CMHA Community Mental Health Association of Michigan

FALL 2018

Connections

for communities that care

LEADERSHIP LIES IN THE POWER OF CONVENING

Clint Galloway

John VanCamp

Leaning over the table for emphasis and to assure I heard, John said, "Leadership lies in the power of convening." This begged the question; what is the secret to that power of convening? Paraphrasing Jim Collins, author of *Good to Great*, John said, "Creating a compelling vision that others see as their own." Later, John made clear that the ensuing vision for Southwest Solutions (SWSOL) was a shared vision articulated by numerous individuals to give expression to their passion, not one he created by himself. The vision is *"to enhance the quality of life, success and self-sufficiency of individuals and families."*

That was the key; it all began to come together. The late lunch in one of John's favorite Mexican restaurants in Southwest Detroit was not only a treat, it was part of the "show and tell" whirlwind tour of a renaissance occurring in Southwest Detroit that was exhibit "A" of this shared passion. Commensurate with this style of leadership, John possesses some profound personal characteristics, three of which have become obvious to me: a sense of mission rooted in compassion, a vision constantly honed by a deepening appreciation for the complexity of life and what constitutes emotional well-being, and finally, humility. To again quote Jim Collins, commenting on the five levels of leadership: "The X factor of truly great leadership is humility – humility combined with a ferocious will for something bigger than yourself, humility in a very special way. I want to be very clear. These people are ambitious. They have tremendous energy. They are often exhausting. They never want to stop. They're utterly relentless. Okay, they have all that, but here's the difference. See, for a 5 versus a 4 – so, for a 4, all that energy and ambition and drive is about them. It's about what they get. It's about how they look. It's about what they make. It's about what accrues to them. It's about whether they are the center. That's a 4. [In] 5s, all that same level of energy and drive and ambition is channeled outward into a cause, into a company, into a culture, into a quest, into something that is bigger and more enduring than they are. Level 5s lead in a spirit of service, and they subsume themselves and sacrifice for that."[1] That's John, and that helps explain the renaissance occurring in Southwest Detroit.

Somewhat acquainted with John's legacy, I approached him about two years ago to write this story. After numerous unwarranted apologies by John, it dawned on me that to capture the essence of this story, I needed to go to Detroit and witness John's work. A few days later I was swallowed up in the morning rush hour traffic on interstate 96 all the way into Detroit, exiting just before the Ambassador Bridge. My presence was another example of John's engaging gift of bringing people to the table. John had meticulously planned a tightly packed eight hour schedule of "show and tell" during which I saw, heard, and even tasted what's happening in Detroit. It has forever changed my impressions of not only what is occurring in Detroit, but how the same transformative strategies can and are fostering a new generation of healthcare that includes not just people based strategies but also incorporates place based strategies. Enhancing the quality of life requires more than addressing what afflicts our bodies; it also demands attention to the place where we live. Touring the streets of Detroit I saw both the signs of decay that we often associate with what has afflicted many metropolitan areas as well as the impressive transformations occurring under the style of healthcare leadership practiced

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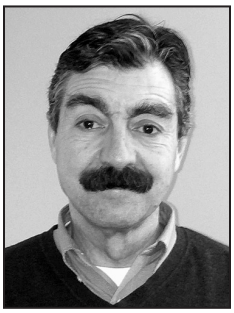
[1] https://www.jimcollins.com/media_topics/level-5-Leadership.html

Healthcare Transformation

Social Determinants and Adverse Childhood Events

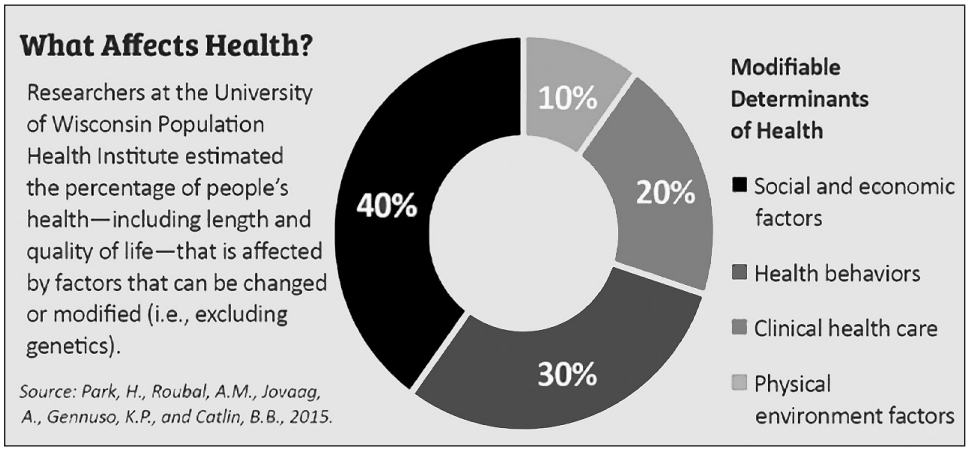
Robert Sheehan, CEO, Community Mental Health Association of Michigan



Robert Sheehan

This edition of Connections revolves around a number of themes, central among them the power and importance of social determinants to the health of all of us. While our system and Michigan's healthcare system is involved, in the main, in the provision of clinical and related services and supports, it is key that we recognize and take on the challenge related to the recognition that these social determinants – housing, employment, income/poverty, race, social connections, family functioning, environmental factors, among others – are more important to the health of individuals and the entire community than any of our clinical interventions.

As the chart here illustrates, only 20% of a person's health is impacted by clinical healthcare and related supports and services. So, while we must continue to provide high quality, accessible, person-centered, community based services and supports, (recognizing that Michigan's public mental health system is one of the most advanced and comprehensive and community-oriented in the country), we cannot stop there. To provide these services and supports while not addressing these social determinants, physical environmental factors and healthy behaviors (most of which are the result of the social determinants and environmental/family factors) is to ignore the causes of the mental and physical health needs that we are working to address.

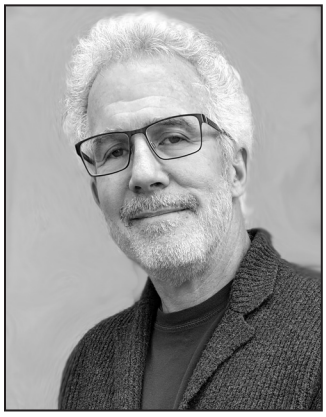


One of the starkest examples, and one that thankfully is highlighted by the popular press, is the impact of adverse childhood events (ACE) on the health of children, continuing as they mature into adulthood. ACEs include: physical abuse, sexual abuse, emotional abuse, physical neglect, intimate partner violence, substance misuse in the family, household mental illness, parental separation or divorce, and incarcerated household member. While the resilience of children is often sufficient to overcome the impact of one or two of these, since the initial study in the 1990s, research repeatedly finds that the impact of a number of incidents without intervention, seriously impacts both childhood and adulthood. The cumulative impact is dramatically negative in a number of the dimensions of that person's life. Without services and supports, the effects include: early and harmful drug use, higher rates of suicide attempts, higher rates of lifetime depression, higher rates of high-risk sexual behaviors, poorer fetal outcomes of babies born to high ACE mothers, poorer physical health, and poorer dental health.

There are two lessons to learn in the recognition of the impact of ACEs on the lives of children and adults. The first, and the one often taken up by health care providers, educators, and human services providers, is the need to identify children and adults with a high number of ACEs and to provide the trauma-informed interventions needed to overcome or mitigate the impact of these events. The second lesson – and one that is often ignored – is the need to work to prevent these events from happening to the children in our nation, our state, and our community. We cannot treat these conditions as simply being the normal course of life in the world as it is. We must recognize that these events are the result of actions that we, as a society, choose. We must work to prevent these events from happening through supports, services, and preventative measures in our families and in our communities. Only when we recognize the need for such pre-emptive action that address these social determinants will we be able to prevent the devastating harm that adverse childhood events have on our fellow community members.

On Community and Healing

James Madden, System Coordinator
Children and Youth Mental Health System, Ontario, Canada



James Madden

In the Spring 2018 issue of *Connections*, Ron Manderscheid called on us to incorporate the neglected dimension of *community* into our efforts to more effectively support, care for, and promote the healing of those of us who suffer with mental and emotional distress. In his article, Manderscheid reminded us that our understanding of mental health and wellness has undergone a corrective, has become enlarged and enriched in recent decades – *health* being defined by the World Health Organization (WHO) as more than the mere absence of disease, to include "a complete state of physical, mental, and social well-being."[1] Further to this, the WHO (2014) has defined *mental health* as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." In this article I want to dialogue with and expand upon some of the ideas Manderscheid introduced, particularly the notion that intervening at the level of community may be an impactful and fruitful way of promoting and supporting mental health. We will explore current understanding of how social and community context influence mental health and mental illness, and consider some particular examples of community-level mental health interventions. I will conclude by suggesting some principles and qualities that characterize effective community-level mental health practice.

Beyond Biomedical and Individualistic Models of Mental Health

Many readers will recognize in this call for inclusion of a community-level perspective, a shift away from exclusive reliance on a bio-medical model as the dominant paradigm for our understanding of health and illness. The bio-medical model has held sway in our approach to treating illness more generally for good reason; it has been and continues to be very effective and powerful – lifesaving – for individuals suffering from many bio-physical, "medical" conditions.

I would argue that the bio-medical model is not wrong, but rather incomplete and limited, especially as regards mental health. An indicator of the ongoing, outsized influence of the medical model on community mental health systems, is the extent to which we treat those suffering with mental and emotional distress as though the source of their suffering lie exclusively or predominantly in some genetically or biologically-based disorder or malfunction of their individual organism, or in some individual character weakness or moral failing leading to poor behavioral and lifestyle choices. Even when our therapeutic modalities are not specifically medical (e.g. prescribing psychotropic medicine), we predominantly rely on individual treatment behind closed doors (individual psychotherapy). We tend to pathologize those suffering mental and emotional distress, treating them as defective individuals that need to be fixed. To the extent that we employ approaches such as family systems therapy we have moved a degree away from an overly individualistic model toward understanding individual mental health and well-being as being embedded in a social context.

The Social Determinants of Mental Health

If bio-medical and individual psychotherapy models are insufficient, then what? As Mandersheid briefly alluded to, the idea that through the dimension of "community" may lie critical and effective mental health interventions, this fits with the social determinants of health (SDOH) model. The SDOH model took root within the disciplines of public health and population health and has arguably become the most important model guiding public health interventions over the last 10 to 15 years. The fundamental insight of the SDOH perspective is that social, economic, political, and cultural factors within which individuals are born, grow and develop have the greatest impact on health and well-being over the life course, far greater than "lifestyle" and individual health behaviors.[2]

Consistent with both bio-physical and SDOH perspectives, we know that a complex interacting *(Continued on Page 4)*

[1] To this definition I would add the spiritual dimension, in solidarity with the world's great religious traditions. The medicine wheel shared in common by many of North America's Indigenous communities, depicts the physical, emotional, intellectual, and spiritual dimensions of healthy life in balanced harmony.

[2] Having made that point, I think it is important to avoid casting the discussion in simplistic either/or terms. Of course individual agency matters, but individuals are always embedded in social contexts which profoundly shape, enable or constrain, the structure of opportunities, choices, and life chances.

web of causal factors – genetic, familial, community, and broader social forces – influence whether any individual will come to struggle with mental illness.[3] We know that at any given point in time, about 20% of the population in "westernized" societies suffers with a clinically significant mental health problem – i.e. a problem that interferes with reasonably normal functioning in terms of carrying on satisfying relationships with family and friends, the ability to find and maintain reasonably satisfying work, and participate meaningfully in community life. No doubt this statistic will have included at one time or another many people reading this article. All of us, regardless of socio-demographic, religious, or cultural background have a friend or family member who has struggled with mental health concerns. All of us struggle from time to time with what might be called ordinary emotional distress – anxiety and depression – just as a function of being human. Just by virtue of being human and living in a complex society undergoing rapid social, economic, and technological change wherein many are displaced, and the once secure basis of identity has become tenuous, most all of us are at risk for developing mental illness. In addition, a particularly provocative and robust finding from the SDOH literature indicates that the greater the degree of economic and social inequality in a society, the poorer the health outcomes for the entire society (all social strata), including those in higher income groups.[4]

All of us struggle from time to time with what might be called ordinary emotional distress–anxiety and depression–just as a function of being human.

The literature on SDOH typically enumerates lists of specific social determinants that vary somewhat depending on context. The U.S. Center for Disease Control, in a report entitled "Healthy People 2020," describes five SDOH domains:

- Economic Stability
- Education
- Health and Health Care
- Neighborhood and Built Environment
- Social and Community Context.[5]

Applying the SDOH model to mental health per se, the Canadian Mental Health Association (CMHA) specifies the following three social determinants as particularly important with respect to mental health: *freedom from discrimination and violence, social inclusion, and access to economic resources.*[6]

Trauma and Attachment

Embedded in these social determinants of mental health, are two factors that demand particular emphasis – *trauma and disordered attachment* relationships in early childhood. Over the last 20 years or so, tremendous advances in neurobiology – in our understanding of the way brain, body, and social relationships interact to produce mental health and well-being or mental distress and illness – have demonstrated how profoundly childhood physical and sexual abuse, and emotional neglect and abuse affect mental health. The emotional responses to adverse childhood and subsequent traumatic events become encoded in implicit memory, in the body and the brain. Individuals become susceptible to being re-traumatized (flooded with implicit memories and fight/flight/freeze responses) when triggered by events or situations in the present that in some way resemble the past traumatic event. The individual literally experiences this neurologically as though the past event or situation is happening again in the present. This is how a person suffering with PTSD experiences a traumatic flashback.

Those with insecure or disordered attachment unconsciously reproduce relationships in their adult lives that restage early childhood experience, leaving them feeling fearful, insecure, and unloved. In addition to these stressors, many face systemic factors including structural unemployment, with its attendant chronic economic insecurity, and racialized discrimination. The result is chronic activation of the fight/flight/freeze response which literally transmutes psychosocial stress into physical and mental illness. And as Gabor Maté demonstrates in his brilliant book, *In the Realm of Hungry Ghosts* (2010), virtually all addiction originates in early childhood trauma and abuse which over time neurologically predisposes the *(Continued on Page 8)*

[3] Research indicates that this is true even for mental illnesses that are usually understood to have a genetic basis such as schizophrenia and bi-polar disorder. For example, Barlow, et. al., in Abnormal Psychology: An Integrative Approach. Toronto: Nelson (2015), conclude that the only safe generalization that can be made with respect to genetic influences, is that "genes are responsible for making some individuals vulnerable to schizophrenia" and that moreover, that there is a "complex interaction between genetics and environment" (pp. 476-477).

[4] See for example, "The Inner Level: How More Equal Societies Reduce Stress, Restore Sanity and Improve Everyone's Wellbeing" by Richard Wilkinson and Kate Pickett (2018).

[5] https://www.cdc.gov/nchs/data/hpdata2020/HP2020MCR-C39-SDOH.pdf

[6] http://ontario.cmha.ca/documents/mental-health-promotion-in-ontario-a-call-to-action/

ACQUIRING CULTURAL COMPETENCY

Dr. Hakeem Lumumba, PhD, LMSW, LPC

Dr. Hakeem Lumumba

The purpose of this paper is to explore the concepts of what is cultural competence, how to become culturally competent, and why becoming culturally competent is imperative to the delivery of behavioral healthcare to clients. More importantly, this paper is designed to stimulate your intellect and your ability to apply sound reasoning.

I have had the privilege and pleasure of serving as a clinician and as an administrator in Behavioral Health since 1982. In doing so, I have encountered and interacted with various cultures. It has been my experience that we all share some similarities and some differences. However, each individual has his/her own uniqueness from a genetic perspective. One of the challenges that we face is establishing an appreciation for our differences without feeling too uncomfortable. How does one accomplish this task?

Recently, I read a West African Proverb that states, "To not know is bad; not to wish to know is worse." How many of us wish to know? How many of us are willing to admit that we are too afraid to know? How many of us are aware of what we do not know and that our perceptions have been formed by our environment? What is your definition of the following terms – a) indoctrination and b) education? Based on your definition of these terms, which one best describes your state of mind towards cultures other than your own?

What is Cultural Competence?

First, we must approach it from the following standpoints: historically, geographically, anthropologically, climatically, and scientifically. Historically, there have been many scholarly debates as to the origin of human beings. According to Louis Leaky and Mary Leaky, British Anthropologists, the original human beings came from the region known as Kenya, Africa. They came to their conclusion after extensive examinations of human fossils using sophisticated radiocarbon dating. According to the Leakys, there is only one race, the human race. From a geographical point of view, at one point of time the earth was one land mass known as the Pangaea (large land mass). Scholars have estimated that humans began to migrate to various parts of the world and their physical features changed due to the various climates.

Scientists have proven that individuals who reside in the warmer climates, tend to develop certain physical features such as dark skin complexion. On the other hand, an individual who resides in a colder climate tends to develop light skin complexion. The reason for the changes in our skin complexion is due to the body production and/or under production of melanin which is a natural defense mechanism to protect us from our indigenous climates. There are other physical features that are influenced by the indigenous climates, such as our hair texture, the shape of our lips and nostrils, height and weight, etc.

Of all our various physical features, it seems that mainstream society tends to focus on skin complexion as the marker to determine what is acceptable. For example, historically, in the United States, there has been significant focus on two groups of people, those who are of dark complexion (i.e., African Americans) and those who are of light complexion (i.e., European American). We have missed opportunities to expand our knowledge of humanity more specifically of our diverse cultures. I have often wondered what goes through the minds of individuals from other cultures when most of the mainstream's focus is on the relationship between African Americans and European Americans. Do they feel left out, ignored, or have they simply accepted this reality?

To become culturally competent, we need to challenge ourselves to go beyond skin complexion and give ourselves permission to explore other cultures. This is especially true in the field of behavioral health where our client population has become more diverse and unique. In addition, I would invite the readers to enhance their scholarship by reading about the Leakys and their work with identifying the original humans. Furthermore, study the effects that climates have on human beings' physical features and the role of melanin.

How to Become Culturally Competent

To become culturally competent, we must examine the formulation of our perceptions of people in general. For example, it is common for human beings to have certain biases whether it be towards race, religious beliefs, sexual orientations, or languages. How do we arrive at our perceptions that lead us to develop biases? Today, we are inundated with a plethora of information via the media. This information is

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available 24 hours per day, 365 days per year. Oftentimes, the information is delivered very quickly and with biases. We do not take time to analyze the information before formulating our opinions and perceptions, therefore, whether consciously or unconsciously, we develop our perceptions about certain people before getting to know them.

For example, how often have the media painted a grim picture about a certain culture to the point that it has influenced your perception about this culture? Most likely, you have already formed an opinion before interacting with this culture. As behavioral health providers, we are supposed to deliver quality, fair, and unbiased care to our consumers. However, because we are exposed to the media's perceptions of a certain culture, we do not deliver unbiased care. Often, we are assigning diagnoses to clients based on our perceptions of their culture rather than from a sound clinical evaluation. Quite frankly, I believe that we have become apathetic when it comes to filtering out the accuracy of information that has been disseminated. Part of the reason is due to the speed that information is conveyed. To become culturally competent is being able to form our own perceptions with minimal influence from the media and from other people.

To become culturally competent is to explore the impact of our significant influencer (e.g., parents, guardians, educators, entertainers, etc.) early in life. For example, depending upon who reared you, their influence shaped your perceptions and attitudes toward your culture and other cultures. It is conceivable that you grew up being afraid or having negative thoughts about certain cultures. The sad part about this is that your attitudes and negative thoughts were formulated before you had contact with these cultures.

By default, as we mature, we tend to interact with various cultures. Sometimes, we discover that we were misinformed by our significant influencers. In some cases we begin to change our perceptions and attitudes. However, there are other times when we maintain our negative attitudes toward other cultures because of our family traditions even after we have discovered that we were misinformed. Having the courage to rethink and challenge old ideas are crucial in becoming culturally competent.

One final thought; what are the main differences between cultural competence and political correctness? At face value, one could say that cultural competence is having accurate knowledge and perception about a culture, while political correctness is a conscientious effort to not offend anyone. With the latter comes a certain degree of anxiety due to being afraid of not offending anyone. However, if we allow ourselves to interact with other cultures, it will increase our comfort level to the point we are aware of what is offensive versus what is not. Our interactions would become less anxiety provoking and less uncomfortable. Perhaps you have noticed that we have evolved into a highly sensitized society where we can make a benign statement and be viciously attacked by our supervisor, peer, or perhaps by the media. I have often wondered why we have evolved into this level of intense scrutiny. There is a part of me that believes that it is designed to keep us from communicating with each other, especially interculturally. In other words, if we are too afraid of saying something that may be perceived as offensive and of being viciously penalized by default we will gradually refrain from interacting with other people or, if we do, make a conscious effort to "say the correct thing" even if we do not believe what we are saying. If my perceptions are correct, then we will remain in our cultural silos.

The Importance of Cultural Competence in Behavioral Health

In early 2000, I began to observe a cultural shift in the type of individuals seeking substance abuse disorder treatment and mental health treatment. At the time, I was employed as an administrator for a major healthcare system in an affluent area of Metropolitan Detroit. Up to this point, my experience had been that most individuals seeking the aforementioned treatments were of either European American descent and/or African American descent. However, there started to be a gradual influx of individuals seeking treatment of East India descent, Chaldean descent, Jewish descent, Spanish descent, and Asian descent. In addition, there was an influx of individuals with various sex orientation preferences and Islamic individuals. Finally, we began to see an increase in young adult, Suburban European American individuals who were opiate dependent.

As this was occurring, I began to ponder, "Are we prepared to serve this growing diverse population?" Starting with myself, I concluded that we were not prepared, primarily because of our "cultural encapsulation." This is a term that means cultural blindness. For me, it was somewhat surprising that the East Indian descent and Asian descent populations struggled with certain social issues such as substance abuse and mental illness. The reason being is because in all my academics, counseling courses, seminars, and trainings, there was never any mentioning of these populations suffering from substance abuse and mental illness. In addition, mainstream media had not focused on these population as having substance abuse and mental illness along with some of the activities that are related such as crime, domestic violence, and incest. As we began to admit and treat these various cultures, I began to decrease my cultural encapsulation by not only providing therapy but *(Continued on Page 16)*

Memories and Life Lessons – *Seeing the person behind the face*

Michael Geoghan, L.M.S.W., R.N., Executive Director (retired), Newaygo County Mental Health

Michael Geoghan

Following the announcement of his retirement as CEO of Newaygo Community Mental Health, Connections *asked Michael Geoghan if he would consider sharing some of his most memorable stories. He graciously complied. What it reveals is none other than a remarkable legacy of compassion. — Editor*

Learning to see the person behind the face was a process that started with my parents teaching me, among many things, the "Golden Rule," that is, treating others as you would like to be treated I learned through both words and example, not only in how they honored one another in their marriage, but in how they responded to those they served through their church, work, and friendships.

My first job in the healthcare field was working as an orderly in an extended care facility. My primary duties were to attend to the care of the male residents. My primary interests in pursuing that job were, in part, due to the reported hourly wage of $1.71 (which at the time was far better than what I was making as an assistant manager at a fast food restaurant); and in large part, a growing desire to help others. I must admit I really had no idea what I was getting into at the time.

Some of my first memories of this job were when I first walked into the care facility and smelled the lingering odors of urine and feces, heard the crying and moaning of bed ridden patients, and saw the harried looks on some of the care staff as they answered a patient's light. My initial orientation and training was to shadow the orderly on the first shift. My training was primarily "OTJ," being taught the duties by whomever I was assigned to. My first mentor, if you will, was a young male orderly who was also enrolled in the nursing program at a local hospital. It was during that time that I first became aware of and interested in becoming a nurse – a professional career that was predominantly staffed by women. After my enrollment into the Nursing Program, I met a young lady who was in the class ahead of me who would later become my wife. The work was hard, but as I got to know the folks I took care of, I began to see it less and less as a burden and more like an honor to care for them – if but for a few hours a day – to show kindness and respect in an environment that sometimes left them forgotten.

In getting to know the folks I cared for, and as I earned their trust, they shared snapshots of their lives. One gentleman for example, use to drive for Al Capone. Another was a former pool shark. Still another told me how it was growing up in the South as a black man and having to use a "colored" washroom, and to eat in the back room of restaurants as the white patrons dined in the main dining rooms. Many of my patient's faces would brighten in recalling past memories, and yet others would tear up when remembering loved ones that had passed but were not forgotten. During my time working in the nursing home, I became the "adopted grandson" by several as they got to know me, my family, and my girlfriends (and as they had to "approve" of the latter). Lasting friendships developed with some of the patients I cared for that carried over into my personal life. When a small number were able to return to their homes, they would invite me to visit them; but I also witnessed the first of many of their deaths – people I had cared for and cared about.

After acquiring my RN degree, on my first job as an RN charge nurse on an acute care unit in an extended care facility, I found out quickly that I was in over my head without enough medical/surgical or management experience to oversee other care staff such as LPNs and CNAs. Working as an RN on an acute care inpatient psychiatric unit, I had my first experiences working with persons struggling with acute behavioral health care illnesses such as schizophrenia, manic depression (i.e., bipolar disorder), major depression, multiple personality disorder (DID), borderline personality, etc. I decided to pursue an LMSW.

I also learned a lot working as a RN in correctional settings, in both a medium security prison, and a county jail. I was trained as a correctional officer at the Michigan Reformatory (MR) in Ionia, during which time I experienced a "lock down" in the middle of the night due to an attempted escape. While there, I learned about all the various weapons prisoners make while "doing time." I was trained how to defend myself were I to be confronted with a physically aggressive inmate, including use of take down and physical restraint techniques. I was exposed to a "culture of incarceration."

The majority of my correctional health care experience was in the county jail where I cared for men and women from all walks of life. I managed an ambulatory clinic in a 250 bed jail, working independently under the clinical oversight of physicians and using established clinical protocols. I recorded an average of 17 inmates *(Continued on Page 14)*

developing brain to impaired executive functioning and poor emotional self-regulation. Implicit, non-conscious memories of trauma, abuse, or profound neglect trigger the embodied brains of vulnerable individuals to send signals and release chemicals which result in compulsive, addictive behavior. Particularly under adverse circumstances, such vulnerable individuals can seem to find some measure of relief only through ingesting substances or engaging in neurochemical inducing behaviors (cutting, gambling, shopping, sex, video games) just to be able to live in their own skin.

Community Level Intervention

What is the relevance of all this for the work of public community mental health associations? The SDOH perspective reframes our understanding of the forces that generate increasing demand for mental health services in our communities, beyond individual psychopathology. It also begins to suggest *more impactful levels of intervention* beyond individual treatment of persons listed on a mental health agency's roster of clients. This is not to disparage the importance of individual treatment for any particular individual. Indeed, readily available, high quality, affordable mental health treatment is usually a necessary element in an individual's recovery of mental health, and may be considered one of the social determinants of mental health. Treatment may be necessary, but is not sufficient. The root and ongoing maintenance of good individual mental health is a health-supporting community context which invites the knowledge and use of community level interventions

Treatment may be necessary, but is not sufficient.

What is Community?

Before we begin exploring more concretely what effective community interventions look like, it is important to acknowledge there are different meanings of the notion of community, and by implication, different types of community-level mental health interventions. From a sociological point of view *community* may have distinct, multiple and/or overlapping meanings. Community may refer to, for example, a specific geographical place (a neighborhood or town), an interest group (the chamber of commerce or neighborhood association), an affinity group (a community theater association), a recreation association (local running club), an identity group (LGBTQ), a cultural/ethno group, or a religious community. We can talk about a *sense of community* – a feeling among people of belonging and being included based on shared identity, and common experiences. From a mental health promotion point of view, any activity that brings people together based on some sense of community, as a context in which to provide formal support and services, or promote informal peer support, may be considered a community-level intervention. In this sense, a community intervention may be based on both shared pain and struggle, as well as shared strengths. From an ecological point of view, we can envisage intervening anywhere along a continuum from small group, through informal association, formal organization, neighborhood, to the municipal level.

A community intervention may be based on both shared pain and struggle, as well as shared strengths.

Intervening at the community level is not a new idea (although its application to mental health specifically may be to some degree). There is a very rich, multidisciplinary, *community development* tradition, international in scope. One particular variant that is worth exploring in the context of community mental health is John McKnight's "asset-based" approach, which is very congruent with various strengths-based approaches to mental health. In a nutshell, McKnight advocates building community (and hence individual) resilience by weaving together and leveraging informal associations and formal organizations that already exist in a community in novel combinations (i.e.,creating partnerships), based on perceived needs and community-defined priorities, and harnessing and applying the collective expertise and energy of its members toward these community-defined goals.

An Example of a Municipal–level Community Intervention

Let me give an example of a municipal-level intervention along these lines, from London, Ontario, the community I have been living in for the past 32 years. London is a city with a population of almost 390,000, located about 60 miles due east of Port Huron. About 10 years ago, municipal community and social services staff were empowered by senior administrators to work with various community and social service providers, both public and private, to promote greater coordination of family and children's services. All community-level stakeholders serving social service needs

of families and children were invited to be part of a comprehensive process. The existing system was to be analyzed for gaps, unnecessary duplication, barriers, etc. Over time more than 170 organizations became involved from various sectors including child care, child welfare, public health, the school system, mental health, recreation, religious, public library, and informal associations. The result was the formation of the *London Child and Youth Network* (CYN).[7] A multi-pronged effort evolved over several years involving hundreds of people. Work conducted with and by community members, and supported by municipal staff, included an analysis of community strengths and risk factors, neighborhood by neighborhood, using various available data sources. By consensus, the community identified four priority areas:

- Ending Poverty
- Making Literacy a Way of Life
- Leading the Nation in Healthy Eating & Healthy Physical Activity
- Creating a Family-Centered Service System

Each area has multi-year work plans and evaluation frameworks with community-level indicators identified to monitor progress. (Go to the CYN website to learn more about this initiative, including performance measures and outcomes.) It is worth noting that there has been much research and many innovative practices developed for the purposes of guiding communities in effectively conducting these kinds of community-level interventions. Perhaps the most prominent example of this currently comes under the heading of *collective impact.* (An internet search of this term will turn up a great deal of applied research and practical tools.)

The CYN's *Family-Centered Service System* priority deserves special attention. A number of at-risk neighborhoods were identified though analysis of census, municipal planning, and school-system data. Substantial resources were made available to begin creating a network of multi-service, Family Centers, physically integrated within existing or newly built publicly-funded elementary schools. The particular configuration of services offered and partners engaged at any given Family Center depended on the particular needs of the community, but typically included child care, mental health, and public health services. Initially four *Family Centers* were created. Three more came on line within the last year, and one more is slated to open very soon.

These Family Centers create a new, *non-stigmatizing* institutional setting or context in which mental health promoting synergies may be generated through creative partnerships and authentic engagement of community members. As an excellent example of this, the children's mental health agency I work for –*Vanier Children's Services* – has recently begun offering infant/parent mental health clinics at each of the seven Family Centers on a rotating basis. These early identification, early intervention clinics are staffed by just one highly skilled Child and Family Therapist, a member of Vanier's Early Years team who is trained in "Circle of Security," an evidence-based infant/parent attachment intervention model. The neurobiology research over the past few years has demonstrated irrefutably how an infant born into an environment of "toxic stress" is at very high risk of developing mental illness.[8] In partnership with day care and other child and family support staff, community members who exhibit symptoms of toxic stress and poor infant/parent attachment are referred to the Child and Family Therapist for counselling and support. The clinician also offers consultation, support and guidance to other Family Center staff members, so that they may recognize and respond appropriately when signs of toxic stress and poor attachment are evident.

There are many different levels and intersecting opportunities for community mental health interventions.

In Bronfenbrenner's framework (page 16), the creation of Child and Youth Network would be an example of intervening at the exosystem level.[9] The creation of a network of Family Centers as part of the CYN initiative would be an example of an intervention at the intersection of the meso- and exosystem level. The locating of the infant/parent mental health clinics on site would be an example of an intervention *within an intervention*, at the intersection of the meso-and microsystem level. These examples illustrate that there are many different levels and intersecting opportunities for community mental health interventions.

(Continued on Page 10)

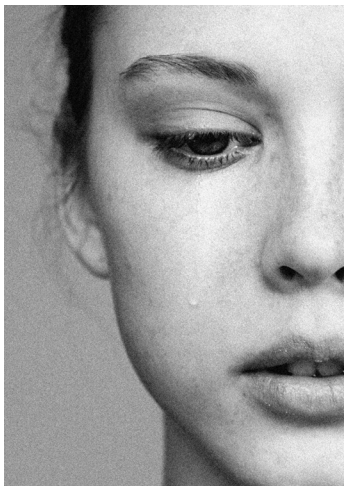
[7]http://londoncyn.ca/

[8]Clinton, J., Feller, A., & Williams, R. (2016). "The Importance of Infant Mental Health." Paediatrics & Child Health, 21(5), 239–241.

[9]One would expect that the macrosystem in Canada is more amenable to the marshalling and application of public funds for interventions such as this, as compared to most places in the U.S. at this moment in time.

My Sister's Place: Healing a Marginalized Community

A second example of a community-level intervention I would like to describe is also based in London, Ontario. *My Sister's Place* (MSP) is a transitional support program for women who experience mental illness, substance misuse, and chronic poverty. This is arguably the most marginalized and stigmatized population in London. Many of the women who visit MSP engage in street-level survival sex work. Many are Indigenous women. MSP started out as an initiative by a few feminist community activists who saw a need and acted, including members of the Sisters of St. Joseph, and women with lived experience. While MSP is now incorporated as a program within Middlesex branch of the Canadian Mental Health Association (CMHA), which is the publicly-funded, adult community mental health agency in the London area, it got started when one paid community mental health worker reached out to the Sisters and a handful of women's advocates, and began reflecting on the problem and imagining what might done.[10] This led to a series of participatory, action-research projects which gave central voice to the women of lived experience these activists wanted to serve. Over time, a program of formal and informal supports and services was built up, with many community partners. The program was initially housed within one of the properties owned by the Sisters, and eventually moved to a rented old house in the core of the city. Initially, there was only one position, and then eventually a few workers' positions funded. Much of the work is done through partnerships.



On the strength of the leadership and charisma of the program director, the strength of community partnerships, the quality of engagement with the women, and the impact of the program on participants, MSP began to gain greater and greater notice in the community. Full disclosure: Susan Macphail, the founding Director of MSP (until she retired this past July) happens to be my spouse. I had the privilege of watching this program evolve in fits and starts over the course of about 15 years. Susan is particularly gifted at engaging authentically with people and speaking and acting from deeply held principles and values. I have observed her speak extemporaneously about MSP, sometimes alone but most often with the women who form community there, to groups large and small, religious and secular, charitable and business organizations. A turning point came when the matriarch of a local entrepreneurial family heard Susan speak, was deeply moved, and decided to fund the purchase and renovation of a beautiful Victorian-era mansion near the city's core to become the home of MSP. As it stands now, about one-third of MSP staff salaries are supported by the publicly-funded CMHA, one-third are supported by other community funders including the United Way and the City of London, and one-third through fund-raising. Virtually all program and infrastructure costs are supported by community fund-raising. CMHA also runs a program for men who experience mental illness and chronic poverty, based on the same principles and values which I will discuss further below. The community of London has stepped up (with the aid of very intentional and skilled community relations work) to support this initiative through millions of dollars in donations and hundreds of thousands of hours of volunteer power.

Many of the women who have come to MSP have been supported in transforming their lives from conditions of chronic poverty, addiction, and incarceration to find stable housing and employment. Some have gone from chronic homelessness to earn university degrees and find meaningful work helping others based on their own lived experience. Many others continue to struggle, but have a safe place and sense of community. The emphasis is on peer support and "sisterhood." In addition to clinical supports, programs include a theater group, a music group, and a social enterprise in which women make exquisite jewelry, a portion of the proceeds go to the women and a portion to program support. The principle is to support people by creating a safe, radically inclusive space, accepting people where they are, in their pain or brokenness, while also recognizing, emphasizing, and building on their strengths, skills, and abilities. Another way of putting this is that, at MSP women are healed through community.

The principle is to support people by creating a safe, radically inclusive space…

[10]For an excellent and inspiring guide (based on a complexity theory perspective) to what is possible when a few committed people pour sustained and creative energy into a project like MSP, see Getting to Maybe (2007) by Westley, Zimmerman, & Patton.

What is a Healing Community?

I want to pause for a moment and reflect on that last idea – to be "healed through community." As many others writing on health and healing have observed, the etymological root of the word health is akin to whole. So at an individual level, to be healthy is to have various facets of our human being, – physical, mental, emotional, and spiritual, become conscious, integrated and congruent. From psychodynamic (depth psychology) and mindfulness points of view, we know that we must have self-compassion and self-acceptance of our imperfections, lest we repress and project our fears and insecurities about what we might become on others, and consequently rejecting and lashing out at the "other" – the mentally ill, the homeless, the addict, the refugee, etc. If an individual's mental health is shaped, enabled, or constrained by the community, then for healing to happen, the community must strive to be whole, that is, inclusive of various facets of its social being. A community that is unduly exclusive or too homogenous is not a potential context for healing. An unduly inward looking community that demands rigid conformity and the squelching of individual uniqueness and aspiration is not a healing context. I know of no more insightful accounting of this essential dialectal tension between individual and community than a little book by Jean Vanier, the founder of *l'Arche* – the network of international communities for people with intellectual disabilities – entitled *Becoming Human* (1998). Vanier writes,

> "It is not easy to strike a balance between closedness, having a clear identity that fosters growth in certain values and spirituality, and openness to those who do not live with the same values… being too open can dilute quality of life and stunt growth to maturity and wisdom; being too closed can stifle. It requires the wisdom, maturity, and inner freedom of community members to help the community find the harmony that not only preserves and deepens life and a real sense of belonging but also gives and receives life. Then the community truly becomes an environment for becoming human, helping all to openness, freedom and commitment to the common good (p. 65)."

Principles of Community-Level Mental Health Intervention

Working from the premise that healing in community can happen in many ways at many levels, let me try to pull together the various threads of this discussion by reflecting more broadly and attempting to formulate some general principles for community-level mental health work.

Effective community mental health interventions may not follow any particular formula or model, but they are always *highly intentional*, by which I mean developed collaboratively with a broad array of community partners, based on critical reflection, informed by research, including participatory research and evidence which includes the lived experience of those who would be served, and ongoing developmental evaluation.[11]

The healing community is radically inclusive and welcoming. The community is welcomed and present in its diversity. Individuals are welcomed in their strength and in their woundedness. For example at My Sister's Place, no one is banned or exiled from the community. This is unusual, as many agencies that provide services to people experiencing chronic mental illness and poverty routinely ban persistently aggressive or difficult to serve community members. In order for this principle to be operationalized, staff members must be temperamentally suited, well supervised and supported, and well trained in principles of trauma and violence informed care.

The healing community is radically inclusive and welcoming.

The community is welcomed and present in its diversity.

Individuals are welcomed in their strength and in their woundedness.

Relatedly, in a healing community members are actively engaged to envision together and articulate the values they want to see embodied. At My Sister's Place safety is a shared value. So many marginalized community members have suffered trauma and abuse so that they feel profoundly unsafe and are easily triggered, which sometimes activates violent behavior in self-defense. Community members help each other to remember and abide by this value of safety, with the support of skilled staff members. In the event of an aggressive or threatening incident, the triggered community member may be required to "step away" for a period of time, but he or she is supported in reconciling with and reintegrating into the community as soon as possible.

The healing community reflects the diversity of the community, including people of different ages and stages of life, different professions, ethnicities, religious beliefs, sexual orientations, etc. In the healing *(Continued on Page 12)*

[11]Patton, M. Q. (2011). Developmental evaluation: Applying complexity concepts to enhance innovation and use. New York, NY, US: Guilford Press.

On Community and Healing *(From Page 11)*

community people interact in a variety of life domains. There may be clinical supports and services, but also employment and educational support, recreation and artistic opportunities, community celebrations, etc. The emphasis is on building on strengths, and generating opportunities for growth and development.

Finally, it is also important to note in this age of social media, that although social media may be a powerful tool for facilitating community connections and supporting mental health, a genuine healing community of necessity involves actual face-to-face, human interaction and contact. In my view, there are essential qualities of human community and relationship that cannot be fully mediated through smart phones.

Conclusion

Toward the beginning of this piece I suggested that our traditional medical-model influenced, individualistic mental health treatment approaches were not so much wrong as incomplete and insufficient. I argued for an understanding informed by the social determinants of health and social ecological models, and interventions informed by community development approaches. It seems to me that as erstwhile healers, when we see individuals exclusively or primarily through the lens of psychopathology, we may see in them what we're afraid of or reject in ourselves. We risk rejecting part of what makes them up as whole human beings, and treating them as other or alien. To avoid this as community mental health workers, self-awareness and self-acceptance is required. Healing in community then, is a matter of emphasis and balance. In a healing community, the emphasis is on care more than cure, mutual support more than expert service. Instead of emphasizing the identity of patient or client, community mental health workers, administrators and policy makers working through the dimensions of community-level interventions emphasize and privilege the identity of neighbor and community member, and in doing so dignify and amplify their efforts.

(For those who want to dig deeper, continue reading)

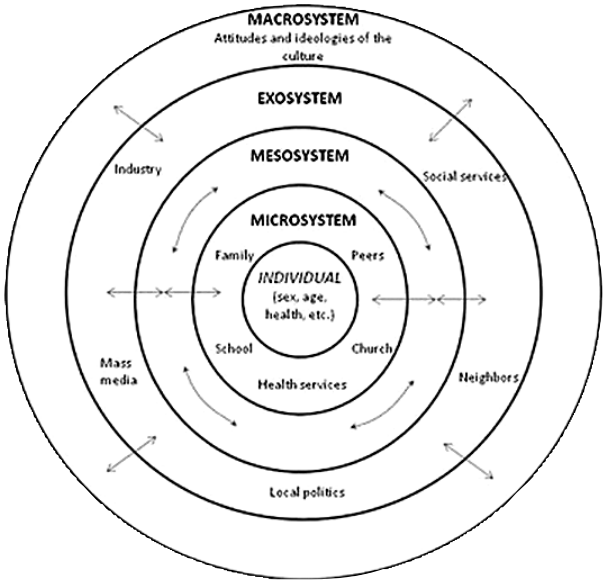
A Social Ecological Framework for Conceptualizing Community Level Intervention

Addendum to "On Community and Healing"

By James Madden

A very useful framework for exploring possible levels of intervention beyond the individual is Bronfenbrenner's ecological theory, which he originally articulated in 1977. Many readers will be familiar with this model.

Bronfenbrenner continued to develop and apply his model until his death in 2005, to understand how the multilayered and interacting web of social and biological processes affects mental health.[12] The image presented here is a basic depiction of a very complex model. It is presented here primarily as a conceptual tool that may be helpful in understanding how individuals are embedded in sets of interacting "microsystems" which bear on their mental health. (In any particular community, there may be a multitude or paucity of mental health promoting microsystems.) Formal and informal interactions and linkages between microsystems constitute a "mesosystem." From a complexity theory perspective, a mesosystem would be seen as an emergent phenomenon of interacting microsystems. Mesosystems and microsystems are in turn shaped, enabled, and/or constrained by the encompassing exosystem and macrosystem. Individuals are shaped by and shape microsystems, and through organized effort, can shape exo-and macrosystems. One can use this framework to analyze the social ecology of particular places, particular communities. To what extent does the social ecology of a particular community promote or inhibit resilience and mental health? When we see more clearly the dynamic social embeddedness of individuals, perhaps we can imagine more vividly and creatively community-level modes of mental health promoting and protecting interventions.



[12] For a current review of this model see "Different Uses of Bronfenbrenner's Ecological Theory in Mental Health Research: What is Their Value for Guiding Mental Health Policy and Practice." Eriksson, M., Ghazinour, M. & Hammarström, A. "Soc Theory Health" (2018). https://doi.org/10.1057/s41285-018-0065-6. See also "Introduction to Special Issue on Social Ecological Approaches to Community Health Research and Action." Lounsbury, D.W. & Mitchell, S.G. Am J Community Psychol (2009) 44: 213. https://doi.org/10.1007/s10464-009-9266-4.

Hindsight Is 20/20: Our Current Health Crisis

Dan Buettner

Fellow, National Geographic
Founder, Blue Zones

In the Blue Zones project cities, we've seen double-digit drops in smoking rates and obesity rates, millions of dollars in health-care savings, and a drastic rise in levels of community engagement and well-being.

For 30 years, my life's work has been identifying and then studying extraordinary populations around the world and unlocking their secrets to longevity and happiness.

Several longevity hot spots surfaced through my expeditions—the Barbagia region of Sardinia, Italy; Ikaria, Greece; Okinawa, Japan; the Nicoya Peninsula in Costa Rica; and Loma Linda, California. People in these "Blue Zones" regions not just live longer, but they live better. Besides having a large number of centenarians, people in these areas remain active into their 80s and 90s and do not suffer from the chronic diseases common in most parts of the industrialized world. Armed with a team of demographers and scientists and a grant from the National Institute on Aging, we set out to reverse-engineer longevity, or establish why these populations live the healthiest and longest lives in the world.

Several common denominators, or longevity lessons, were distilled into the "Power 9:"

Move naturally throughout the day

Have and cultivate a strong sense of **purpose**

Downshift every day to relieve stress

80% Rule: stop eating when you are 80 percent full

Plant Slant: Make beans, whole grains, veggies, and fruit the center of your diet

Wine @ 5: Enjoy wine and alcohol moderately with friends and/or food

Belong: Be part of a faith-based community or organization

Love Ones First: Have close friends and strong family connections

Right Tribe: Cultivate close friends and strong social networks

At the beginning of this exploration, we were interested in figuring out if DNA had anything to do with the exceptional health and longevity in these regions. What we learned was that it's not DNA and it's not geography. As the Western-influenced lifestyle and diet come in, these "Blue Zones" regions are dying out. The reason most of these places had such incredible health outcomes was partially because they were isolated, geographically, from the rest of the world. It took a while for fast food, processed food, and large quantities of meat to infiltrate their diets. But as we see in Okinawa, Japan, the newer generation has a more modern lifestyle and eat a more Western-pattern diet. And now they are starting to have the health problems of the Western world. Their geographic location hasn't changed—their lifestyle has.

It's a mistake and misunderstanding of research to think that you can go to a Blue Zones region and find a special anti-aging ingredient there to mix into your smoothie or rub onto your face. That's not at all how it works. You only have to look at the Blue Zones region of Loma Linda, CA to understand that the Blue Zones are not geographic locations. Loma Linda, CA, a town about 60 miles away from Los Angeles, is surrounded on all sides by unremarkable California suburban towns. But Loma Linda residents live about a decade longer than other Americans, with much lower rates of chronic diseases and afflictions like dementia. Seventh Day Adventists in Loma Linda have largely protected their lifestyle. The cafeteria at Loma Linda University is vegetarian, residents fought the introduction of fast food chains to the town, they remain actively involved in their faith and church community, and they are physically active into their 80s and 90s.

In the Blue Zones project cities, we've seen double-digit drops in smoking rates and obesity rates, millions of dollars in health-care savings, and drastic rise in levels of community engagement and well-being.

(Continued on Page 15)

Memories and Life Lessons *(From Page 7)*

per day. I assessed and treated (within established physician protocol) both physical and behavioral healthcare needs, including acute appendicitis, delirium tremors (DTs), prenatal care, hypertensive crisis, heart disease, diabetes, tonsillitis, body lice, scabies, liver disease, STDs, psychotic and depressive disorders, anxiety disorders, and other conditions. I counseled and provided health education to both inmates and deputies. An enduring lesson was becoming able to see each inmate as a person, many of whom were in jail from living in a generational culture of criminal activity, living in poverty, little to no education, unemployed and /or underemployed, or making poor choices.

Some of these indelible memories have a lighter side. As a civilian deputy, I was invited to observe, and in some cases, participate in law enforcement activities. One such activity was when I volunteered to participate in an undercover sting operation which took place around Halloween. I dressed up as a werewolf and was planted at a party where the land owner had been alleged to be selling alcohol to minors. My assignment was simply to infiltrate and observe until such time that the deputies would converge on the scene and bust the party.

At the time, there were only a limited number of command officers who knew that I was participating. When the deputies converged on the scene and started to gather all of the partiers, I of course was one of them, and in playing the part, I was less than cooperative and ended up being ordered to "assume the position" against a squad car, where I was patted down, handcuffed, and placed in the back of the squad car. Later, the arresting officer was informed by his command officer who it was he had just arrested, at which time he drove me to the outside perimeter of the area while profusely apologizing to me for having treated me as such. I assured him that he was just doing his job and reminded him that I was not cooperating and therefore, "got what I asked for."

However, this particular story did not end at that point. Simultaneous to the sting operation, the local law enforcement was conducting driver "stop and checks" for intoxicated drivers. Shortly after my "release from custody," and while driving with the undersheriff back to the station, we received a call for assistance in transporting to jail an intoxicated driver that had been detained by another deputy. So, with me still made up in my werewolf makeup and attire, I sat in the front seat of the command car and the drunk driver was placed in the back seat. While en-route back to the station, the Undersheriff and I were engaged in a conversation. The drunk driver, seeing my side profile, asked, "What kind of police force are you?" I simply turned to face him and said, "Canine Squad," and turned back around for the remainder of the ride. Upon our return to the station, while I was changing clothes and cleaning up, a booking officer came into the command officer's office and said to both the command officer and myself, "You have to hear this!" So, we went to the intercom outside of the booking office and listened in on the conversation the man we brought in was having with another booking officer. "I tell you, officer, that dog was talking!" We all had a laugh and I couldn't help but wonder what that man would say when he was arraigned before the judge.

Another time, while seeing inmates during a scheduled med clinic, a young man new to the jail asked me a question while waiting to be seen in the clinic waiting room. "Doc," (I received the nick name "Doctor Death" as a joke from the deputies) said the young inmate, "I heard you did time, is that true?" I paused before answering him and then said "Yes." The young man then asked, "For what?" I looked at him and said, "For impersonating a nurse," and walked into the exam room. The young man responded "Really? How big of a "bit" (i.e., sentence) did you do?" To which the older inmates started laughing and teasing the young man as they knew I was telling a tale.

I have many more stories that I could share, as I am sure each of you have as well. Each of my experiences came with a lesson in human behavior. Yes, unfortunately I often saw people at their worst, both the inmates and deputies, but I also saw moments of compassion and caring amidst this brokenness; and in those times, I found meaning and purpose in not only what others do, but in my role as a health care professional. I was able to see the person behind the behavior and to remember, "There but for the grace of God go I." As it was and is indeed by His grace that I can do what He has called me to do. Not by my strength or goodness, rather by His and His alone.

Carl Rogers once said, "True empathy is always free of any evaluative or diagnostic quality. This comes across to the recipient with some surprise. If I am not being judged, perhaps I am not so evil or abnormal as I have thought."

A longtime friend and spiritual mentor once told me "We are but turtles on a fence post," to which he added, "How does a turtle get on a fence post? It has to be placed on that fence post." Thus I believe we are called, and through faith and trust in the one who calls us, we can see the real face of our fellow man in times of triumph, but especially in times of failure.

Hindsight *(From Page 13)*

It isn't enough to simply try and adopt the Power 9 lessons individually. Our environment dictates so much of our habits and our health, and we've set up most of our communities in the United States to accommodate our sedentary lifestyles—sitting in our cars and on our couches—and to fill up on processed, high-calorie foods.

Stemming from extensive research, the Blue Zones Project came to life—an initiative that works with communities to introduce high-impact changes to make the healthier choice the easier choice. Based on the Power 9 longevity principles, permanent and semi-permanent changes are created aimed at affecting entire communities and future generations.

The results have been stunning. Albert Lea, MN was the first Blue Zones Project city, and in just a year, residents added 2.9 years to their lives and city healthcare claims dropped by 29 percent. In other Blue Zones Project cities, which we administer with a partnership with Sharecare, we've seen double-digit drops in smoking rates and obesity rates, millions of dollars in health-care savings, and drastic rise in levels of community engagement and well-being.

Even as Silicon Valley and researchers spend billions trying to find the magic bullet to living longer and better, the best way to improve health and longevity are low-tech. We won't find the answer to our current health crisis in a test tube or a line of code. Instead, we need to go backward to move forward. We need to eat and live as our great-grandparents did.

This article first appeared in the 2018 Milken Institute **Power of Ideas** blog. It is reprinted here with the permission of the Milken Institute.

http://powerofideas.milkeninstitute.org/global-conference/2018/hindsight-is-2020-our-current-health-crisis

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To learn more about Blue Zones which was founded by Dan Buettner, see:

https://www.bluezones.com/

https://www.bluezones.com/2018/08/secret-to-longer-life-is-low-tech/

Respond to the Surgeon General's Call to Action on community, health and prosperity

BEHAVIORAL HEALTHCARE EXECUTIVE, 10.19.18

By Ron Manderscheid, PhD, Executive Director
NACBHDD and NARMH

I am absolutely delighted to report that U.S. Surgeon General Jerome Adams, MD, MPH, is in the early phases of preparing a new *Surgeon General's Call to Action*. This effort will focus on how we can improve community health, wellbeing, safety and prosperity. Now, we have an opportunity to provide input on this endeavor.

Why is this report so important? We have known for quite some time that most issues with health, wellbeing, safety and prosperity have their origins in how our communities function. In healthcare, we call these community factors the "social and physical determinants of health", and we appreciate the exceptionally important role they play in physical and mental health and well-being.

Read more:

https://www.behavioral.net/blogs/ron-manderscheid/policy/surgeon-general-s-call-action-community-health-and-prosperity

by learning more about their cultural backgrounds as well as their culture's perceptions of substance abuse and mental illness. In addition, I began to learn how to greet clients in their indigenousness languages. I noticed an immediate impact in my ability to engage them and the high level of respect that developed between me and my clients. I began to examine the cultural makeup of my staff. It became apparent that the cultural makeup of the staff did not match our diverse client population. Consequently, there was a conscientious effort to increase our staff's diversity and as a result, we gradually became the provider of choice for various cultures. In addition, we noticed that our clients' retention and satisfaction rates increased.

This brings me to a crucial point; what are the main criteria used by Behavioral Health Key Decision Makers to hire their staff? Typically, most employers post a job description that provides a general overview of the position. As a result, there are several applicants. Afterwards, the recruitment process commences. So the question is raised again, what are the hiring criteria? Do some Key Decision Makers have a hidden agenda, and if so, for what purpose?

Recently, I developed a model to enhance cultural competence in the behavioral health workforce by examining the following:

a) Talent/Skills Natural Set.

b) Cultural Uniqueness (Race, Religious Belief, Dress Attire, Name, etc.).

c) Appreciation of Uniqueness.

d) Qualifications (Academic & Credentials).

e) Opportunity to be hired, grow, and produce.

With this model, key decision makers are implored to base their decision to hire someone on other than their academic qualifications and credentials. There are some very talented applicants who are automatically dismissed as potential hires based on their names, dress attire, or because of their accent. Recruiters have access to this information via telephonic interviews, skype interviews, as well as other methods. The sad part about these biases is that they hinder the company's growth because they miss out on hiring these talented individuals. Some of these applicants could be difference makers. I am challenging key decision makers to reassess your hiring and recruiting agendas and protocols. Rather than basing the hiring decision on qualifications, you should ask what's missing at our agency that could help us with our delivery of care, increase our efficiency, increase our proficiency, and increase and improve our cultural competence. In addition, once a decision is made to hire these difference makers, there must be a mutual acculturation to retain these individuals. In other words, rather than expecting the new hire to adapt to the work culture, the culture must also adapt to the new hire culture.

One final thought, many of you are probably familiar with Motivational Interviewing (MI). With MI, come stages of change. Starting with Pre-Contemplation (unaware of the need to change), Contemplation (contemplating changes), Planning (strategy to change), Action (producing the change), and Maintenance (maintaining and improving on the change). I encourage you to assess your level of cultural competence by using the MI Stages of Change. I suspect that many of you are in the Pre-Contemplation Stage of Change and it could possibly be due to your social conditionings. As healthcare professionals, we challenge our clients to change some of their thinking and behaviors; however, we do not challenge ourselves. Whether it is conscious or unconscious, we tend to engage in clinical hypocrisy.

Conclusion

The purpose of writing this was to stimulate, challenge, inspire, and promote critical thinking among behavioral health professionals and key decision makers regarding your ability to deliver optimal care to our culturally diverse clients. I wanted to provide a catalyst for self-growth, self-improvement, self-care, and self-esteem. Finally, I am very receptive to engaging in healthy and stimulating dialogues with readers who are interested in furthering their knowledge in this important subject matter.

Visit Dr. Lumumba's website at: counselingenterprise.com

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by Southwest Solutions. These transformations are an integral part of the health and wellness of the residents.

It is becoming apparent, like all great sagas, this story will have many chapters. Perceived from a historical and cultural perspective it is just beginning. Its central theme is about yet another incredible transformation that is reshaping our institutions that are essential for healthcare as we appreciate more fully what it means to be healthy. A more inclusive and therefore complete term may be "emotional well-being." When this becomes our focus, being healthy is not just about our bodies, as important as that is, it is also about the places where we live and work, having affordable housing in a safe and secure environment with access to essentials as well as a meaningful job and sufficient income. What needs to happen to diminish human suffering and enhance our emotional well-being must include the strategies that address the various dimensions of poverty in order to nurture a healing community. An understanding of this social dimension helps clarify and guide the transitioning of community mental health via the inclusion of a focus on the mental health of a community. If I live in a distressed neighborhood, my wellness requires more than treating the symptoms of a physical or psychological diagnosis. In fact, the former may well be a significant factor in the latter. Community development is equally essential for health. In this story, Southwest Detroit is ground zero but the mission, values, and strategies are applicable in any community.

Community Innovation

Before we venture further into the story of SWSOL, let me share some background John provided that has helped me understand community interventions thereby providing a framework for the transformation I witnessed. The winter 2004 issue of the *Stanford Social Innovation Review* (SSIR) included an article entitled, "Leading Boldly" that distinguished between technical and adaptive social problems. Technical problems are well defined and the solution is known in advance by a limited number of organizations. Applying their expertise, the resolution is described as isolated impact. An example of this is the development of a robust system of information technology that provides data to guide decision making. It could similarly apply to the construction or remodeling of a physical structure that houses these services. We can contract with competing organizations that have these skills to accomplish our tasks. In contrast to this, the answers to adaptive problems are unknown and no individual entity has the resources or authority to bring about the necessary changes. *Improving community health is an adaptive problem*. In order to reach an effective solution, it requires learning by all the stakeholders involved in the problem as well as changes in behavior to create a solution. We need to adapt! The results of this collaborative work are captured in the concept of collective impact. Southwest Solutions is aptly named as a response to an adaptive problem. The power of convening is recognition of the need for a collective impact. (To understand this more fully, see the companion article by James Madden, "On Community and Healing.")

The Evolution of Community Mental Health – the Need to Address the Mental Health of a Community

John provided some history, "In some ways you have to go back to the mid-sixties when President Kennedy started the conceptualization of community mental health." Within that frame you can understand the beginnings of Southwest Solutions that was founded in 1970 by Monsignor Clement Kern (1907-1983), the legendary pastor of Most Holy Trinity in southwest Detroit. Kern was known as the "conscience of Detroit" because of his passionate commitment to helping the poor and disenfranchised. The church was located near downtown Detroit and was attended by bankers, judges, elected officials, and business people. Kern made sure that those who were homeless or had a mental illness or drug addiction were also included. He not only developed a community within the church, he also worked in the larger community. Clem Kern's deep passion still animates the organization. The mission and values instilled at the start still compose who and why they are, it defines and assures their continued existence. What has changed is a growing appreciation for the complexities that *enhance the quality of life, success and self-sufficiency of individuals and families* and as this understanding has evolved, so has the shape and form of the solutions that pursue this vision.

SWSOL became a mental health agency in 1972. In the wake of deinstitutionalization, Southwest's mission was to help the mentally ill live in the community by providing psychiatric counseling and medication. John has been with Southwest Solutions since its beginning, when the agency had a staff of only ten people. He started as an administrative assistant and became head of the organization in 1981. To comprehend the evolution of SWSOL we need to appreciate that John was a pioneer in understanding the efficacy of community development when this critical dimension of mental health was only beginning to be recognized. As such, he advocated for expanding the vision. In addition to the traditional array of counseling solutions he believed that reintegrating the mentally ill and homeless into the community required providing decent, affordable housing and support services. It became imperative for the organization to actively participate in neighborhood revitalization and economic development. What began as a compassionate response to the needs of those with mental illness, utilizing the knowledge and understanding dominant in the 60s and 70s, soon grew into a multi-dimensional cluster of solutions designed to address the emergent knowledge of the various dimensions of emotional well-being. One way to frame this journey is the struggle to find a balance between people based strategies and place based strategies, a struggle that is enjoined by every community mental health agency that progresses. A head turner for

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those still immersed in a bio-medical model is how a response initially focused on placing individuals housed in mental hospitals into the community has now adopted the long-term evaluative measure of making a significant contribution to reducing poverty. However, this is exactly what has happened as SWSOL pursued their mission that embraced the wedded values of diversity, equity and inclusion. They discovered that people who participate in multiple services which constitute communities of shared interests improve their lives faster. As more people achieve these connections, momentum builds and contributes to population health. By maintaining a focus on what is essential for quality of life; community mental health has been evolving by addressing the mental health of a community. It is important to understand that many of the additional skills and activities that address the mental health of a community may be best acquired by partnering; this is an adaptive problem that requires the concerted efforts of multiple stakeholders.

A PEEK AT THE COMPLEXITY

Today, Southwest Solutions is a family of nonprofit and for-profit corporations that offers more than 50 vital and community-building programs and employs more than 350 staff. It is a foremost provider of human and housing services and real estate development. Its programs impact 12,000 people a year and are nationally known and recognized for achieving outstanding results in improving lives and strengthening communities. The extraordinary growth of Southwest Solutions and its national renown as an effective integrated-services and community-building organization stem from John's vision and knowledge linked to a style of leadership that enabled it to happen: *the power of convening*. In sorting out and addressing the various dimensions of emotional well-being, John has successfully convened, not only those in need of services, but also previously "siloed" experts, aligning their knowledge and resources. Their ongoing collective impact is impressive. As such, the corporate structures have mirrored the developing knowledge. Today there are three divisions: Southwest Counseling Solutions, Southwest Housing Solutions, and Southwest Economic Solutions.

A few moments of self-reflection may well be sufficient to appreciate the complexity of the organizational structures that have emerged to address quality of life and success of individuals and families in southwest Detroit. We are complex! One's emotional well-being has many dimensions or facets, each being dependent on innumerable relationships/connections.

SOUTHWEST COUNSELING SERVICES

Southwest Counseling Solutions has served the Southwest Detroit community since 1970. They help more than 7,500 individuals and families a year, improving their lives through four Centers of Excellence: Adult Counseling Services; Early Childhood and Family Literacy; Children, Youth and Families; and Supportive Housing.

Southwest Counseling Solutions is a 501(c)(3) that employs more than 250 staff persons. They represent the fields of psychiatry, psychology, social work, counseling and education. Focused on inclusiveness, they have more bilingual counseling professionals than any other organization in Michigan, one in three of their counselors are bilingual. Their adult counseling program for Spanish speaking consumers is highly effective, with 98% avoiding hospital psychiatric services. In partnership with Covenant Community Care, SWSOL has developed a model of integrated physical and mental health services.

It is also one of Detroit's largest providers of services to the homeless. In the last decade, they have placed into housing more than 1,900 homeless persons, and their housing retention rate after one year was at 94% which is one of the best in the nation. They are the lead agency to end homelessness in the city. The number of chronically homeless and homeless veterans has declined significantly in the past few years through the concerted and coordinated effort to address homelessness. Piquette Square is a 150-unit permanent supportive housing project that provides comprehensive support services, including access to healthcare, employment, benefits, and education. It is recognized as a national model in helping the veterans rebuild their lives and reintegrate into the community. Their Supportive Services for Veteran Families, (SSVF) has helped over 2,500 low-income veterans remain housed. In all its Centers of Excellence, Southwest Counseling Solutions is consistently recognized for its leadership, expertise and excellence. At the same time, they are known for their collaboration with numerous community partners to expand and enhance the services in all program areas.

SOUTHWEST HOUSING SOLUTIONS

Southwest Housing Solutions began in 1979 and is a leader in the planning, development and management of affordable housing and commercial property in Southwest Detroit. Their mission is to revitalize their community through collaborative, high-quality and innovative projects, and by promoting home ownership and resident-centered development initiatives. Their mixed-use projects stimulate commercial and cultural development.

They are the leading nonprofit multi-family developer of affordable housing in Wayne County, having developed or renovated nearly 1,400 units in multiple neighborhoods, including single-family homes and multi-family apartments. More than 2,000 people reside in their quality, affordable apartments and townhomes. They have renovated and sold more than 650 homes in the metro area that were vacant, helping to reduce blight and revitalize neighborhoods. They offer programs for home buyer counseling, foreclosure prevention, financial coaching, mortgage lending, and no interest home repair loans. More than 2,500 families are homeowners due to their programs. One of every ten homes purchased in Detroit with a mortgage in 2016

was assisted by their home buyer programs.

Southwest Housing Solutions is a trusted nonprofit partner with a deep-rooted commitment to community development and a proven track record–

- $150 million of real estate development completed or in progress
- 26 multistory buildings restored for residential and retail use
- 225,000 sq ft of commercial space created or managed for lease
- Neighborhood Preservation Team helps residents better the community
- Developer of Piquette Square, a 150-unit project for homeless vets
- Acquired, renovated and sold more than 400 REO homes that were vacant and are now owner-occupied

They manage more than 600 apartment units that they rent to low and moderate-income families and individuals –

- Safe, affordable and quality housing in beautifully renovated buildings
- Housing and support services for homeless or special needs persons
- Permanent supportive housing for formerly homeless veterans at Piquette Square
- A full range of services and opportunities for their residents
- Property management consulting services for other property owners

Southwest Lending Solutions is a community-based lender offering services to help prospective homeowners overcome home financing challenges, plus highly competitive rates and terms.

SOUTHWEST ECONOMIC SOLUTIONS

The mission of Southwest Economic Solutions is to provide opportunities for individuals and families to achieve greater economic success. They promote and preserve homeownership and advance financial literacy, and have become a leader in workforce development and adult literacy services. All their services are free for eligible individuals and families.

Their Adult Learning Lab helps adults improve their literacy, math and computer skills so they can be better qualified for employment.

ProsperUS Detroit is an entrepreneurial training and small business lending program for Detroit residents, particularly those who are African-American, Arab-American or Latino. By helping emerging entrepreneurs develop successful businesses, ProsperUS will help strengthen neighborhood economies, create jobs, serve residents with new goods and services, and cultivate community-based leadership. ProsperUS Detroit is the leading entrepreneurship program for aspiring minority business owners in the city. More than 850 ethnic and immigrant entrepreneurs have graduated from their program since it began in 2012, resulting in 150 new small businesses. ProsperUS has provided more than 1 million dollars in loans to 50 small businesses.

ProsperUS serves five neighborhoods:

- Cody Rouge
- Grandmont Rosedale
- Lower Eastside
- North End
- Southwest Detroit

The Center for Working Families (CWF) is based on a promising national concept and is designed to help low-income families reach financial stability, access income supports, develop educational and employment opportunities, build wealth, and move up the economic ladder. Participants are assisted by a financial coach, workforce development coach and benefits coach.

Financial coaching helps participants manage income, reduce debt, review credit, and plan for a more successful economic future. They offer one-on-one financial coaching and financial capability workshops.

They offer a variety of programs to help a family buy a home or keep their home. Their agency is HUD-approved, and their professional counselors are MSHDA certified and NeighborWorks trained and certified. They have English/Spanish bilingual counselors available.

The foreclosure intervention counseling provided by Southwest Economic Solutions serves homeowners throughout the metro Detroit and tri-county area.

They offer home buyer education classes, pre-purchase counseling and financial coaching through one-on-one sessions, group workshops, and community events. They offer special programs to help aspiring homeowners qualify for incentives such as down payment assistance and low-interest home loans. They also offer assistance for current Detroit homeowners to apply for the City's no-interest home repair loan program.

To address workforce development, they offer several programs to help eligible participants obtain the skills, resources and opportunities they need for gainful employment. *Earn+Learn* is an innovative and comprehensive model of workforce development that involves multiple partners working together to train, place and maintain participants in employment.

Homeless Veterans' Reintegration Program (HVRP) helps

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Leadership *(From Page 19)*

homeless vets find meaningful employment through a broad range of training, support and employment services.

PATH (Partnership Accountability Training Hope) assists welfare applicants and recipients to become self-sufficient and integrated into the labor force, based on the workforce needs of Michigan's current and emerging economy.

GAME CHANGERS

This incredible expansion of services has all been the result of a growth in understanding the components that constitute quality life, success and self-sufficiency of individuals and families. This burgeoning knowledge has enabled SWSOL to identify seven game changers. Retaining fidelity to the complexity we are as human beings, there is recognition that each game changer has a cascading effect, that is, each has an impact beyond its particular area of emphasis. This means that the various sectors and partners must align their strategies and objectives. Likewise, it means integrating services to address the interrelated needs of individuals and families, significantly increasing the likelihood of their well-being and success. We are more apt to retain effectiveness and relevancy if we focus on game changers rather than on the existing iteration of a program. In doing this, *why* has precedent over *what*. Instead of defending a program, we can ask, what are we doing to address this game changer? Are we making a difference? Where do we excel? What's missing?

The seven game changers are:

- Health
- Housing
- Income, Employment and Financial Empowerment
- Early Childhood and Education
- Transit
- Community Security and Stabilization
- Community Building and Engagement

A future article will focus more closely on these game changers and how they are indeed, having a significant impact on Southwest Detroit!

John VanCamp *retired in 2018 after a 45-year career with Southwest Solutions – the last 37 as Chief Executive Officer.* Connections *Editor, Clint Galloway, researched Southwest Solutions – and subsequently saw first hand the impact the organization has had on the renaissance taking place in Detroit – when VanCamp guided him on a tour a few weeks ago. This article is a result of that research, the visit to the organization, and conversations with VanCamp.*