Michigan Association of Community Mental Health Boards

FALL 2014

Connections

for communities that care

THE WINDS OF CHANGE

James K. Haveman, Director, Michigan Department of Community Health

I am writing this article on September 2, 2014 a few days after I resigned my position as Director. I had planned to stay longer but a minor stroke on Memorial Day lead my wife and I to decide that a change of pace was warranted. Thus I am using this format that Clinton Galloway—via *Connections*—has given to me to share a few outgoing thoughts with you.

I leave after 46 years of public service. It has been a great ride, and I leave proud of the relationships I have had with many of you and what we have collectively been able to do throughout the past decades. However, now is not the time to rest on our laurels. We know delivery models have to change and we continue to work together to lead those reforms. Governor Rick Snyder has asked us to reform our health care system, and that process continues.


James K. Haveman

When the behavioral health community-based services movement began in the 1960s, many of us worked hard to carve out behavioral health services because physical providers were not interested in doing so. Nowadays, we find ourselves moving forward with both budgeting and policy changes at lightning speed to integrate the mind and the body.

I have said for years we are in a period of great change in the delivery of services. I have no doubt that the twists and turns from this change will continue for the next several years as various systems shake out. The old models will be gone and will be replaced by ones that provide greater access to services, more technology, integration of care, and new treatment modalities. We will look back someday and wonder how we ever provided care without mobile apps, medical assisted therapies, electronic medical files, self-management and data analytics. But until then, we have much adapting that still needs to be done.

The question we all are facing is whether the community mental health model that was built in 1960s as a carve out will be able to adapt and adjust to the new models of care. As we work to answer that question we must remain committed to full integration of services to ensure those we serve seamlessly get their behavioral and physical health care services in their communities.

While the exact steps for making this happen are not yet clear, now is time for purposeful dialogue and courageous action.

I would submit that the future for community mental health boards is reliant upon broadening depth and scope of services for all those who need mental health services.

We can no longer think institutionally. Michigan Protection and Advocacy Service estimate that more than 4,000 consumers in Michigan are in inappropriate housing situations. Beginning next year, the federal government and Michigan Protection and Advocacy Service will closely monitor consumers living situations to ensure patient choice is the priority. How these issues are resolved going forward will take careful negotiations with clear respect for self-determination and choice.

During the most recent budget process, the issue of General Funds was a point of contention. While we certainly always want to engage in productive dialogue, I think it is important for all partners to understand that the funding model of the past needs to be modernized and better reflect the needs of consumers. The reimbursement system is quickly moving to a per member, per month contract with a health care organization, and the major funder going forward will be Medicaid. Until the Medicaid funds are pooled and a treatment plan implemented with all providers from

(see WINDS *on page 2)*

WINDS OF CHANGE *(from page 1)*

a single source of payment, true integration will not take place. The Michigan Department of Community Health's budget beginning October 1, 2014 is $18.3 billion. What a collective responsibility we have to use these resources effectively and efficiently.

The focus will be on population health and who best can provide the comprehensive integrated care that consumers and funders are seeking. In particular we all must adapt the services we provide to comprehensively serve those who are veterans, homeless, not guilty by reason of insanity, elderly, victims of human trafficking, dually eligible, autistic and high utilizers of hospital and community services (both children and adults). We need to be vigilant in ensuring we pay close attention to these vulnerable populations so that they receive comprehensive services and do not fall victim to falling between the cracks. This includes ensuring we better integrate the substance use disorder and mental health service delivery systems so the experience of an individual's care is not fragmented between two access points, two medical record systems and uncoordinated care.

> **"When considering the changing health care landscape, one program that stands out in particular is the Healthy Michigan Plan."**

When considering the changing health care landscape, one program that stands out in particular is the Healthy Michigan Plan. With more than 381,000 residents enrolled already, this is one program that is working well and can serve as a model going forward. Let us all learn from its innovation and creativity. Make sure you read Public Act 107of 2014 for it is the harbinger of the future and lays out a path forward.

Consumers of the future will rely more heavily on self-management of their health status and will want to utilize technology such as their smart phones for appointments, information, monitoring, and live interactions with professionals. Persons who are developmentally disabled will find more educational opportunities and renewed efforts by the Michigan Department of Education, Michigan Rehabilitation Services, and others to provide housing, educational and work experiences.

In the future, much of what we do will be guided by predictive models. We will utilize algorithms as partners in treatment plans. We will adapt to bundled payments for care, and we already are working closely with providers, communicating via electronic medical records.

The future of these changes does not rely totally on a common, shared electronic health record. We know that providers and Community Mental Health Boards already have a variety of electronic health records; so instead, we now need to focus on common ways to exchange those existing records. It is the development of standards for those systems that will move us forward. I encouraged the Community Mental Health system to work with providers in developing these standards for both behavioral and physical health services.

Further, changes in the Mental Health Code are needed and necessary. The Mental Health Code has not been revised since it was written in the mid-1990s. The Mental Health and Wellness Commission has made a number of recommendations for improving the code and better serving our residents. To address these necessary changes, the Mental Health and Wellness Commission has clearly identified areas of new services needed and requests for proposals will be coming out soon to address those issues. As you know, the Fiscal Year 2015 budget allows the Michigan Department of Community Health to contract directly with providers if appropriated and needed. Community Mental Health must be engaged in these solutions and I look forward to seeing the progress that will be made on this front.

Now is the time for the public mental health system to be responsive to the needs and resources of your communities. Using the strong network of quality private providers we've built over the years, we can reduce administrative duplication, and improve service structures within our communities. And even in doing so, I am confident that our community mental health system will continue to stand ready to develop innovative solutions and deliver services to fill gaps.

The legislature and our residents are looking for those who are part of the solution, bring new ideas to the table, and can demonstrate their ability to deliver the desired outcomes of both the State of Michigan and its residents. With all of the changes we are facing in the healthcare industry today, now is not the time to sit by and wait for the changes to sort themselves out. We need to be active in shaping the growth and future of Michigan. As Governor Snyder has said, a healthier Michigan is a stronger Michigan, and I firmly believe that by continuing to work together we can provide the comprehensive, integrated services our consumers deserve.

THE CRITICAL NATURE OF SOCIAL CAPITAL

Al Condeluci, MSW, PhD, CEO of Community Living and Support Services

In September 2014, SAMHSA celebrated the 25th anniversary of National Recovery Month. Connections has featured numerous articles on the nature and importance of the concept of recovery. Recovery has rightfully so captured our attention the past two decades. However an equally powerful ingredient in achieving quality of life has in comparison received minimal attention; it has to do with the building of social capital. It is what Connections has been about since its inception, the importance of relationships. Enabling those whom we serve in building their social capital will challenge the nature and existence of many of the community institutions we have erected the past fifty years. Nevertheless, the road ahead to wellness is clear and the charge is being led by those committed to quality of life for everyone. Condeluci is one of those who is paving the way. You can expect to read more about social capital in the coming issues of Connections.

Social Capital is a term that describes the notion of friendship and social connectedness. Clearly, all people have some form of social capital, but it hasn't been until recently that sociologists have come to realize the power and potency of this concept.

Alexis de Tocqueville first wrote about the concept of social connectedness in his 1850 analysis of the United States titled, *Democracy in America*. In this work, de Tocqueville described a phenomena he called "habits of the heart" where people watched out for each other for no other apparent reason than what is good for you is good for me. By the end of the Civil War and beyond the turn of the century in the 1900s, Americans began to enhance these "habits of the heart" to a whole new level. As our society shifted from primarily agrarian to industrial mode and as immigrants came from all the Eastern European countries, all types of clubs, groups and associations began to develop and strengthen. From 1871 until 1920, over sixty groups moved from a parochial context to become nationwide entities, all creating a buildup of culture, community and connections. People need people and need to feel useful.

L. J. Hanifan first coined the idea of social capital in 1916, although his focus was to put a "face" on the notion of "habits of the heart" that de Tocqueville identified in 1865. He defined social capital as "those tangible substances that count for most in the daily lives of people: namely good will, fellowship, sympathy, and social intercourse among the individuals and families who make up a social unit."

In a basic way, this notion of social capital is critical to all of us. Stop and think about it – your life is a complex web of people who you relate to on various levels for various things. Those people you are closest to are your covenant relationships. These are the people you love and spend the most amount of time with. Next, all those people, with whom you freely exchange make up your friendship relationships. You spend a fair amount of time with these people and rely on them for things you need as your situation becomes more complex. Last are all those people that you know and see in your daily or weekly activities. You exchange pleasantries with these folks and might even discuss or debate events around you, but you do not go much beyond these dimensions.

Robert Putnam (2000) defined the concept of social capital as "referring to connections among individuals—social networks and the norms of reciprocity and trustworthiness that arise from them…[It] is closely related to…civic virtue…A society of many virtuous but isolated individuals is not necessarily rich in social capital."

Social Capital and Health

Over the past 25 years researchers have been looking closely at the potency of social capital on health and happiness. Study after study have been conclusive that the more social capital an individual has, the less sick days and sad days they experience. A study done in Alameda County California (Berkman and Syme, 1979) found that healthy adults who were more socially integrated with deeper forms of social capital such as wives/husbands/partners as well as with close friends and associates were more likely to still be living nine years post study that others who were less connected. Twenty years later Berkman and Glass (2000) found that the more social capital the greater the survival from heart attacks, less risk for cancer recurrence, less depression/anxiety, and less severe cognitive decline with aging. Similar studies over the same time frames found that

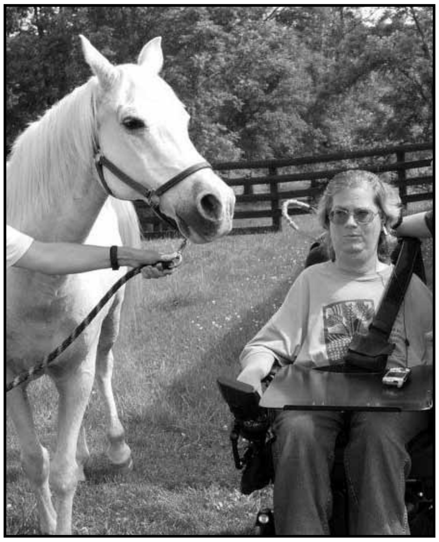
(see **Social Capital** *on page 12)*

Partners in Personal Assistance

A Unique Approach to Home and Community Based Care

A small group of people with disabilities and their Personal Assistants began meeting in Washtenaw County in 1996 to discuss challenges they were experiencing with assistance in their homes and out in the community. They considered such issues as finding and keeping dependable, well-trained caregivers, or Personal Assistants, as well as providing competitive wages and health benefits for those workers. Recognizing the need to empower people to exercise self-determination, they also understood the necessity for people with disabilities to develop good management skills in order to effectively work with their Personal Assistants.

Partners in Personal Assistance (PPA) became a reality in September of 1999, with a tiny office space leased at the Nonprofit Enterprise at Work (NEW) Center in Ann Arbor. With the office originally staffed by volunteers, PPA began to provide Personal Assistant services. Founder Lena Ricks helped secure a startup grant from the Ann Arbor Area Community Foundation. Washtenaw Association for Community Advocacy (ACA) served as fiduciary for pass-through funding until PPA obtained 501(c)3 nonprofit status in 2006.



Peg Ball, is shown here with her friend, Spirit. Assistance through PPA allows Peg to focus not only on her business, but also other life enriching activities.

Based on a model of self-determination and cooperation, PPA's innovative approach to personal assistance achieves a level of integration, empowerment, and equality that benefits both Consumer Partners (or CPs, people with disabilities who use the services of Personal Assistants) and Personal Assistants (or PAs). People with disabilities are able to establish more stable lives when they have high-quality assistance. At the same time Personal Assistants are able to make a meaningful difference in their Consumer Partners' lives while earning a decent income. Consumer Partners and PAs interview each other to decide if they want to work together. Each one has a choice in whether to collaborate as a team, and the two set their schedule together.

PPA offers an empowering solution for people with disabilities and senior citizens who want to exercise independence in directing their personal care. Many of PPA's Consumer Partners are Washtenaw Community Health Organization (WCHO) clients with developmental disabilities and/or mental illness receiving Community Living Supports. The organization also can serve Consumer Partners with funding from Department of Human Services (DHS), private insurance and private pay.

From the beginning, Partners in Personal Assistance valued a non-medical model of in-home care for people with disabilities:

- The individual runs his or her own life, and lives in his or her own home or apartment.
- While the Consumer Partner may involve some medical personnel to provide for their specific health care needs, the role of a Personal Assistant is not of a medical nature; instead, it is to assist the Consumer Partner with personal care tasks of everyday living under the Consumer Partner's direction.
- The Consumer Partner participates in determining what services are needed, supporting the Person-centered Planning motto "nothing about me without me."

Managing one's own personal assistance helps build a sense of ability and self-worth. Being able to live in one's own home with reliable assistance affords a person with a disability the opportunity to participate in all aspects of community life (e.g., education, employment, volunteer work, recreation, travel, entertainment, and social activities). Providing individuals with home and community based care can save thousands of dollars annually when compared to the cost of nursing home care, for instance. The investment is well worth the outcome of Consumer Partners contributing to society and enjoying a high quality of life along with their Personal Assistants. For example:

- Ashley can have PAs come in the morning to help her get up, dressed and off to work, then help with dinner and later, to bed.
- Catherine can enjoy the home she purchased, complete

(see **Partners** on page 15)

Mary Little's Amazing Story of Hope

A *Connections* Interview

For more than 50 years, Hope Network has been providing neuro-rehabilitation, behavioral health, developmental, and support services that give people a chance to overcome life's challenges. Guided by spiritual values that are rooted in the belief that every person created by God can be more, can do more, and can go further than anyone ever imagined, countless people have acquired hope. Each year, Hope Network recognizes one of those individuals with its "Hope On Award". This is the story of the most recent recipient. You are urged to watch the video of Mary Little's acceptance speech before reading this interview. Her acceptance speech can be viewed online at: http://vimeo.com/95512090. —Clint Galloway, Editor

Connections: *Mary, I have listened to the speech you gave when the Hope On Award was given to you. I find your words very inspirational and courageous! But today I want to get to know the Mary Little that has survived all these challenges. Too often we become identified by our trauma rather than our True Self. Too often when people look at us they think of our afflictions and miss seeing the heart and soul that accounts for our beauty and uniqueness. It is these qualities that make us what we really are. So I am here to have you reveal who Mary Little really is. I could ask you about your life but that's a huge question, so I'll narrow it down; what's the most enjoyable time of the day for you?*

Mary Little: Between two and four in the afternoon.

What makes that special for you?

Little: That's when I work at a local nursing home. I clean the rooms and get to know the people there and they are always so thankful—they always thank you for what you do for them.

So you feel appreciated?

Little: Yes, I do, and I appreciate them.

So that makes it the most significant time of the day.

Little: Yes, I live by myself so most of the time I'm around people is at work, and that's when I feel special.

Do you ever dream of doing things that would expand upon those times that make you feel special?

Little: Yes. I thought about being a CNA (Certified Nurse Assistant).

So what would that take?

Little: Probably, I would have to go back to school and my work would pay for it if I did. The reason I haven't is the "diaper" part, changing the beds, etc. I guess I'd have to hold my nose. *[Hearty laugh]*

What would have to happen for you to go back to school?

Little: *[pause]* That's a good question. *[longer pause]* Nose plugs.

Nose plugs! [Obviously referring to the diaper scenes; we laughed.]

Little: I have a hard time when they're changing the diapers —it would be hard to do it.

So it's not so much getting equipped for the job as it is what you would have to do?

Little: I've worked there for ten years. I already know a lot of what to do.

So it sounds like you have some mixed feelings about becoming a CNA. Is there a step beyond a CNA that interests you?

Little: I've thought a lot about going back to school, going into the health field. I already know a lot in the health field. I've even thought of nursing.

What stops you?

Little: I don't know. *[Pause]* I just have to do it. I just have to make up my mind and go for it. There are a lot of people in the classroom; that would bother me. I could always go to school online. *[The tone of her voice picks up and Mary pauses.]* Something I'll look into.

So being around a lot of people makes you uncomfortable?

Little: Yes. It took a long time for me to get used to people around work. When I first started I didn't want to be around anybody. I had to get up, do it, force myself to get used to it. I kept telling myself I just have to get used to it.

So what are the least uncomfortable settings you have in being around people?

(See **Little** *on page 6)*

Little *(from page 5)*

Little: The most comfortable setting is at work. I'm comfortable now.

Why is that so?

Little: Well, because I need to be around everybody there and it's a familiar setting now compared to 10 years ago. I've developed some rapport with them.

So as you build relationships at work does it become easier?

Little: Yes.

The key seems to be being able to build some significant relationships where you're at.

Little: Here *[Hope Network]* it has helped me to be around people, this day of activities. Every Friday they have activities. They pick up everybody and we go do something. I never use to go, I'd think it was my choice, and then I started to go. Now I'm able to hang out with people here. My fears being around people are getting less and less.

Would it be possible to find somebody else, who was going to nursing school and arrange to become acquainted with them before actually attending the classes?

Little: And get support from them?

Yes!

Little: *[pause]* I'm too old to go back—I'm 43…

[I interrupt] I'm 75!

Little: You don't look 75. *[We both laugh]* You don't look 75!

I'm 75 and I still have a lot of dreams to pursue.

Little: *[The mood and subject abruptly change]* The other day I thought of being a veterinary's assistant. I love animals but I'm allergic to them. I had cats and I was sick much of the time I had my cats.

The medical science that addresses allergies has made tremendous advances. So allergies can be addressed. What would it take? [Mary talks about some of the allergic reactions she has had and the conversation shifts away from limiting factors to matters of the heart that shape our dreams.]

Mary, why do you think you were chosen to receive the Hope On Award?

Little: Just because of how far I've come around from where I was as a child to where I am today. I've gotta believe it's a miracle. I'm on my own now; I've had a job for 10 years.

In your acceptance speech you fondly mentioned a foster family in Flushing. You said they taught you what a family is all about.

Little: This family took me in, treated me like I was their own daughter, taught me how to love and taught me how to… everything.

You've shared how that was an important step in your recovery. How would you describe your experiences in Hope Network?

Little: I've gotten out of a lot of programs because they said they couldn't help me anymore. That's not so here. When my brother died, [Mary was very close to her brother] they were there for me 24-7; they helped me, they guided me when I needed it. Kathy *[on the ACT Team]* is always there for me. I can call her anytime day or night and she's always there. They believe in me.

Have you ever given up on yourself?

Little: I have. There are times when I get frustrated and I've tried throwing it all in. Then I think, I've come this far—why are you giving up now? You can always do more, I'm only gonna' get out of life what I put in it. I know that now. If you don't put your all into it you're not going to get what you want. You gotta go for it.

So, if you look down the road five years from now?

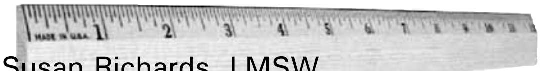
Little: I would like to have school behind me. I want to go—I really want to go. I hope I can be a veterinary's assistant. Yes, I can see myself doing that and not needing ACT so much and standing on my own two feet. Yes! You've just gotta' reach out and grab it.

What wisdom would you like to share with others who may read your story?

Little: First of all, be a survivor; don't give up; don't worry about it. Be a survivor, walk like a survivor, act like a survivor; not like a victim. I learned from everything. I turn it into a positive and treat people how I want to be treated, how I should have been treated. Forget what happened, focus on now! Look forward and treat others how you want to be treated. I think that's part of my work.

Becoming a Yardstick of Quality

A Reflection on Implementing the NIATx Process of Performance Improvement



Susan Richards, LMSW
Quality Improvement Director
Ionia County Community Mental Health Authority

"Be a yardstick of quality. Some people aren't used to an environment where excellence is expected." –Steve Jobs.

I think CARF (The Commission on Accreditation for Rehabilitation Facilities) would agree with Steve Jobs. As a CARF accredited agency, we strive to meet and exceed the standards required to maintain accreditation. When CARF came to Ionia County Community Mental Health Authority (ICCMHA) in March of 2014, one of our surveyors asked what our model of performance improvement was. We did not have a good answer. Their recommendation for improvement included a reference to investigate the NIATx model of performance improvement.

NIATx was founded in 2003 and is a part of the University of Wisconsin-Madison's Center for Health Enhancement Systems Studies (CHESS). The NIATx model was created to help behavioral health organizations improve access to and retention in treatment.

Researching the model, we noticed several things that increased our interest in learning more. Our values meshed well with the NIATx model of being quality-driven, customer-centered, and outcome-focused. Another thing we liked about the model was its ease of use. It teaches you to focus on change in small, measurable, outcome-focused increments. Too often we find ourselves sitting around the table trying to solve a problem and come up with solutions that make perfect sense at the time but end up with unintended consequences. The NIATx model seemed to address this problem. After spending time on the NIATx website and speaking with our lead surveyor for CARF, we decided to attend the Change Leader Academy.

The Change Leader Academy is a two day training to teach you how to lead your team through a performance improvement project. Before attending the academy we were given the assignment to complete a walkthrough of an agency process, providing us with a first-hand experience. However, it's not a "secret shopper" experiment. Everyone in your agency involved in the process is informed that you will be walking through. It's meant to be an open, collaborative experience so that everyone can comment on how the process worked.

With this in mind, Robert Lathers, CEO and I decided it would be beneficial to complete a walk through of our front door process. Our goal was to experience exactly what consumers experience when they first come to ICCMHA. Clerical and access staff were informed that we would be completing the walk through.

We completed our walk through on separate days, presenting a different scenario. I called our main number to set up my appointment. The next day I walked into the lobby and was greeted by one of our clerical staff members. I was then handed two papers to fill out. I sat down and began diligently filling out my papers. I had a hard time filling out the form on health; I didn't understand what a couple of the questions were asking me. The initial paperwork never asked what I came in for or what I felt I needed help with. I then waited for about twenty minutes before I was called back by one of our access therapists. The room I was in was very bright and I let the therapist know that I thought the lighting was a bit uncomfortable. My clinician asked me a series of questions from the screening form and several were the same as the initial paperwork I filled out. In the end, my scenario was deemed not severe enough for treatment at ICCMHA and I was referred out into the community. I was given three different referrals to three different agencies. I was confused on where I should head next. I spent some time after my walk through processing the experience. I thought about what made me feel uncomfortable, what was difficult, what was repeated.

When we arrived at the NIATx Change Leader Academy in Madison, we were asked to use our walk through experiences to guide our group through a process improvement project. The Change Leader Academy was a great way to watch the whole model of NIATx come to life. It provided tools and gave us space to ask questions and make lots of mistakes. Overall, I would recommend that if you plan to implement the model you utilize the training. I had some good ideas of how to begin the process when back home in Ionia.

At the training we learned about the four aims of NIATX: reduce waiting time between first request for service and first treatment, reduce no-shows by reducing the amount of consumers that don't show for appointments, increase admissions to treatment, and increase continuation from the first through fourth appointments. All of these aims are directly related to a fiscal outcome as well as consumer

(see Yardstick *on page 14)*

We Are a Work in Progress

Frank Ross, Chairman
Detroit Wayne Mental Health Authority

The Spring Conference of MACMHB was held this past May in Dearborn at which Frank Ross delivered a very moving welcome address and invocation. We are indebted to Frank for enabling us to reprint those remarks.

Good Morning and Welcome to Detroit and Wayne County, I am Frank Ross, the newly appointed Board Chair for the Detroit Wayne Mental Health Authority.

I am pleased to be with so many colleagues who share a passion to help people with mental illness, intellectual and developmental disabilities, and substance use disorders live a life of dignity in our communities.

I think I have a pretty large task at hand. I have been a member of this board for nearly 19 years and have seen tremendous transformation. But as times change, we must change with it. There's an old saying "He's not finished with me yet." I think it pretty much sums up the work we all do as mental health professionals—we are all works in progress.

Detroit Wayne became an Authority in October 2013 and the staff at the Authority has been moving thoughtfully and deliberately to implement the vision and mission of the Authority: to be consumer and community focused, data driven, and an evidence-based organization. Transforming a system that impacts so many lives can be difficult, making crucial decisions, potentially life-altering decisions, but nonetheless decisions that are critical to the advancement of 74,000 consumers in Wayne County.

The Detroit Wayne Mental Health Authority Board, like so many other of the CMH boards is comprised of well-trained professionals who care about the well-being, rights and survival of the people we serve. We know that every individual we serve—just like every one of us—is a work in progress. It is events like these that bring us together that keep our energy high and our focus on doing right by our fellow man.

When I look at the theme for this conference, "Together Towards Tomorrow," I am reminded of teamwork, change and progress. How many of you remember the days of mental health catchment systems where you were bound by zip codes? We have moved away from institutionalization. It is because of *our* work that Michigan is the largest state to have closed *all* of its institutions for people with intellectual and developmental disabilities.

Pictured are Tom Watkins, Detroit Wayne Mental Health Authority President and CEO (left), with Frank Ross, Board Chairman, Detroit Wayne Mental Health Authority.

Over the years, mental healthcare has progressed. We now promote self-determination and independent living. Many of our systems are providing integrated healthcare. And now Healthy Michigan is part of that same progression. From Wayne County, to Berrien County, to Grand Traverse County, CMHs have exemplified teamwork and doing what's best for the consumer in getting the word out about Healthy Michigan and getting people enrolled. For some, change can be daunting; but we are a work in progress, and change is part of that transformation. Education and information is key to being part of progress.

As CMH Boards and mental health professionals, we have to stand together and essentially share the same goals and objectives statewide: to help the people we serve overcome barriers and achieve their goals. We are challenged with increasing participant awareness, knowledge and skills through the resources available to them through our systems of care.

I want to thank each and every one of you here today for your dedication to the people we serve; for having a voice for the consumers in the respective communities in which you serve. Your dedication, your passion and your commitment allows for better treatment, programs, service and advocacy efforts for the thousands of people you all represent here today. Thank you.

INVOCATION

This morning we have gathered from near and far to share and learn from one another. We all bring experiences, stories, and devotion for the work we do. We are doctors, nurses, social workers, therapists, case workers, consumers, students, etc.

I am grateful that we all arrived here safely. I ask that we fill our minds with knowledge over these next few days, our bellies with food here momentarily…and then return us home to our families and the wonderful work we have dedicated our lives to. Thank you.

Consumers Connect With Community in the Spirit of Recovery

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

Statistics show that one in five people in America, 20% of the population, have experienced a mental illness firsthand. In Saginaw County with a 2013 population of 196,542, that translates to approximately 39,308 people dealing with mental illness in their lifetime. Yet despite how common it is, stigma is still a leading cause of why people don't reach out to get the help they need. People who suffer from severe mental illnesses often feel alone in their struggle, ostracized by the community around them out of fear and lack of understanding. Mental health consumers in Saginaw County refused to be just another statistic - they created and oversee the Friends for Recovery Center (FFRC), a drop-in facility that encourages focus on living a healthy life to the fullest, regardless of a mental illness diagnosis.

Officially opened in February of 2014, FFRC offers individuals a wide variety of classes and activities to better their overall health and wellness. Classes include yoga taught by a certified instructor; "12 Proactive Steps to Recovery" led by FFRC staff; "Be Fit, Eat Healthy," "Healthy Cooking," and "Financial Budgeting" facilitated by Michigan State University Extension; stress awareness and management classes led by Saginaw County Community Mental Health Authority staff; and a variety of recovery and wellness workshops. The facility also has a workout room with exercise equipment, a large kitchen area, a library with computers and donated reading materials, a "movie" room with a large television and video equipment, and a large back yard area that consumers have used to plant a vegetable garden with the help of generous donations from Home Depot.

The FFRC, located at 2720 West Genesee Street in Saginaw, operates as a 100% peer-run facility designed to serve adults in Saginaw County who have been diagnosed with severe mental illness. Initial funding for the drop-in center was provided by the Michigan Department of Community Health (MDCH) through an adult block grant to support integrated health care. Currently FFRC is waiting for a decision on their 501(c)(3) application with the Internal Revenue Service to be an independent, non-profit organization within the Saginaw community.

"We've grown so much in these first few months," explained Miley Stuller, FFRC director. "Our focus from day one has been encouraging each other to focus on wellness and recovery instead of on the diagnosis, and through that we have been able to connect with the Saginaw community in such positive and productive ways."

Aside from activities on-site at FFRC, consumers have also been enjoying trips to the Children's Zoo at Celebration Square, Haithco Park, Castle Museum, Greek Fest, and even a Great Lakes Loons game. "It's a blast for everyone," Stuller said. "We all really enjoy getting out into the community and living life to the fullest. Not only is it great for all of us to participate in activities like everyone else, it really helps educate the community that people with mental illnesses are just like them. Everyone has hopes and dreams and goals regardless of medical conditions, and we're all on this journey together."

FFRC has even garnered attention from across the State of Michigan for its impact on the recovery process, with the director of the Justice in Mental Health Organization (JIMHO) Brian Wellwood sharing his praises. "The health and wellness information offered to members and attendees at board meetings and roundtable discussions is very relevant and informative," he explained. "It has become a part of my own personal wellness changes and has made a big difference in my life. Health and wellness information is something that should be a part of what is offered at every drop-in center." Wellwood added "JIMHO appreciates the support and information provided by the Friends for Recovery Center and Saginaw County Community Mental Health Authority. We look forward to a successful future for the FFRC and plan to refer drop-in center staff and board members from other communities to Saginaw for ideas and networking." JIMHO offers consultation and training support to all of the consumer run drop-in centers across the state.

The FFRC welcomes approximately 20 consumers per day and is continuing to evolve and grow. Currently the center is developing committees that will help structure decisions for activities, fund raising, and other needs. FFRC is also looking to fill a vacant part-time Peer Support Specialist position and take on volunteers with lived experience to help coordinate day-to-day office needs. Additionally, consumers would like to add more classes to their roster to expand options for participants.

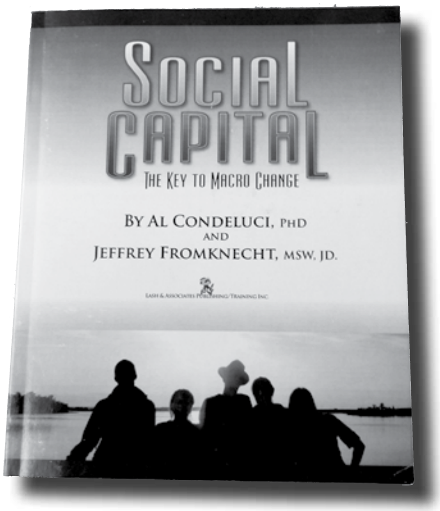
If you are interested in learning more about the Friends for Recovery Center and would like to get involved, connect with them on Facebook and contact Miley Stuller at 989-401-7588 or mstuller@ttiinc.org. Walk-in tours of the facility are also available during business hours. ■

WORTH READING........................

Social Capital: *The Key to Macro Change*

By: Al Condeluci, PhD and Jeffrey Fromknecht, MSW, JD

Reviewed by
Robert M. McLuckie, Principal
McLuckie & Associates, LLC



Al Condeluci and Jeffrey Fromknecht begin *Social Capital: The Key to Macro Change* with a quotation from Sophocles: "Always desire to learn something useful." Then, in just 142 pages, the authors assess core assumptions at the foundation of our service system and offer clear practical guidance for fundamental change. The presentation is clear and compelling. And yes, the reader does indeed "learn something useful", perhaps even essential.

Our "Social Capital" consists of the relationships we develop within the formal and informal communities we associate with. These relationships are important because they support or prop us up in the areas where we are not strong or capable. The central point: "Relationships yield social capital, and social capital is the foundation of health, happiness, and even life expectancy". And further; "formal systems have never succeeded in keeping us safe and healthy. Your circles of support and the reciprocity they create are the most important elements in your safety and health."

> "Always desire to learn something useful."

The book presents a very complete exploration of the function of social capital. The authors speak with a clarity that is born from deep experience in working with persons with life-long disabilities. We hear the voice of respect and appreciation for our system of community services, yet there is unequivocal recognition that "sadly, many people with disabilities are limited in social capital and remain isolated in ways that are manifested in unemployment, limited housing, transportation disparities, and limited opportunities in the greater community." The author's core premise is clearly stated: "We are convinced that the key to change is not found in addressing the disability, but in promoting social capital, which in turn, will change attitudes, assumptions, and promote greater opportunities." They challenge us to change this "system of formality – a segregated system still today – that is often characterized by limited or no meaningful natural relationships." They offer stories and tools from their own journey.

Social Capital: The Key to Macro Change should be required reading for those providing direct support services. Three chapters at the core of the text offer rich and lean discussion of the "how to." These are the sections on "Interdependence and Social Capital at Your Organization," "Investing in Social Capital," and "Social Capital In Action." This is useful information presented with blunt clarity. A four step method for helping people to develop meaningful engagement and relationships within naturally-occurring communities is provided. This is followed by a series of credible testimonial essays from several direct service programs. Nowhere do the authors claim developing social capital is easy. They admit it's difficult and focus on showing us it is possible. Most importantly, they insist: "If there is a single dimension that must be repeated and underscored…it is that of relationship."

The authors challenge us to work toward realizing a caring community for each person who is disconnected as a consequence of disability. This is not an "objective" or a "goal" This is essential. This is transformation.

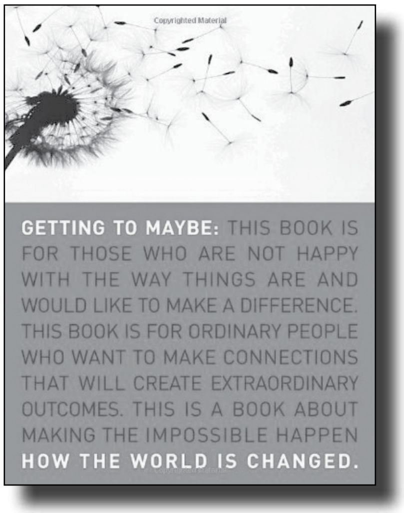
Social Capital: The Key to Macro Change is highly recommended for managers, administrators, and social workers connected with, or interested in, direct services for individuals living with life-long disabilities. It offers content that can be easily adapted and used as training material for direct support staff. Executive team members are challenged to study and champion the cause of building social capital.

Check Al Condeluci's web page for many free downloadable resources. ■

Getting to Maybe: *How the World is Changed*

By: Frances Westley, Brenda Zimmerman, Michael Patton

Reviewed by
Robert S. Lathers, CEO
Ionia County Community Mental Health Authority



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GETTING TO MAYBE: THIS BOOK IS FOR THOSE WHO ARE NOT HAPPY WITH THE WAY THINGS ARE AND WOULD LIKE TO MAKE A DIFFERENCE. THIS BOOK IS FOR ORDINARY PEOPLE WHO WANT TO MAKE CONNECTIONS THAT WILL CREATE EXTRAORDINARY OUTCOMES. THIS IS A BOOK ABOUT MAKING THE IMPOSSIBLE HAPPEN **HOW THE WORLD IS CHANGED.**

In 1989, a group of parents who had children with a disability started an organization called Planned Lifetime Advocacy Network (PLAN). Their goal was to ensure that their adult children would not be cast into institutional care as they outlived their parents. The parents agreed that four factors were necessary to ensure their children would have whole lives: “family and friends; financial security; a home that was a sanctuary and not a warehouse; and the ability to have one’s wishes and choices respected.” These are the kind of lives most all parents in western civilization want for their children—lives of basic sustained dignity.

The parents also discovered research that had been done which concluded that the safety and wellbeing of persons with a lifelong disability was not dependent upon the number of social workers, law enforcement officers, or organizational by-laws, operating agreements, payment structures, etc., but, “Rather their safety was dependent upon the number of relationships the person had with others. The more relationships, the greater their safety. The fewer relationships, the greater their vulnerability.”

The PLAN’s goal was to find a way to increase human networks and connections for each child. Each child would have to be the center of their own network. By the mid-1990s there were over 50 individual networks, by 2003 there were 116 networks, each focusing on developing a full integrated community life for the child involved.

The PLAN is one of dozens of case studies in Westley, Zimmerman, and Patton’s 2007 book, *Getting to Maybe: How the World is Changed,* which also includes the stories of Minneapolis’s Hope Community; Boston’s 10 Point Coalition to end violence; Ulysses S. Seal’s work in Species Conservation; Desmond Tutu’s powerful plan of forgiveness through South Africa’s Truth and Reconciliation Commission; Mary Gordon’s amazing work in the development of her “Roots of Empathy” program to end school bullying; and the story of the one hit wonder, Bob Geldhof of the Boomtown Rats and his all too simple plan to try to end world hunger which got him nominated for the Nobel Peace Prize.

Getting to Maybe is an amazing read that has huge organizational implications. The authors emphatically state that “in complex systems, relationships are key,” a statement that the parents of PLAN would wholeheartedly agree with. However, the authors caution that anyone who tries to change the way things are done will assuredly encounter “the entrenched powers that benefit from and hold in place the existing system” which is the very system they are trying to change. Through a thorough discussion of the roles of Social Innovators, Powerful Strangers, Attractors, and just downright individual solo acts of courageous behavior, the authors assure us that we can indeed make a better world to live in.

On the inside cover of *Getting to Mayb*e is a note that reads “This book is for flawed people who are not happy with the way things are and would like to make a difference. This book is for ordinary people who want to make Connections that create extraordinary outcomes.” That includes each and every one of us working for a better way of community life.

Social Capital *(from page 3)*

social capital predicts who is resistant to illness, and that social isolation (the lack of social capital)—listen to this—actually causes disease.

Summarizing all of this research, Robert Putnam (2000) contended that social capital is not only essential to individuals, but is critical to communities overall because it:

- Allows citizens to resolve collective problems more easily
- Greases the wheels that allow communities to advance smoothly
- Widens our awareness of the many ways we are linked
- Lessens pugnaciousness, or the tendency to fight or be aggressive
- Increases tolerance
- Enhances psychological and biological processes

The fact that social capital keeps us safe, sane and secure cannot be overstated. Most of us tend to think that institutions or organizations are keys to safety. Places like hospitals or systems like law enforcement are thought to keep us safe, but the bold truth is that these systems have never really succeeded in keeping us safe or healthy. Rather, it is the opportunity for relationships that community offers us as well as the building of social capital. Simply stated, your circles of support and the reciprocity they create are the most important element in your safety. In fact, Putnam reports that social isolation is responsible for as many deaths per year as is attributed to smoking.

Drilling deeper on this critical nature of social capital, Sheldon Cohen (2004) contends that there are two major aspects responsible for these positive effects—the "main social effect" and "stress buffering." The "main social effect" is the obvious nature of having your social capital available to support you, and reciprocate when you are in need. This "main social effect" promotes positive psychological aspects of identity, purpose, self-worth and other pro-social aspects that induce health-promoting physiological responses. It also provides information and is a source of motivation and social pressure to care for oneself.

Quite simply, this concept suggests that stress has an adverse affect on health and that social capital buffers the ill effects of stress.

"Stress buffering" asserts that social capital promotes health by providing psychological and material resources needed to cope with less stress. Quite simply, this concept suggests that stress has an adverse affect on health and that social capital buffers the ill effects of stress. The more friends you have the more you can get assistance in dealing with your stressful situation. When someone faces stress alone, the interpretation of the stressful event has ill effects. But if you can talk with friends about this stressful situation, often the interpretation is softened and you can face the stress with less negative impact.

Without a doubt, the potency of social capital is a concept to be reckoned with. The research, studies and reviews are overwhelmingly consistent that the more relationships people have, and especially in key, close relationships, the better they are able to deal with the stresses of life and the better their lives become. Tom Rath (2006) suggests that the literature also indicates that one need not have a lot of relationships. Studies seem to show that the positive effects of social capital kick in when people have at least 4 close relationships. Curiously, more than 4 do not necessarily make your life better, but less than 4 lead to serious ill effects. This study was done at Duke University Medical Center in 2001 with patients having heart disease. Over a 4 year span they found that people in the "isolated" group (those with fewer than 4 friends) were more than twice as likely to die from heart disease.

Social Capital and Life Success

Beyond the health and safety benefits of social capital there is mounting evidence that social capital has a positive effect on the more tangible outcomes associated with life success. That is, when one examines key life success outcomes some simple areas can be isolated for review. These are:

- Jobs and meaningful things to do
- Housing and living choices
- Transportation to engage in community

Certainly there are other outcomes important to people, but when you look at any human service system anywhere in North America supporting people who are disadvantaged, these three measures—jobs, housing and transportation—are often the key activities that services offer. Be they poor, elderly, disabled, addicted, homeless or any other social ill, systems and services are trying to help people get established in these three domains. I know in our own area of expertise —supports to people with disabilities—these areas are critical and funding sources are looking to measure our success here.

Yet when these three areas are closely examined, success in each one is linked to social capital. Quite simply, the more social capital people have, the more options people have in each of these critical life support areas. Consider your typical experiences here:

Jobs and meaningful things to do – Regardless of your age, if you look closely at your job history, you can probably trace job success to your social capital. That is, when you think about your jobs and how you obtained these jobs, probably a friend, family member or associate was directly involved. Then, when you applied or interviewed for that job, you listed more of your social capital as job references. Moreover, when the interviewer called your references, these people (your social capital) vouched for your integrity, diligence, and competence even if they had to stretch.

In our experience there are some clear coincidences in this area of jobs. One is that people with disabilities we support are overwhelmingly unemployed or underemployed. In fact, national statistics (NOD – 2001) suggest that close to 76% of people age 16 to 60 with disabilities are unemployed or underemployed and our experiences bear this out. Similarly, our experiences also reveal that the folks we support who are unemployed are equally socially isolated with limited social capital.

Housing and living choices – Most disadvantaged people are extremely limited in housing options. Often housing that is affordable and safe is off limits to people of limited means. Consequently, many of these people are in sub-standard housing, in the most vulnerable areas, with the worst school systems, resources and the like. In the most severe situations, disadvantaged people end up homeless or on the streets. Much as we see with jobs, people with limited social capital are also limited in housing options.

> ...the route to success in community, no matter the group or agenda, rests in understanding the concept of social capital.

In our work in disability, this housing disparity is overwhelming. Along with the limited social capital to assist with housing, many people with disabilities have the added challenge of needing accessible housing. The net result is that the best that the human service system can do here is to build segregated or congregated housing specifically for people with disabilities. This isolation not only adds to the social stigma, but further limits the opportunity to build new social capital. The spiral continues.

One interesting example here is that of home ownership. The National Council on Disabilities (2001) reports that the overall home ownership data suggests that close to 71% of adults in community either own their own home or live with someone they love who owns the home. Yet when they isolate the disability adult population, home ownership drops to 6.2%. Of course, when you factor in the unemployment rate of people with disabilities (76%) then this segment becomes the poorest in the country. So who can afford a home, or what bank will lend to someone who doesn't have a job?

Again, when we factor in social capital, the impact is clear. People with more social capital have greater options in housing and in whom they might choose to live with. If you needed to change your living arrangement quickly, for whatever reason, your social capital would be there to bail you out. You might have someone who could take you in temporarily, then help you find a new place to live, or perhaps, have you move in with them on a more permanent basis. The net result is that social capital is a key mitigating factor in preventing homelessness.

Transportation to engage the community – There is no doubt that the ability to get around the community is critical to a person's life success. Getting to work, meetings, appointments or to recreate are key to keeping a person (or family) moving forward. Quite simply, the more limited you are in getting around the more limiting life becomes.

People who are disadvantaged are usually limited in transportation options. If you don't have a job, often you cannot afford a private vehicle. This leaves either public transit or finding friends to transport you. If public transit is not available, and you have limited social capital you are stuck. Then, if you need some special features in transit, such as accessibility, you are even further isolated.

Ironically, if you can not get into a community, then your chances of building social capital are further affected. Yet we know that social capital is key to assisting in transportation if you do not have or cannot operate a vehicle. This is a cruel double bind.

Disadvantaged People and Social Capital

It is safe to suggest that people who are disadvantaged anywhere in North America are equally limited in social capital. There is very little literature to back this statement up which, in and of itself is revealing. No one has cared to even measure the social capital network of disadvantaged people. Still, if you have any exposure or contact with groups of people that are often at a disadvantage—the old, poor, disabled, homeless, and addicted—know that these cohorts are disconnected from social capital.

Similarly, disadvantaged people are limited in all the aspects that social capital affects. That is, jobs, housing, and transportation are all challenging areas for devalued people. Equally, we know that disadvantaged people have more sick days, more depressed days and, in some cases, have a higher mortality rate. This is certainly true with homeless, addicted, poor, and disabled populations.

Without any detailed studies, conventional wisdom tells us that all of these populations are more socially isolated than other groups. Without the resources, energy, accessibility, or general community acceptance, members of these disadvantaged groups languish

(continued on back cover)

Yardstick (*from page 7*)

satisfaction. If you focus on these aims, both should improve.

We learned about the five principals of the model: understand and involve the consumer, fix key problems (that keep the CEO awake at night), pick a powerful change leader, get ideas from outside the organization or field, and use rapid cycle testing to establish effective changes. My favorite of the principals is consumer inclusion; so often in our attempts to improve a process we forget to include those who experience it every day. My second favorite is the principal of getting ideas from the outside. NIATx is a collaboration of like-minded organizations who share their challenges and successes so that we can all improve from each other. Process improvement doesn't always mean recreating the wheel.

With tools in hand and support from the NIATx team, we headed back to Ionia with the task of implementing a change project. We decided to start with our front door process. It was something that had been keeping Bob awake at night since experiencing it for himself.

Our first task was to select who would be a part of our change team. When choosing your team you should consider carefully who should be involved. You want a team of 4-8 people who are a part of the process and who will be good at helping to sustain the change. After carefully selecting our change team, we invited them with a formal letter to become part of the process. The NIATx model stresses the importance of having the "executive sponsor" invite the team, in our case it was our CEO. After everyone was invited, we informed our entire staff of the process at a full-staff meeting. The NIATx model was explained and the first project discussed. ICCMHA will be using the model throughout the agency to analyze all of our processes, so it is important that all of our staff be familiar with some of the terminology and have some buy-in to the model.

Next, our change team met. The majority of our first meeting was discussing the entire process in detail. Two members of the team engaged in a walk through. After discussing our experience, we started to flow chart the process from the first contact through the assessment. Flow charting is an important element so everyone can visualize what happens and more easily identify barriers in the process and identify places to start improving. After flow charting, we agreed to focus on reducing no-shows. We spent some time looking at agency data and agreed that the process improvement project should impact our no-show rates.

Our next meeting focused on what we would work on first to improve our front door process. We voted to work on improving the "welcoming environment", the experience you get when you walk through the front door. This includes the lights, the experience with clerical staff, the paper work, and the lobby. The change team can only work on improving one thing at a time!

NIATx teaches you to use the "nominal group technique" to allow all of the solutions in the group to be heard. Everyone on the team was given six sticky notes to write down their ideas. Next, we took turns revealing one solution at a time and sticking it on the white board. After all the solutions were shared, we asked questions of each other about each solution. Lastly, everyone got five votes to select the solution with which we would start. We settled on the paper work that has to be filled out upon entering the agency.

Before implementing our first change cycle, also known as the "plan, do, study, act" cycle (PDSA) the change team has to agree on baseline data. The NIATx model does not believe in change without measurement. If you cannot see the improvement you make, you have no proof that the change you've made is indeed an improvement. We could not agree with a time line to see improvements on no-show data, so we decided to utilize a satisfaction survey to establish baseline data. We put together a series of questions related to our experience with the front door process that our access team clinicians will hand out at the end of their screening session. Consumers can fill it out in the lobby and place it in our locked suggestion box. Once we collect twenty completed surveys we will compile our data and implement our first PDSA cycle. When we make our first paperwork change, we will survey consumers again the same way for a week or two and then compare our data from baseline to implementation of the change in paperwork.

At this point in time, we have been collecting baseline data for about a week. We will meet again when we hit the twenty survey mark, but to keep everyone motivated, I'm sending out updates on the surveys. Part of the whole process is keeping your team motivated and moving through the challenging moments of the improvement process.

While this first change project has taken longer to get started than expected, we are moving forward in making a change that will impact how people experience the agency every time they walk through the front door. It's exciting for both our team and ICCMHA to be embarking on such a meaningful improvement. Not only are we working on improving our processes, but we have the tools to do so quickly and purposefully. NIATx has equipped us with the process improvement model for which CARF was looking. We are on track to be a "yardstick of quality" in the mental health world. ■

For more information on NIATx, please visit
www.niatx.net

Partners *(from page 4)*

with improvements like a roll-in shower, deck, and an automatic dog door to let Max outside.

- Deb can complete her range of motion exercises and take a swim in her apartment complex pool with the help of her PA, Amber.
- Don can volunteer at a local retirement center while his roommate Bob enjoys his time at a senior day program.
- Mary Anne can get rides to shopping and to the local Center for Independent Living, where she participates with their theatre troupe.
- Peg can have help with her housework and personal care so that she can manage her life coaching business.

The mission statement of Partners in Personal Assistance is “to provide personal support services that empower people with disabilities to live full and productive lives, and to educate the Washtenaw County community about the needs and interests of people with disabilities.” In earlier years, PPA held trainings each month for one of three alternating audiences: Consumer Partners, Personal Assistants, and the public. These days, most in-house training is focused on high quality job skills for Personal Assistants, although Consumer Partners often attend and contribute to the PA training experience.

Returning to focus on community education this fall, PPA has teamed up with Washtenaw Association for Community Advocacy again, with funding from the Ann Arbor Community Foundation’s Anna Botsford Bach fund for senior citizens, to present a free speaker series for Washtenaw County residents with disabilities, seniors, caregivers and the general public on many of the questions that these two organizations get asked about on a regular basis, from introductory workshops on self-advocacy to more nitty-gritty details of applying for public assistance, work incentives, and housing options. Parents of children with disabilities will have a chance to hear more about Individualized Education Programs (IEP), and senior citizens can take advantage of workshops on preventing and avoiding falls as well as choosing and supervising competent caregivers. Perhaps most exciting will be their cutting-edge workshops on social media, sex education (for two separate audiences: parents of children with disabilities; and adults with disabilities), and preventing physical and sexual abuse of people with disabilities. ■

For more information on *Partners in Personal Assistance*, visit their website at: www.annarborppa.org.

Autumn Musings

Clint Galloway, *Connections editor*

By the time these pages become available, Mother Nature will be moving south with her palette of colors, having once again provided a feast for our eyes. Those of you in the North have been listening to the crunch this fallen artistry makes beneath your feet as the canvas is once again transformed by muted colors awaiting the splash of white and silver that winter promises. The Greek philosopher Heraclitus (535BC–475BC) declared change as fundamental to the Universe, “Everything flows, nothing stays fixed. You cannot step into the same river twice.” Heraclitus made it clear, unless you expect the unexpected, you will not find it, for it is hidden and thickly tangled. That is the theme of several articles in this issue of Connections.

Why is it that people are uncomfortable with change? How can we orient ourselves in a world of flux so we can capture some meaning and enjoyment? Here again, Heraclitus offers some wisdom. He uses the analogy of a child building sand castles by the sea. Time is a game played beautifully by children, that is the nature of our lives. What we build will be washed away. It is the joy of building that reaps pleasure, not the permanence of the structures.

There is one other key concept in Heraclitus’ philosophy which may surprise some of the Christian faith: Five hundred years before the Gospel of John was written, he declared the importance of “logos”– translated “the Word” or “Reason.” There is a oneness; a hidden order that permeates the multiplicity of what appears and disappears. The fear of change dissipates when we recognize that life is a beach with room enough for everyone to build our sand castles. This orientation makes it more difficult to resist pleasure than anger!

MACMHB Has a New Web Site

If you haven’t checked out MACMHB’s redesigned web site, don’t wait! You will find new, user friendly features, you will be able to easily maneuver around the site, where you will find legislative updates, a place to register for trainings, look for a job, read past issues of *Connections*, and so much more.

Take a few minutes and visit www.macmhb.org. We think you’re going to enjoy the look and the ease of navigation!

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Social Capital

(from page 13)

in the area of social capital. To this end, it seems that human services for these groups of people are missing the boat. Each year, millions of public and private charitable dollars are directed to "helping" disadvantaged groups, but when efforts to help fail to identify and then utilize strategies to help build social capital, it appears that these efforts will be doomed to failure.

Conclusion

We are convinced that the route to success in community, no matter the group or agenda, rests in understanding the concept of social capital, and then developing strategies and supports that will facilitate disadvantaged groups in building, maintaining, or sustaining social capital. When we move in this direction we are convinced that we will finally make progress in helping people find value and relevance in community. ■

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For more on Social Capital visit www.buildingsocialcapital.org and follow Al Condeluci on Twitter; @acondeluci.

The David LaLumia Outstanding Professional Service Award

David LaLumia was the first executive director of the Michigan Association of Community Mental Health Boards. Lalumia began his career in Michigan as a legislative staff person to Senator Joe Snyder in 1975. He assisted in the merger of the Board and Directors associations into MACMHB in 1983 and was appointed as its first full time director in 1984. He served in that capacity until 2008.

The *David LaLumia Outstanding Professional Service Award* honors employed individuals from within the public mental health system who, over time, have made an outstanding contribution to Michigan's publicly funded CMH system. This award will be presented at annually at the MACMHB Fall Conference.

The leadership of the Michigan Association of Community Mental Health Boards is pleased to announce that the first recipient of this prestigious award is **Georjean Knapp**, a member of the MACMHB staff in Lansing, Michigan. Knapp was nominated by the Metro and UP Regions of MACMHB. The award will be presented by David Lalumia on October 27, 2014.

Our congratulations to Ms. Knapp for her commitment and contribution to quality mental health services in Michigan.