wouldn't be a social worker if I didn't (or at least not a good one), and I wouldn't still be here and speaking if I didn't believe that in my heart and soul. I have always believed that everyone is always doing the best that they can in every moment. I have always believed that people who are hurt, hurt other people. It takes more than just saying these things, though. And I surely have not always exemplified these beliefs and morals. I have been in those dark and scary places. I have put blame on people and situations that was unwarranted and mean, because the thought of a similar situation happening to me was unbearable. And that's okay. It's okay for us to be imperfect – all of us.

We need to embrace all that we are and not run and hide from the parts that we don't like. We need to understand where we have been and where we are trying to go. We need to pay attention to our bodies and our behaviors. We need to check ourselves. We need to allow ourselves to be vulnerable and have those meaningful relationships. In recovery, it's about those bear attacks being part of your story, not omitted or minimized, nor allowed to become the whole story. When we allow ourselves to feel the discomfort of trying something different, whether it's beginning to trust, or talking with a counselor, we are providing an opportunity to make real change – for ourselves, our neighbors, and our communities, because we all matter.

Elizabeth Burtch is a young social worker, infant mental health specialist who got thrown into the Flint Water Crisis from the beginning. She has been on the front lines of all things water crisis, and also does groups and listening circles for the care givers and staff. Even though it was written for people dealing with the crisis, it is applicable to everyone in our field.—

Dan Russell, CEO, Genesee Health System.

Pinter *(from page 5)*

care. The consumer is the middleman in this triad; payers control the financing and providers control the care, but the service outcome is the consumer's alone to bear. Either the individual gets better or does not. This is the reason that health care is so personal for all of us.

A self-directed approach will move the health care system toward recognizing the individual consumer as the essential element of any service outcome. It transitions the role of the insurer to that of a fiduciary agent or fiscal intermediary thereby strengthening the direct bond between the consumer and the provider (incidentally, the relationship that is often cited as having the most impact on achieving improved service outcomes). A self-directed arrangement transfers the power and control of health care resources from insurers and service providers to the individual consumer. The consumer assumes more direct responsibility for managing their health care arrangements and tools for interacting with the larger provider community. This includes the use of individual health care budgets and peer service brokers to empower the individual to be both responsible and accountable for their recovery and service outcomes. These basic changes have the potential to revolutionize the health care market by reinserting true individual consumer freedom into the traditional supply and demand relationship.

A self-directed approach will move the healthcare system toward recognizing the individual consumer as the essential element of any service outcome.

A self-directed approach is consistent with the conceptual foundations of self-determination as it creates the opportunity for individuals to pursue improved quality through the powerful combination of personal liberty and fiscal responsibility for health care decisions. This is also symmetrical with our collective marketplace experience that has demonstrated the infinite potential of aligning personal responsibility and accountability in the commerce of providing a service to others.

Bay-Arenac Behavioral Health implemented a self-directed care option for specialty behavioral health services and supports in early 2016 with the support of the Michigan Department of Health and Human Services and the Transformation Transfer Initiative. The initial results of these self-directed arrangements have been very positive: 13 participants demonstrated increased emphasis on personal responsibility for wellness, expanded engagement with community relationships and increased productivity in relation to educational and employment pursuits. These factors led to increased personal independence and reduced the overall net health care expenses for the individual consumers.

These results were directly related to the courage of individual consumers in assuming both responsibility and accountability for their care decisions. The primary role for Bay-Arenac Behavioral Health as a support system was to ensure the availability of effective fiscal intermediary, peer support broker and case management services. The individual participants embraced the concepts of self-direction and brought the change to realization.

The implementation of self-directed models of care continues to progress throughout the United States. It is being applied to nearly all service populations: persons with physical disabilities, persons with intellectual/developmental disabilities, persons with serious health conditions, families of children with autism and even returning military veterans. It can be the future of health care. All it requires is that the stakeholders invested in the current system (i.e. insurers, payers, hospital systems, manufacturers and providers) recognize that health care is really about the individual consumer, and not about us. Would we expect anything different for our own health care? ■

Arnold *(from page 9)*

they are protected in America.

I want to educate professionals on how to deal with consumers like me. The key is communication and discussing options. Fear tactics do not work on the informed consumer. Love, honesty, transparency, and education are the best ways to build bridges.

I intend to stay engaged with my mental health professional community. In fact, I want to share my story. I want to answer questions in professional development courses and conferences. My agenda is to inspire and open doors of communication. Communication saves dollars, lowering expenditures on emergencies. It builds trust and quality of life for the consumer as well as the professional.
I am a busy person, but the people under you as well as you matter!

Mental health matters. Let's make a difference in our local community. Thank you. ■

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Haveman *(from page 3)*

of the five questions he asked. You will quickly see that, in my opinion, there must be full integration of health services and the existing carve out for CMH systems of care needs to end. Health systems, insurance companies, consumers, hospitals, and providers will be part of integrated health care system in Michigan. In five years, there will be five major integrated systems of care in Michigan (that includes behavioral health) and that will change to a fewer number over time.

1. WHAT NEEDS TO CHANGE?

The answer is simple….a willingness to change! I yield to the following great thinkers/doers to demonstrate my point:

"Change is hard because people overestimate the value of what they have and underestimate the value of what they may gain by giving it up." — Belasco and Stayer

"If you do not change direction you might end up where you are headed." — Lao Tzo

"Time and conditions change so rapidly we must keep our aim constantly on the future." — Walt Disney

"There is nothing permanent except change."
— Heraclitus

"There are three constants in life; change, choice and principles." — Steven Covey

2. WHAT ARE THE MOST IMPORTANT PRINCIPLES AND VALUES THAT WILL GUIDE US?

- Seamless services
- Consumer choice and self-determination
- Technology is our friend
- Best practice
- Kindness, caring, good communication, reliability and trust
- Integration of the mind, body and spirit
- Simplicity of consumer experience and truth
- Accessibility to health care is a right
- Early assessment and intervention

3. WHAT ARE THE OBSTACLES TO MAKING THESE CHANGES?

- Legacy and unwillingness to give up the past
- Fear of change and competition
- Politics and lack of health care legislative champions
- Work force lagging to produce specialized personnel to meet the needs of the aging consumers and complexity of diagnosis in consumers
- Job security and counties fear of losing funds
- CMH boards becoming providers at the expense of private agencies
- Computer systems that don't interact
- Consumer's and advocacy voice is gone
- Advocates who are fronts for interest groups
- Licensing and regulations
- Duplication of services and requirements
- Complexity of consumers today
- Lack of training for new consumer challenges
- Cost of prescription drugs
- Confusion over future federal policy and funding
- Public fights of those who are trusted to provide quality care
- Confusion if CMH system is private agency driven or funder driven

4. HOW CAN WE OVERCOME THEM?

- Focus on statewide integration and forget the four pilots
- Thinking smarter
- Start with needs of consumer, not the "systems"
- Realize there will be less funding in the future to meet expanding demand for services
- One information technology platform that interacts with all systems of care
- Amend the Mental Health Code to mandate integration of services and eliminate the carve out for Mental Health services by CMH
- Separate behavioral health delivery system from the system for people who are developmentally disabled
- Provide incentives for mergers and acquisitions
- Phase out the ten PIHPs and have MDHHS allocate Medicaid funding to Health Systems
- Foundations and universities will lead the way for innovation

5. WHAT ARE THE FIRST STEPS?

- Rationalization of State and Federal responsibilities
- A shakeout of providers and insurers
- Full acceptance of integration of health
- Amend the Mental Health Code to accommodate reality

- CMH boards that are funders become part of Health Systems of Care or become a private provider contracting for services.
- Allow the entrepreneurs, foundations, and universities to help us
- Flatten the administrative levels between the state and providers
- Focus more funding and time on social determinates
- Separate out strategies for persons who are behavioral health and those persons who are developmentally disabled
- Intensify efforts at screening and early intervention
- Department of Health and Human Services to fund only best evidence services
- Spend more time on analytical work with big data to better design purposeful services
- One-stop services within integrated health building
- Full acceptance of new technology including telehealth, sensors, tablets, mobile phones and the use of autonomous vehicles to achieve one's goals.
- Accept that most therapies in the future for behavioral health will be medically assisted interventions.

Let me end my comments with a quotation from Henry Ford:

> **"Coming together is a beginning, staying together is progress, and working together is success."** ■

Sheehan *(from page 10)*

- Association's members are operating behavioral health homes under Section 2703.
- The Association and its members have been actively involved with the Michigan Department of Health and Human Services in the development of a 1115 Medicaid waiver furthering healthcare integration.
- The sponsorship, by this Association, of a two-tier (early development and advanced) multi-year health care integration learning community, involving the Association's members (which will soon move into its next phase).
- The annual survey of healthcare integration efforts, conducted by the CMH Association, identifying the hundreds of healthcare integration initiatives in which the Association's members are leaders or active participants (the most recent survey, conducted in 2017, will be released later this month).
- The shared coordination (with the State of Michigan) of a federal and state funded Employment First payment reform (pay for outcomes) technical assistance effort, using subject matter experts, involve a number of Association members.
- The formation of an Emerging Healthcare Integration Practices and Structures Study Group (a group of the Association's members identifying and analyzing, with the guidance of a range of healthcare consultants, public/Medicaid healthcare integration efforts from across the country.

Over the past year, the Association has provided its members and allies with a number of opportunities to learn of these innovative integrated care structures and practices. These opportunities have included: regular updates in the Friday Facts and Connections; plenary speakers, workshops, and pre-conference offerings at the Association's conferences; the development of a number of white papers (by Association staff and consultants) on a range of healthcare innovation practices and structures; and the formation of the Emerging Healthcare Integration Practices and Structures Study Group to examine a range of innovative healthcare integration approaches.

In the continuation of this theme, during the next year the Association will be highlighting such innovative integrated care practices and structures during its conferences and publications. The upcoming CMH Association Spring Conference will include such an opportunity: a pre-conference, on April 30, featuring leaders of innovative healthcare integration partnerships from a number of states.

So, Michigan's public mental health system continues to pursue innovation with courage, vision, and commitment to the health and well-being of some of Michigan's most resilient and vulnerable residents and the communities in which they live. ■

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Galloway *(continued from page 2)*

Sheehan reminds us that the rich tradition of innovation in Michigan's public mental health system has been stunning. This is particularly poignant when we recognize that the public systems came into existence to create a safety net for those without the means to acquire care, a recent development in the history of humankind. Public systems are exhibit "A" for a growing empathic response to others.

Manderscheid challenges us to incorporate community (health) into our model of well-being and illness with the staggering statistic that our current healthcare system, including primary and behavioral health, "only accounts for 10% to 20% of our health status. Fully 80% to 90% of our health status is due to what happens to us in our communities." How do we come together to accomplish that? Who needs to be at the table?

Pinter cites some of the signal events in the rapidly changing healthcare system as a preface to the very promising approach of self-directed care. This approach directs our attention to the individual consumer as the essential element of any service outcome. The implications of this approach are staggering; more to follow.

McLuckie has a way of polishing facets, some of which are often ignored, of what enables a person to shine. Calling upon his rich history within Michigan's community service system, he reminds us of three elements of a life of meaning and joy: relationships, the inner life, and a daily practice.

Burtch provides us a vignette into the face-to-face experience of one that does the polishing. Thrust into the whirlpool of the Flint Water Crisis, she shares her personal account of being one who is called to care. We catch a glimpse of the heart of the "system".

Arnold (Daniel) provides the voice that is often unheard; yet, it is this voice that informs us as to what we should be all about and whether or not it is for naught. It is from the heart of what matters. Thank you Dan!