CMHA Community Mental Health Association of Michigan
Connections
for communities that care
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THE EVOLUTION OF SELF-DIRECTED CARE

Christopher Pinter, CEO, Bay-Arenac Behavioral Health

The traditional professional approach to mental health treatment has always been anchored in the illness-oriented model of care: 1) an individual reports or presents with a problem or symptom, 2) professional staff (physicians, nurses, psychologists, social workers) assess the problem or symptom to identify methods for remediation, and 3) a treatment plan is developed to eliminate the problem or symptom.

This model can work effectively for acute, short-term, and reversable problems such as dehydration, a biological infection, torn muscle or a fractured arm. These involve a rehabilitative medical response, whereas a skill or ability temporarily lost is repaired. However, the illness model has had a historically more tenuous relationship with alleviation of chronic mental health conditions such as mood disorders, psychotic disorders or addiction, and the rehabilitative nature of the model often has no applicability to persons with significant physical, intellectual or developmental disabilities.

The challenge to the professional mental health service system is that many individuals with longer term disabilities will more likely need habilitative services. These are services that assist people in adapting or accommodating skills or abilities that may never have been in place. Although the different types of mental health services and supports may be deployed in either a short or long-term manner, in many ways the traditional illness model emphasizes continued reliance upon a professional system of care instead of focusing on individual recovery. As a result, the utility of the illness model for persons with longer-term mental health and physical/intellectual disabilities is rather limited.

A self-directed care model attempts to move professional services from a problem-focused to a recovery-based approach. It does this by building on the person-centered planning process to expand service decisions to be based on the strengths and interests of the individual. The longer term arc of recovery from significant mental health, addictive, and physical/intellectual disabilities is recognized as a central component of service delivery. As a result, service objectives based on the full range of health, social/family relationships, employment, civic participation, and education are emphasized. Many of these are areas of recovery that can only be minimally impacted by the traditional illness based model. Self-directed models attempt to further the use of natural supports (i.e. family and friends), community resources, and professional health care services to enable persons to move beyond the challenges of mental illness or disability.

On the surface, self-directed care appears to be consistent with the comprehensive, person-centered planning approach mandated by the Michigan Mental Health Code at 330.1712. However, self-directed models take the planning and service delivery process further by implementing these key foundational elements: 1) Individual control, 2) Personal responsibility, 3) Individual choice, and 4) Avoidance of conflicts of interest (Cook, Shore et al., 2010). These elements ensure that the individual person is invested in care decisions that will be supportive of the most important aspects of their lives.

The first element of self-directed care is ***individual control***. This is evidenced by the development and implementation of a person-centered recovery plan inclusive of the future goals, professional services, natural supports, actions, and timelines as defined by the individual. This is essentially the person-centered mandate from 1996. The individual controls the planning process, the persons/family members present, and selects the location of the meeting themselves. This establishes the concept of the individual being in control and responsible for their own recovery.

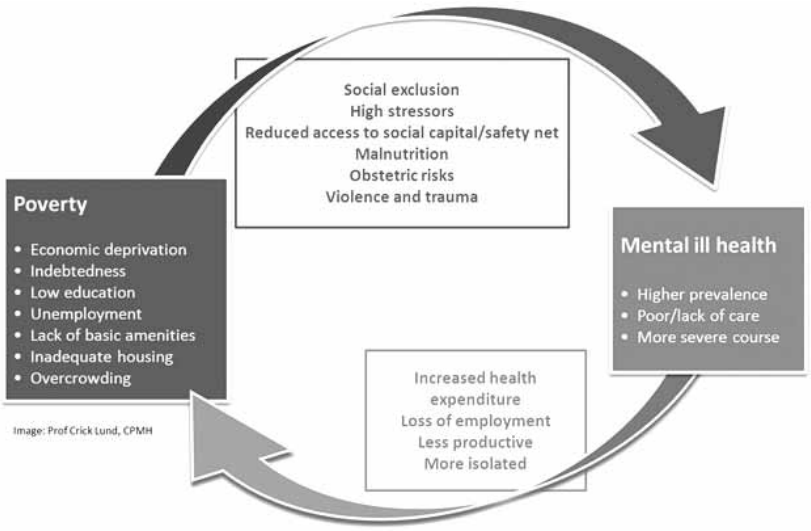
The second fundamental element is ***personal responsibility***. The individual works with professional staff to develop a budget to allocate resources for accomplishing the goals of their recovery plan. Although there *(Continued on page 19)*

Poverty and Mental Illness: *the relationship goes both ways*

Robert Sheehan, CEO, Community Mental Health Association of Michigan

Those of us with mental illness, who have friends or family members with mental illness, and those of us who serve, support, and treat persons with mental illness are often struck with the high rates of poverty among those with mental illness. What research is underscoring is that there is a two-way link between poverty and mental illness with each causing and exacerbating the others.

Researchers from across the country and the world, including Crick Lund, of the University of Capetown; the faculty and researchers at the McSilver Institute for Poverty Policy and Research at the NYU Silver School of Social Work; Chris Hudson, of the School of Social Work at Salem State University; the federal Substance Abuse and Mental Health Administration (SAMHSA); and the World Health Organization (WHO), have given us clearer insight into the bi-directional nature of the relationship between poverty and mental illness. The graphic, below, developed by Dr. Lund, provides a clear picture of the causative factors that link these two conditions.



Research Findings: While the findings, drawn from the work of the researchers and centers cited earlier in this article, are not surprising to those of us in the mental health field, a review of some of those findings, below, is eye-opening, sobering, and for many of us, a motivation for action:

- The rate of adults experiencing mental illness is highest among those with family income below the Federal poverty line
- Persons with the lowest socio-economic status are at eight times the risk for schizophrenia than persons with the highest socio-economic status
- Persons with schizophrenia are four times more likely to be unemployed or underemployed than persons without schizo phrenia
- Adults living in poverty are more likely to experience severe mental illness and have serious thoughts of suicide
- The odds of a household experiencing food insecurity in creased by 50 to 80 percent if a mother had moderate to severe depression
- Families living in poverty are rarely successfully connected with the mental health services they need
- Heightened exposure to violence and other traumas in low-income communities furthers the cyclical nature of poverty, trauma, and mental illness.
- Adults aged 26 or older living below the poverty line were nearly twice as likely to experience serious mental illness than those living at the poverty line and nearly three times as likely than those living above the poverty line
- Poverty has been shown to increase the likelihood of the onset of mental illness

Action needed: SAMHSA, WHO, and others thought leaders have outlined a number of actions designed to address both of these conditions and cut the link that exists between them:

- Implement a range of anti-poverty initiatives, with an eye to ensuring that persons with mental illness have access to these initiatives, including:
  - Increasing employment opportunities, with fair wages, to persons without higher education
  - Improve access to sound and affordable housing
  - Improve access to healthcare with an emphasis on maternal healthcare
- Improve access to mental health care, with an emphasis on early intervention for chidren, adolescents, and adults
- Implement efforts to reduce childhood trauma and violence including:
  - parental support, education, and guidance
  - substance use disorder and mental health treatment for parents
  - community-based crime and violence prevention initia tives

These actions are not extraordinary. They represent the aims of many of us and the conditions that many of us believe are core to a civil healthy society.

LIFTING the ROOF:

Strengthening & Improving Transparency in Community Mental Health Agencies | Jeannie Goodrich, CEO, Summit Pointe

Jeannie Goodrich received her bachelor's degree with an emphasis in organizational management from Spring Arbor University and her MBA from Notre Dame University. In addition to being the CEO, she also is a member of the Regional Health Alliance Leadership Cabinet, The Coordinating Council Leadership Cabinet, and a Trustee for the Union City School Board.

Creating effective governance for a community mental health services program is primed with great challenges. CMH organizations are public governmental agencies that are formed to provide services to a patient population that has chronic mental and behavioral health conditions. The mechanisms to provide this care, the funding and the overall matrix of rules that govern the public entity are complex and governance that maintains an appropriate balance of efficiency and oversight can at times be difficult. The lack of balance in either direction can prove to be problematic for the organization.

Since 2015, as the new CEO of Summit Pointe/Calhoun County CMH, I was challenged to create an environment and culture that would create the right balance of efficiency and oversight with a newly minted *leadership team* and a newly appointed board. The board was clear in their direction to me as the new CEO, "Create a culture and environment that is transparent to the community, the staff, and the patients of Summit Pointe," and create this culture and environmental shift while sustaining the volume of high quality clinical services to the residents of Calhoun County. From that point in time, it would feel like we were starting a new agency while still operating an existing one!

On the staff organizational level I ensured that communication was available to our front line staff and that I was available as much as staff needed to answer questions, to ensure that staff felt secure with their positions and to provide proactive communication about the changes in our everyday procedures. On the leadership level, I created a team that had a mix of seasoned leadership members, some from within and outside of the CMH system, in addition to staff of Summit Pointe that have always been the informal leaders of the organization. This helped build the trust of the existing front line staff quickly as they saw some continuity of our organization.

On the board level, we were establishing a new organization. First, we established a five year strategic plan that received feedback from our patients, staff, providers and the community. The board established, with that feedback, a solid strategic plan that would encompass a blend of strategies including staff development, exploring stronger community collaborations, strengthening our provider network, and overall enhancing Summit Pointe presence in Calhoun County.

The board itself identified through the strategic planning process that they needed to examine and put into effect the proper governance. The governance style that evolved very quickly with the events in 2015 was an extraordinarily heavy dose of oversight that was necessary until the proper oversight by a functional Summit Pointe leadership was put in place. Once there was stability within the leadership team and key positions filled, the board could then begin rebuilding an effective governance style that would ensure the proper compliance and oversight.

Together with management, the board implemented board policies that they felt would sustain the organization long term, meet statutory guidelines, and provide the right balance of oversight and monitoring needed. In addition to the board policies, they also reviewed and approved bylaws that provide a subcommittee structure focused on human resources, finance/audit, corporate compliance and IT. Through this process, there are designated board members serving on the subcommittees who provide oversight to these functions and where appropriate make recommendations for action to the board.

Within the organization, I have built a leadership team structure that has evolved since 2015. While rebuilding the board level governance, the internal management oversight had just as much auditing and monitoring to be done. There have been foundational financial and compliance policies implemented that are required as a CMH organization. These are the two areas that have had the most structured change with both policies and process. I have now made it a personal goal to strike the right balance between efficiency and oversight for the organization– and in what I would still consider an *(Continued on page 19)*

Jeannie Goodrich

Using Adaptive Leadership to Address the Challenges and Opportunities of Section 298 – *One Leader's Approach*

Lisa A. Williams, Ph.D., Executive Director
West Michigan Community Mental Health

When I was first invited to attend a meeting on Section 298 in February of 2016, with then Lt. Governor Calley, I never thought I would spend the next several years trying to navigate, advocate against, understand, resist, and ultimately build a model for Healthcare Integration in Michigan. On that day in February, I could not envision a circumstance where West Michigan Community Mental Health (WMCMH) could support the concept of financially integrated managed care in Michigan, let alone apply to become one of four Community Mental Health Service Programs (CMHSPs) in the state to lead this effort. Although our organization had clearly crafted its mission, vision, and strategic plan with an understanding of the national healthcare drivers narrowing in on integrated care and funding, I must admit that the constructs we embraced around integration were clearly focused on care integration but theoretical and vague when it came to financial integration. We knew the care concepts would result in better outcomes for the people we serve, but we were skeptical about the necessity of financial integration to support this outcome.

The 298 Pilot and much of the work done within the context of the pilot have personally and professionally challenged my understanding of what it means to be a leader.

The 298 Pilot and much of the work done within the context of the Pilot have personally and professionally challenged my understanding of what it means to be a leader. WMCMH's internal work with Jeff Lawrence, a leadership consultant whose expertise is in *Adaptive Leadership*, has helped me to gain perspective on the challenges associated and leadership opportunities contained within the 298 Pilot, not only for myself but the entire leadership team at WMCMH. The competing perspectives I experienced and described above really epitomize most of my experience and leadership learning associated with being a part of the Pilot. That said, my internal tensions and continuum of experience are not unique to leading in the context of 298. These types of tensions become real in the work leaders in any system or business experience when they have come to the realization that the outcomes they are trying to achieve for their business are no longer attainable in their current operational, organizational, or systemic context.

The answers to three critical sets of questions helped WMCMH describe and gain insight into the tensions we felt when we came to understand that we were quite literally stuck in a constant cycle of problems and obstacles with limited solutions. Thinking through these questions was a pivotal point of discovery in our organization, not just specific to 298, but to other challenges we had been facing. I'm confident that other leaders who read these questions can infer many of the internal dialogues and questions that our organization faces. Perhaps they are even some of the same questions you asked yourself as your organization approached the many challenges and perceived threats associated with 298. As the Executive Director for WMCMH, our responses to these three questions changed my role in 298 from a leader who strongly advocated for maintaining the current system and advocated against 298, to actively pursuing relationships with the Medicaid Health Plans (MHPs) and applying to become a 298 Pilot Site.

Question 1: What is the role the leader plays? More specifically, where does my loyalty as a leader lie? Am I loyal to the current way of doing things or to the outcomes we've described for the organization as a whole?

I came to WMCMH almost 20 years ago in the midst of a family crisis. WMCMH was intended to be a brief stop along my way to a different job, back in line with my career aspirations. Literally, my plan was to be at WMCMH for six months and then to return to academia, research, and teaching. What happened in those six months changed my career trajectory forever. Everything I had been taught about community mental health as a clinical psychology graduate student went by the wayside as I got to walk in and experience the vision of community-based mental health services. The commitment within the organization to advance recovery and self-reliance for persons with chronic mental health, substance use, and intellectual and developmental disabilities grabbed me by the heart and planted me firmly on the ground exactly where I had never imagined being. As a leader in the organization 20 years later, my loyalty still

lies there, exactly at that place, dedicated and convinced of the importance of community-based services for the people we serve.

Question 2: What is the nature of the work we are trying to accomplish? Can we continue to tweak to try to attain the desired outcome or is it time to look for a better way to achieve the outcomes? When is the problem no longer "tweakable"? Are we continuing to perpetuate the problem by not looking outside our current understanding? Is there a more sustainable, different solution that will achieve the desired outcome?

My ability to serve the organization and achieve the vision that drew me into this work has been fundamentally challenged by funding, system structures that create barriers to access, and boundaries that make physical healthcare access to the people we serve insurmountable. Although my loyalty remains strong to achieving outcomes for people we serve, my beliefs about how to accomplish that have dramatically changed.

All of our organizational efforts to advocate for better funding, apply for grants, redesign internal and external administrative structures have bought us time but ultimately borne little fruit in terms of securing sustainability of services for our communities. We have co-located in primary care and have attempted primary care co-location in our service sites. We have shared staff resources with other organizations to maximize access and outreach. Our staff has spun themselves in knots attempting to improve outcomes while tweaking processes, revising policies, and addressing barriers that in the end result in little progress. This is not because our efforts are tempered or are misguided. It is not because our productivity is insufficient or our performance is poor. It's because the process tweaks and the policy changes are no longer sufficient to achieve the outcomes that we aspire to for our organization, our communities, and most importantly the people we serve.

Our organizational decision to meet with the MHPs and explore different mechanisms for integration was not one we took lightly. I still remember the July Board meeting where my board chair courageously encouraged me to begin reaching out to MHPs to explore other ways to achieve the outcomes critical to the people and communities we serve. He, like me, could no longer see additional ways to exert pressure on our existing structure or demand more of our team. He could see no effort that could result in any outcome other than more of the same. Our fears and our perceived sense of loss of stepping outside of our comfort zone became less important that day than our desire to get a better outcome for the people we serve. It was both that unbelievably simple and that incredibly complex.

Question 3: **How do we maintain perspective and focus when it becomes clear that a significant change in approach is necessary? When it's clear that the current approach isn't working, how do I hold true to the organization's values while asking the team to take an approach well outside their comfort zone and current understanding? And, most importantly, how do I make the purpose of the change clear and hold the banner high for the individuals who are scared of or threatened by the unknown?**

WMCMH had been solidly in step for years with our Association and our CMH and PIHP colleagues in protecting a carve-out in Michigan. We had built our organization to be responsive and strong in managed care and had invested significant resources and time in helping form collaborations with other entities, two separate PIHPs, and strong relationships with local partners. But the resistance we feared was less important to us organizationally than the benefits/outcomes we could begin to see from considering a different way. Well in advance of the pilot RFI, we began by reaching out to individual MHPs and by vetting conversations with MDHHS, trusted colleagues, and experts. We started by sticking our toe in the water by having discussions with individual leaders in MHPs, forming relationships, asking questions, and researching other states' efforts and outcomes. We had hard conversations with other trusted colleagues within the system that we knew would be challenged by our decision to explore a 298 pilot but who we believed could give us balanced feedback. We found, not surprisingly, that we were not alone in our experience that all of our best efforts and skills at fixing problems in-house and in current context were not working. And, we also found understandable resistance.

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As 298 has progressed, these three leadership questions are consistently a part of discussions within our organization. We ask these questions now specific to challenges and debates about what particular types of changes can be tolerated to advance integration and what types of changes are too risky or pose too great a threat. If the change cannot be reliably perceived or projected to result in a better outcome for the people we serve, then the cost is too great. Change for changes' sake is not okay. Change because it's easier is not okay. We consistently *(Continued on page 18)*

Hal Madden and Me | Robert S Lathers, LMSW

2019 Distinguished Alumnus of Grand Valley State University School of Social Work

The following is the acceptance speech delivered by Robert S Lathers in October, 2018 as the recipient of the Hal Madden Outstanding Service Award. This award is given to an individual annually by the Community Mental Health Association of Michigan in recognition and appreciation of their exceptional efforts as an advocate and ambassador for community mental health services and the people we exist to serve. The dedication and compassion of the awardee stand as benchmarks for all those who are committed to providing quality services in the community.

I first met Hal Madden when I was 15 years old and he scared me to death.

Hal was the Assistant Superintendent of Schools in my community, a four-year veteran of the Marine Corps, and a former defensive end and basketball player at Central Michigan University. He had an opportunity to tour the Mt. Pleasant Center while in college and claimed that it was a life changing event for him. "That's no way for people to live," he was known to exclaim when he told the story. That experience led him to be a life-long advocate for persons with mental health and developmental disabilities.

I, at 13 years old, through a highly traumatic event became an orphan and went to live with my six brothers and sisters with my aging grandparents. For the most part I was left to wander our Polish Catholic neighborhood and the city at large. But it seemed that everywhere I went I was always encountering teachers or school administrative staff who would never fail ask me, "What are you up to?" and was I "fifteen yet?" because at 15, I could get a work permit and get a job. I managed to land a *Detroit Free Press* paper route, but when I turned the magical 15 "Hal's people" contacted me and signed me up to work in the Federal CETA Youth Work Program for disadvantaged youth.

My first job paid $1.35 an hour and it was washing windows at the school administration building where Hal Madden's office was. It was a terrible job. Hal himself was constantly checking my work and mostly disapproving it, always with the admonishment from Hal, "You can do better!" I hated it. Through my charm I was able to convince the head of the maintenance department to reassign me. So, they put me to work scraping gum off the bottom of desks at the Jr. High. Do you know how much gum is stuck to the bottom of those things? It made me not like gum for a long time.

Then, the maintenance department (no doubt at the suggestion of Hal) decided that I would paint all the chain link fence in Ludington. To this day I swear that the city has more chain link fence per capita than any city in the country. The paint was a glossy rust resistant silver color. At the end of each day when I was walking home from that day's painting assignment, I looked like the Tin Man. People and kids in cars driving by would yell out from their rolled down windows things like, "Hey Tin Man" or "There's a tornado coming" or "Have a heart" and my personal favorite, "Dorothy is looking for you!" But nobody ever offered me a ride. It seemed that Hal would regularly check up on my work and have the maintenance supervisor deliver messages like, "You can do better" or "Don't be satisfied in just doing a job. Do it better!"

As a freshman in high school I tried out for the basketball team, and even though I had very little talent, I made the team. I didn't get to dress for every game, but I was on the team. I made the JV team the next year and dressed for every game even though I rarely played. It didn't really matter to me because I was part of that group of kids. As a junior I tried out for the varsity and at 6'3" I made the team. That is when I first started to suspect that Hal may have been influencing the coach's roster decisions. Then as a senior I lettered on one of Ludington's best-ever teams that lost our final game in the State Semi-Finals at Jenison Field House.

All the while I kept working for Hal and his maintenance department during summers and on weekends, snow days, etc. It gave me a steady income. During my senior year, while I continued to get paid, I fell behind and "owed Hal hours for work paid but not yet worked." Hal's maintenance supervisor would tell me that once basketball was over, they had a lot of work for me to do. But, the day after basketball ended, I decided I would go out for track. This did not sit well with my employer. I had never participated in track. I really was not all that interested in track but saw it as an opportunity to put off making up my hours.

On the very first day of track practice I was approached by a student teacher from CMU who introduced himself to me as Mr. Taylor and told me that he had been assigned as my personal track coach. "There must be some mistake," I protested, "Mr. Gomez is the track coach and I'll be fine with him. Thanks anyway." "Oh, there's no mistake," Mr. Taylor said with a grin, "I am YOUR personal track coach. I've been assigned by the school administrator's office." While I had been thinking about running the mile, I quickly changed it to the half-mile (less work). But Mr. Taylor worked me so hard, I hurt a lot and began to regret extending my athletic career. And then I made all-conference in track.

(Continued on back cover)

DEPRESSION: THE CHALLENGE AND PROMISE OF A BREAKTHROUGH THERAPY

Clint Galloway, Editor, *Connections*

As I write this, I'm filled with hope in spite of the grim statistics –16.2 million adults in the United States, equaling 6.7 percent, have experienced a major depressive episode in the past year. Nearly two thirds of these experienced an episode that resulted in severe impairment. To see a recent account of the statistics, go to: https://www.verywellmind.com/depression-statistics-everyone-should-know-4159056

Depression can be a grim reaper. My father took his own life at the age of 56. Another contributor to this issue, Tom Watkins, lost two brothers to suicide. Chances are that you know of someone who suffered a similar fate. Untreated depression, or what we label as "treatment-resistant" depression, greatly increases the risk of suicide – the 10th leading cause of death in the United States. It's the second leading cause of death among people ages 15-24. Approximately 44,000 Americans die by suicide each year. This is the tip of the depression iceberg.

Nevertheless I have hope; there is a lot of work being done to provide more effective treatment. Even before an individual seeks treatment, the National Alliance on Mental Illness (NAMI) is vigorously chiseling away at stigma which prevents people from taking that first step seeking help. (There is a wealth of stories there!) To capture a glimpse of new and promising treatments, the FDA provides a list of applications it reviews. I quote from their website designed for patients: "Speeding the availability of drugs that treat serious diseases are in everyone's interest, especially when the drugs are the first available treatment, or if the drug has advantages over existing treatments. The FDA has developed four approaches to making such drugs available as rapidly as possible: 1) priority review, 2) breakthrough therapy, 3) accelerated approval, and 4) fast track. Because each of these approaches implies speed, there can be confusion about the specific meaning of each, and the meanings and distinctions of each..." can be acquired here:

https://www.fda.gov/ForPatients/Approvals/Fast/default.htm

Of particular interest for those suffering from depression, is that on October 23, 2018, the FDA granted Compass Pathways a *Breakthrough Therapy* designation for a new therapeutic approach that addresses treatment-resistant depression. More information on how the FDA describes the *Breakthrough Therapy* designation is available at: https://www.accessdata.fda.gov/scripts/fdatrack/view/track.cfm?program=cber&id=CBER-All-Number-of-Breakthrough-Therapy-Requests-Received-and-Approvals.

As positive as this appears on the surface, there is a more salient feature about this therapeutic approach that warrants serious reflection. The dynamics involved in the *preliminary clinical evidence that demonstrates substantial improvement* are far more profound than simply tweaking the neurobiology of our brains. As such, it will require special training of those administering the treatment (elaborated on in the following article). This is indeed a breakthrough therapy, not simply the introduction of a new drug! As such, it will require much more preparation than simply making available a new pill your doctor can prescribe to be picked up at your local pharmacy, while another coin clinks in the coffers of a pharmaceutical company. As such, it will require the development of a new culture for addressing the symptoms that rob millions of quality life.

Since it involves the administering of a psychoactive substance that has been associated with the counter-culture – psilocybin – we will need to address the biases we may have developed regarding psychoactive drugs. We need to make the critical distinction between recreational and medical use; not letting the former contaminate the latter.

There is the additional requirement for a change of how it is classified by the FDA, however, this is definitely the lesser challenge in that their decision will be guided by the careful accumulation of clinical evidence. That is how this breakthrough therapy was selected. Unlike medications we can pick up at the drive-through window of our local pharmacy, this breakthrough therapeutic process includes the critical role of administration of the medication. This, as well, is discussed in the following article. Although we are aware of the push in some states for the legalization of psilocybin for recreational use, this is not discussed simply because we do not support such a move, in fact, such a movement may well threaten the progress of implementing this therapeutic breakthrough designed for medical use if it polarizes public opinion.

Following is an interview with Bill Richards who has been at the heart of this work for more than 50 years. The interview was conducted prior to the announcement by the FDA of this breakthrough therapy for treatment-resistant depression. As such, it does not reference by name this particular trial by Compass Pathways. There are many other research trials being conducted that utilize a similar therapeutic process to address other afflictions which are referenced in this article.

THE POTENTIAL PROMISE OF ENTHEOGENS

A *Connections* Interview with Bill Richards

Connections is providing the following interview with Bill Richards to inform our readers of an emerging school of thought; one that holds both promise and controversy.

It was exactly 60 years ago this fall that I met Bill Richards at Albion College where we were both freshmen pre-theological students. Our shared values quickly cemented our friendship. We ended up becoming roommates for the next three years and our friendship has endured. Bill spent three days visiting me this July, and having read his book, I decided to grab my recorder and capture some of our conversation to share.

Richards pursued a post-graduate degree at Yale University. As part of that study, he spent a year at the University of Gottingen in Germany. While there in 1963, Bill became interested in the Department of Psychiatry and subsequently experienced the administration of psilocybin (a hallucinogen obtained from the mushroom Psilocybe mexicana) that profoundly shaped the future direction of his work. In addition to reading about this in his book, Sacred Knowledge: Psychedelics and Religious Experience*, you can acquire an abbreviated story in,* "How to Change Your Mind: What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression, and Transcendence," *(pp. 53 following) Michael Pollan, Penguin Press, 2018.*

Bill is a clinical psychologist at the Johns Hopkins Bayview Medical Center. In addition to institutions noted above, he attended Brandeis University, Catholic University and Andover-Newton Theological School. He has participated in the psychedelic research at the Spring Grove Hospital Center and the Maryland Psychiatric Research Center in Baltimore from 1967-1977 and at the Johns Hopkins School of Medicine during the past 18 years. Pollan considers Bill to be the bridge between the early research occurring before it was driven underground and the new emergent renaissance.

–Clint Galloway, Editor

Galloway: *Since reading your book, "Sacred Knowledge," in which you provide a comprehensive review of the use of psychedelics over the past six decades, I am discovering that there is a vibrant renaissance of the implications they have for our health and well-being. I must confess my ignorance, no doubt much of which can be attributed to cultural biases which we will get into later, but for now, let's explore the emergent activities that are essential for re-opening the pathways that can harvest its efficacy. It is difficult to avoid using superlatives when articulating the promise that the responsible use of psychedelics holds for addressing many of the symptoms we see every day in our mental health centers. [I will identify some resources during this interview for the benefit of you who desire to learn more.]*

Let's begin by providing definitions. As we well know, words can trigger powerful emotions, skewing our rational mind. At times we use them to persuade and influence our audience. One of those incendiary words – acquiring emotional impact in the 60s and 70s – is the word "psychedelic." You also use the word "entheogen." Please explain.

Richards: Personally, I use both words: psychedelics and entheogens. Psychedelic simply means mind-manifesting. The experiences they typically elicit within human consciousness are non-ordinary or alternate. There are many different kinds of experiences: childhood memories, conflicts, visionary religious states, transcendental or unitive consciousness. "Entheogen," coined in 1979 by Carl Ruck, a professor in Boston University's Classical Studies Department, has been growing in acceptance. Using entheogen connotes a religious or spiritual experience; it literally means "discovering God within." However, there are many forms of experience triggered by psychedelic substances that are not characterized by visionary or mystical content, which most of us would view as having relevance for religion or spirituality. There are many, many different experiences. So there's no such thing as a distinct psychedelic experience. You can access these non-ordinary experiences with psychedelic substances or with natural childbirth, sensory deprivation, sensory flooding, creative

performance, athletic performance, the "runner's high," meditation; there are many ways of triggering these profoundly meaningful states. The value of psychedelics is they provide potency and reliability. So it allows us to study these in a laboratory, a very nicely outfitted laboratory I might add, not quite what we think of with white coats & stethoscopes. It also paves the way for developing new treatments and accelerated psychotherapy for treating depressions, for treating addictions, and PTSD. If these applications for the medical use of psychedelics hold up, as the early pilots indicate, then we're going to see new mainstream treatments in the mental health world.

G: *Tell me about the pilots you are referring to?*

R: There are many studies that have appeared in prestigious peer reviewed journals. A recent one that we're building on, using psilocybin, which is the ingredient in so-called sacred mushrooms which college students call "shrooms," is in the treatment of depression and anxiety in cancer patients. There is a study at Johns Hopkins that essentially parallels one in New York University that finds dramatic improvement in both depression and anxiety after a single administration of psilocybin. This requires a maximum of maybe six hours in which the subject experiences different states of consciousness and then we find it's the memory of that experience in the follow up of over 6 months that decreases or eliminates the anxiety and depression. This involved a single administration of the substance. So it's not a drug like Prozac that you have to keep taking over and over. Rather, you receive the drug in the presence of someone that builds assurance through careful preparation, who knows what they're doing, who uses the pure substance and the right dose. And you have this profound experience, and then you integrate the memories and insights from that experience into your ongoing life. That's quite a new model in psychotherapy.

There is a study at Johns Hopkins that essentially parallels one in New York University that finds dramatic improvement in both depression and anxiety after a single administration of psilocybin.

G: *So, what would be the kind of credentials or training that one might have to have in order to administer this?*

R: Right now we require some kind of mental health certification; a psychiatrist, a psychologist, a social worker, a psychiatric nurse–someone who is qualified to provide what we consider good psychotherapy, eliciting the healing processes from within the person as opposed to imposing suggestions from without.

G: *This does sound different. I'm assuming that there would have to be some differentiation between those who are graduating today with a master's degree in social work or clinical experience and what you'd be looking for in someone who was going to administer the psychedelic.*

R: As of right now, there is a program at the California Institute of Integral Studies (CIIS) for acquiring a certificate in psychedelic-assisted therapy and research. To get into that program you have to be a licensed mental health practitioner. I would urge anyone interested to check them out.

[https://www.ciis.edu/research-centers/center-for-psychedelic-therapies-and-research/about-the-certificate-in-psychedelic-assisted-therapies-and-research]

G: *Is there any indication that there is a growing acceptance or desire to acquire this kind of training or to receive this treatment? In other words, what do you see the future holding?*

R: At CIIS, the current group includes 60 students. (An aside: I hesitate to use the word students because many of them are professors.) However, many really seasoned professionals are eager to become qualified to work with psychedelic substances, either in research or treatment, as soon as it becomes legally possible to do so.

G: *In order for psychedelics to become legally integrated into mental health care, they would need to be rescheduled, that is moved off of Schedule I (or Class A in Europe), which assumes they have no medical use, have high abuse potential, and are dangerous even with medical supervision. How might that be accomplished?*

R: Actually there are two different studies just beginning, one based in London, England, another designed by the Usona Institute in Madison, Wisconsin. [Usona Institute is a medical research organization focused on alleviating depression and anxiety in people for whom current medical treatments fall short. https://www.usonainstitute.org]

Both are designed to apply psilocybin in the treatment of depression. Those studies have been designed in consultation with *(Continued on page 10)*

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the FDA and EMA (European FDA). This research is designed to come up with the data that are required to establish safety and efficacy in order for psilocybin to come off of Schedule 1 and to become integrated into the culture by trained people, for example, to make it available in palliative and hospice care and probably in the treatment of addictions in the near future.

G: *Tell me more about those applications.*

R: People who receive psilocybin, and especially those who have deep visionary or mystical experiences, afterwards report decreased anxiety and depression--sometimes it's eliminated. They report more meaningful interpersonal relationships; they're "living until they're dying" instead of lying bed-ridden from their depression while approaching death with cancer. Many people report decreased preoccupation with pain and need less medication. But what's most interesting is that those who have these deep mystical types of experiences typically claim to have lost the fear of death. And instead of being anxious about death, they're kind of curious about it. They have no desire to speed it up, but the focus is on being thankful for every day they're given and to live each day as fully as they can, with the intention of spending their final days with the people they love, and maybe with a little music and laughter instead of feeling hopeless, depressed, trapped, and anxious.

G: *Two questions come to my mind…*

R: Only two? *[laughter!]*

G: *First question, how many palliative centers are actually using this now? And the other is, where could I find some studies or reports that would illuminate this practice?*

R: How many centers would use this? That's unknown. We haven't reached that point. I know there are oncologists who are very interested in being able to offer this as part of their treatment in their oncology centers, so this remains to be seen. But we do have published studies; one of the best places to go to is the website of The Heffter Research Institute.

[https://heffter.org/]

For those who want to look at the statistics and research design, you will also find them primarily in the *Journal of Psychopharmacology*.

In April (2018) *The Journal of Palliative Medicine* published an article, "Taking Psychedelics Seriously." *[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5867510/]*

G*: It appears that while the studies show great promise, the actual practice is in its infancy.*

R: Yes, but the promise is based on experience which actually extends over several decades, and it's a fairly substantial experience. There are numerous teams working in different areas we haven't mentioned and in a number of Universities. For example, there's a study at the University of Alabama in Birmingham using psilocybin in the treatment of cocaine addiction, work with alcoholism at New York University, and with nicotine addiction at Johns Hopkins University.

G: *Talk more about the work with addiction.*

R: What is there in the psychedelic experience that can impact a longstanding addiction? Bill Wilson, the co-founder of AA, was very supportive of LSD being used in the treatment of addictions. But the AA Organization has considered that embarrassing.

G*: Why was he supportive?*

R: It was based on his personal experience.

G: *What is there about the experience that addresses the addiction?*

B: It seems to be the change in how one views oneself, other people and the world. It's like discovering parts of your mind that you never knew were there. They're beautiful, strong, creative, loving and when you awaken to those realms within, why would you put anything in this wonderful body that would damage it, and why would you pretend to be a hopeless failure because you know better; you know by experience, to use the language of "a Higher Power," that there are resources available, that are really real. It's not just an abstract intellectual concept, it's not even a belief, it's a fact. You've related to it; you've experienced it, and it's an unforgettable experience.

G: *It's that experience that constitutes the healing?*

R: It's the memory of that experience; taking the memory of that experience into everyday life. It helps to have a supportive group in which to do that. This facilitates a process of integrating an internal experience into your outer life; it's not magic for most people. It still takes work, but there's something you know, if you want to use the word God, that "god" is real, or there's something incredibly meaningful and loving and constructive and intelligent within your consciousness. We recently had a very deeply dedicated atheist who said, "I'm still an atheist, that's my religion, but I saw God." *[laughter!]*

It's the experience people have in the depths or heights of their minds; they know it first-hand. It seems to be within us, a given within our consciousness and people of any culture, any religion, and any non-religion, seem capable of discovering this experience.

G: *This "change of mind" sounds different than what I usually think of when I imagine what the person on the street would say lies at the root of addiction and how to treat it. What seems to be the dominant perspective in the therapeutic community regarding addiction?*

R: There are many different languages and conceptual schemes used to try to understand it. But as a whole, people who fall prey to addictions are often feeling overwhelmed and under-supported in life and they feel the need to escape from the pressures of everyday living. They are out of touch with their inner resources to cope constructively with their stressors. Then depending on what the substance is, some physiological syndrome kicks in that seems to make the body crave that substance. One of the most dangerous addictions that kills the most people is actually nicotine. We've done pilot research at Hopkins where one to three psilocybin sessions were offered to people who had been addicted to nicotine for an average of 31 years. In a six month follow up, 80% were nicotine free.

People mean a lot of different things when they talk about depression. It's not just feeling sad. It's often feeling numb, having constricted awareness, a downward, repetitive spiral in thinking…

That's incredible, just in the terms of preventing death. The number of people who die from lung cancer and nicotine-related illnesses every year is immense, not only in the US but in China and throughout the world.

G: *And then you factor in the enormous cost to the health care system that is acquired during the stages of the disease.*

R: That's right, and if the research holds up, we now have this substance called psilocybin, that is administered once under ideal circumstances, is non-addictive, non-toxic, and has effects that may last for months if not years, in terms of helping people stay drug-free.

G: *Again, what comes to mind is the need for personnel who are going to be qualified to administer this. Talk more about its use in treating depression. That's one of the most common illnesses that afflict people.*

R: People mean a lot of different things when they talk about depression. It's not just feeling sad. It's often feeling numb, having constricted awareness, a downward, repetitive spiral in thinking, a narrowing of consciousness, if you will, and a feeling of hopelessness, feeling trapped, a lack of joy, lack of playfulness, lack of spontaneity. Robin Carhart-Harris in London at the Imperial College posits that psilocybin essentially resets the default mode network of the brain, the area that controls the life of the ego. It's sort of like throwing things up in the air and letting them land in a fresh, new way that opens up new pathways within the brain to sections that have been sealed off or forgotten.

["Psilocybin for treatment-resistant depression: fMRI-measured brain mechanisms" Robin Carhart-Harris
https://www.nature.com/articles/s41598-017-13282-7]

It sounds very simplistic, and it is, but it's a helpful medical description of the kind of getting out of the ruts a depressed person is stuck in and kind of resetting the way you are in the world. There really is beauty in the world; there are people who care about me; I do have some talents I haven't developed yet; I've got some resilience to go for things; I want to learn; I want to set some goals. It's like a whole new world waking up that has always been there but the person has lost contact with it.

G: *Or never had contact?*

R: Yes. You can get into developmental issues, issues of being abused or deprived as a child. There's a lot of early suffering in life that often appears to lay the foundation for depression later in life.

G: *Bill, you have been a part of a vibrant, but generally unrecognized research trajectory for over 50 years. What do you see the future holding regarding the use of psychedelics for our mental well-being?*

R: I hope to live long enough to see them legally integrated into hospice, palliative care, addiction treatment, treatment of depression; I think that could happen within the decade, maybe closer to 5 years. We'll see. It might happen in Europe before it happens in the U.S. – or it may not.

G: *What are the biggest challenges?*

R: There is good research that *(Continued on page 12)*

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needs to be completed, that's been designed, and is being implemented. It's in process. We need to wait for the results of the really big research studies before the FDA would feel comfortable in making psilocybin legal. But there's also a whole lot of misinformation, prejudice in the culture, and echoes of the craziness of the 1960's that need to be addressed. There are a lot of well educated people who, when they hear the word 'psychedelic', think of, if not deformed babies and people jumping off skyscrapers, it's the crazy kids in Golden Gate Park saying "make love and not war" and not going to work. The stereotypes need to be corrected. The drugs really are very safe when used responsibly.

G: *Would you agree that they can be misused and perhaps lead to a lot of crazy behavior?*

R: There's probably no drug out there that can't be abused, misused, etc. Marijuana used responsibly by those who choose to do so now and then can be abused by chronic smoking all day long and not working. It's not the marijuana; it's how you choose to use it. Alcohol: we can have a glass of wine with dinner or become an alcoholic who's not going to work and has liver damage. So it's not just the drug, but it's how the drug is used and the reason it is used. With psychedelics there's a huge difference between what's usually called recreational use, which is usually very low-dosage and often in a large group at music festivals, etc. and the serious medical use, which is one-on-one treatment of depression or addiction or whatever. With careful preparation, skillful guidance, wise use of music during the period of drug action, a safe confidential physical setting and help to apply the insights that occur, we facilitate outcomes that tend to be very different from just taking some mushrooms at a concert.

G: *Is there anything else you would like to say?*

R: We have in our midst a very fascinating frontier that could transform mental health care, or at least provide a viable alternative to what we're able to offer right now. I think there will always be people who just want a drug to make them feel better and who are not interested in the psychological work that psychedelics require. Some people don't want to go through their grief and their guilt in their bleakest hour; they just want to chase the anxiety away. I personally have seen hundreds of people, many hundreds, who have dramatically benefited, and they've been people from all different occupations, ages, races, degrees of physical health, cultural backgrounds, men and women.

G: *What are the youngest?*

R: We have always restricted the use to people 21 and over. That's controversial enough, but it doesn't mean that this form of treatment could not be helpful to younger people in certain ways.

G: *That brings to mind autism, has there been any research there?*

R: Yes there has been but I'm not qualified to address this area. You might contact Alicia Danforth who has some experience in this area at UCLA.

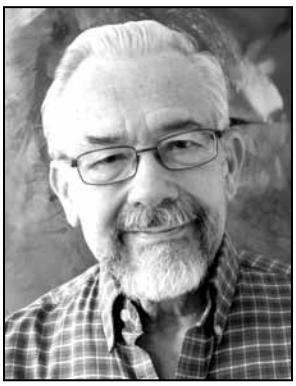
[https://www.aliciadanforth.com/faqs/]

G: *That sounds like an area that is more in it's infancy than some other areas you've mentioned.*

R: Yes. However in the big picture, besides being applied in medical treatment, psychedelics provide us with an incredibly valuable set of tools for understanding human consciousness, the mystery of what we are, and in that framework it has religious and educational implications, as well as medical implications.

G: *Which is to look beyond its application to our deficits, where we are suffering, to that of exploring our human potential.*

B: Yes. My friend Robert Jesse, is the Convener of the Council on Spiritual Practices (csp.org). CSP's interest in non-ordinary states focuses on "the betterment of well people," in contrast to the medical-model treatment of patients with psychiatric diagnoses. There's a lot of interest in facilitating creativity; there may be value for people who are considered high-functioning. If you want references for this kind of work, besides my own book, see "How to Change Your Mind: What the New Science of Psychedelics Teaches Us About Consciousness, Dying, Addiction, Depression and Transcendence" by Michael Pollan. (2018). He provides a comprehensive history of the past, present and potential future.



Bill Richards

Creating a *Life* that Starves Addiction

Amanda Franklin, Certified Peer Recovery Coach, West Michigan Community Mental Health

I was born into a family where my 2 younger siblings and I went to church every Wednesday night, Sunday morning of course, and Sunday night. We were very involved in our church and the friends that I can remember coming over were of the church fellowship. I belonged to the youth group, and was *en fuego* for the life I had created for myself. My parents have always installed in us great morals, work ethics and standards to exceed our potential. I never witnessed my parents drink, and there was never a drop of alcohol or drugs in our home.

Since I have been able to talk, I've been in love with music and singing. I have recorded in the Barbara Mandrell recording studio, won the Jimmy Dean Country Showdown, opened for John Anderson, auditioned for American Idol, sung in countless weddings and Relay for Life, and wound up at a local community college, fresh out of high school, with a full scholarship singing with the Collegiates.

Even though I was still living at home with my parents when I went to community college and, I was introduced to a new and intriguing lifestyle. After growing up in a home and environment with no exposure to alcohol or drugs, I was suddenly exposed to both. My life changed dramatically. It was filled with nights of drinking and barely making it to class.

When I turned 18 years old, I met someone who I thought would change my life. I was right. He changed my life. There are a lot of things that I share that are personal to me; this is a part that I will just sum up in two words: self-hatred. That's what I felt from that point on.

I did everything in my power to numb whatever pain I was feeling. I quit school. I retreated into my room in the home I still shared with my parents. They had no idea what was going on with me. I refused to talk with my friends. I went to church because it was "required" of me to go. I no longer felt that I had any worth. I absolutely despised what I saw when I looked in the mirror.

I worked at a little bar in my hometown, and became the head bartender there, making more money than I knew what to do with. While working at this bar, I would run up tabs that exceeded my paychecks. One night while running up my own bar tab, I met a girl who was very well liked and popular in our community. "S" and I became the best of friends, so close a friend that she was in the delivery room when my son was born. We were like Thelma and Louise.

"S" introduced me to people that I thought were important, and to things that I thought mattered. She taught me how to make money. She was my partner in crime, in all the literal senses.

I found myself pregnant at 26 after a one-night stand following the closing of the bar. I remember thinking, "there's no way that I can take care of a baby, I can't even take care of myself!" I called my mother who told me the harsh reality that I needed to shape myself up and get my life back into order.

I quit the bar, started working for my parents at their store, as a DOT Drug and Alcohol Collector. Mason was born in February of 2005, in room 225, at 2:25 am, my little miracle baby. You would think that a newly single mother would have only one priority in mind. I had the best intentions of taking care of Mason and being the mom that he would be proud of, heck, that *I* would be proud of.

I found myself pregnant at 26 after a one-night stand…I remember thinking, "there's no way that I can take care of a baby, I can't even take care of myself!"

I was once told that my addiction wants me dead, but will settle for miserable. Addiction waits. It has all the time in the world to wait for a moment of weakness to come crawling back. Addiction will *always* take you back, in a heartbeat. That moment of weakness followed soon after having Mason. I began a self-maintenance program, and I felt that if I used after I put my child to bed, and shut the bedroom door of his room, that I was being a good mother.

"S" had a daughter who was six the first time I saw "S" hand her a joint. I remember thinking to myself, "I will never be that kind of mom." I watched her put a needle in that little girl's arm. I watched as she went to rehab at the ripe age of 12 after she stabbed her mother with a knife during a dispute over a pill.

I ignored every warning from my mother, thinking that my mom didn't know "S" like I knew her. And I told myself that I would *never* be that bad.

A house that I rented (conveniently, from S's parents) became party central. I began using cocaine, and of course

(Continued on page 14)

Creating a Life *(From page 13)*

crack followed right behind. I had found heaven and hell on earth. I loved and hated that drug more than everything in my life.

I also found that people wanted to be around me while I was using, because I was fun, happy, and social. I never took into account that I was also their dealer. Addicts love you when you're providing them with something.

In 2007, "S" introduced me to a gentleman that I married in 2008. He worked at the prison and we were extremely toxic for each other. There were so many fights, arguments, and physical altercations between us.

I was diagnosed with an illness that had me follow up with a doctor regularly. I found Dr. "Feelgood." He gave me literally anything that I asked for. I was learning things from "S" about what to ask for and how to ask for it without sounding like I was drug seeking. I began a routine. I knew what to take to make me feel better at *all* hours of every day. I had mastered self-medication.

In August of 2012, I put my seven year-old son, Mason, to bed. I was dyeing my hair, and took my nightly ritual of a handful of pills that night. I woke up several hours later in the bathtub with the water running. I watched my son with tears in his eyes and fear written all over his face as he shut the water off. Mason saved my life that night.

I put my seven year-old son to bed…and took my nightly ritual handful of pills. I woke up several hours later in the bathtub…I watched my son with tears in his eyes and fear written all over his face as he shut the water off. Mason saved my life that night.

In and out of consciousness, I told him, "Do not call the police," not for my benefit, but for his. Mason's biological father had not been involved in his life; there is no name on his birth certificate. He would have been placed in the care of the state immediately. I knew that much. Mason instead speed dialed my in-laws accidentally, and they got hold of my parents, threatening to call Child Protective Services if my parents didn't remove him immediately.

My parents came and took him from my home. I had fractured my femur during my fall in the bathtub and was in major pain and knew only one thing to help my pain. I was not in the right frame of mind when they took him. Still, I was okay with it. The night I took that handful of pills I remember thinking to myself, "If something were to ever happen to me, Mason would be loved so much better by my parents. I'm not worthy to be his mother."

My Dad called the next day and told my husband to pack up everything I was taking (all the substances I was using) and to bring me to him. He took me to the hospital in Cadillac, where we met Ed and Phyllis Gilbert. Ed Gilbert is an individual who woke up 40 years ago, on the streets of California ready to take his own life after being lost in his own addiction. He heard the voice of God telling him that He had more in store for his life. Ed has been sober ever since and is now a Pastor. It took us three and a half hours to make a 45 minute trip to Cadillac because I was so sick. I was in detox because my Dad had all my "stuff" on him in a brown paper bag. I was so angry with him. He could clearly see how sick I was and wouldn't listen to me about what I needed to do to *not* be sick. He just kept pulling over for me to be sick.

When we arrived, a male nurse took us into a room and he started taking pill bottles out of the brown paper bag. Each one, I claimed, "wasn't mine." I looked over at my Dad, who was sitting with his head down and hands held together. For the first time in 34 years, I watched my father sob. I looked at the nurse and said, "I think I have a problem." I'll never forget his next words, "Honey, you've taken the first step into your new life." He then gave me a shot of morphine, and sent us on our way to Traverse City, where they had arranged a detox facility for me there.

I spent six *awful* days there. Detox is not something you can put into words. To explain: it's pure agony. Knowing that I had done it to myself, made it worse. Following detox, I went to Munson Behavioral Health Center, for their 14 day rehab program.

I found out on my first day there that I had eight felony warrants out for my arrest. I contacted the sheriff back home, and they allowed me to finish my program with the intent of turning myself in when I completed rehab. My then husband asked for a divorce over the phone, which I quickly agreed to, knowing that we were so insanely toxic for each other.

I never did anything small. I never smoked half a joint. I never drank half a drink. I never snorted half a line. While I was in rehab, I decided that my recovery was going to be the same. I couldn't do it by half. I had to go big, or I was going home.

I completed rehab and returned to my hometown of Manistee, and turned myself in. I bonded out and awaited my sentencing. I was sentenced to a jail term.

I was cleaning one night in the cell with the other inmates when one of the guards who was supervising us, asked, "Why'd you go to rehab before you came here?" I did *not* hesitate with my reply, "Why do people come *here* before they go to rehab?" It was then that it clicked.

- I had a disease.
- had an addiction that wanted to take my life from me.
- I realized at that moment that I was worth something.
- That my life *did* matter, and I could stay sober.
- Not only could I, I *wanted* to.

After my release from jail, I had two years of probation, three meetings a week, an incredible amount of fines, and random drug tests at my probation officer's discretion. I started working a program, I went to meetings *five* days a week, I obtained a sponsor, and I started a Facebook recovery page that now has over 10,000 likes, and reaches over 212,000 people daily. That's a lot of recovery!

I paid back people who I owed money. I started paying on debts that I had racked up during my active addiction. I had a $50 co-pay for each ER visit (I had used the ER as a means to get my substances when the streets didn't work for me). Six years later, I am still paying monthly on a $17,000 bill of emergency room copayments.

When I was almost a year sober, I was sitting in an AA meeting at noon. In came walking this blue-eyed, cutest boy I'd ever seen in my entire life. I literally told the girl who was sitting next to me that I was going to marry him. She laughed it off; she obviously didn't know me very well! My sponsor was completely against the two of us being together until I had one year of sobriety under my belt. I was angry at this decision she decided to make *for* me! She wasn't the boss of me, in fact, I even told her that many times!

Whatever her reason, I listened to her. On my one year sober birthday, I received my anniversary coin and we went out on our first date. Soon after we started dating, he lost his brother to an overdose. I was there while I watched him agonize over this passing, and I was there when he relapsed because of not knowing how to "handle" his emotions, just like I once did. Not for one minute did I give up on him or our relationship. There have been many bumps and trials on our journey together, but I wouldn't trade them for anything.

Today this man is my best friend. He's the one that I cry out to when I am struggling. He's the one who holds me up when I cannot pick myself up from the day. He's the man who is adopting Mason as his own. He's the man who made a name in this community and turned it around and rose from the ashes. He's my recovery partner, and my husband of five years.

I started as a Peer Recovery Advocate at WMCMH on the Recovery Management Services team on February 1st, 2017. I am now one of the Certified Peer Recovery Coaches at WMCMH. I have the opportunity every day to walk with somebody in their recovery journey. Whether they're walking the straight and narrow path of recovery, or not even considering it at the time, I have the joy of being able to come up beside them and to walk with them. It's my role to believe in them until they begin to believe in themselves, to gain their trust by sharing my personal story, to let them know that they're not alone and that they have somebody in their corner to help them when they come in and say, "I want to get sober, but cannot imagine a life where I stay that way."

I'm grateful for a heart that today beats for a life that lives and breathes recovery. I'm grateful for a life beyond my wildest dreams.

My motto is this: I don't know how to do much, but I do know how to live life sober. I know what it takes when life throws curveballs at you and the only thing you know how to do is run back to the addiction that will take you back at any given second.

I absolutely love my job. I walk into the doors of WMCMH every day knowing that it's going to be a hard day, but completely worth it.

The Recovery Management team goes into jails to give a warm "hand off." We go to courthouses and sit and talk with prosecutors, lawyers, and judges. We go to doctors' appointments, funerals, and help people give blood because the thought of a needle going into their arm after sustaining recovery can be overwhelming for some.

I love the agency I work for. I love how we take care of our community. I am proud to come to work and to see the awesome people I work with who take such pride in their work and have a passion for their work.

For me, this has never been a job, it's been a lifestyle. And I'm grateful for a heart that today beats for a life that lives and breathes recovery. I'm grateful for a life beyond my wildest dreams. I'm grateful for a life that is exactly that.

A Life.

Pictured are: Amanda Franklin (right), Mason (middle) and (left), Amanda's husband, best friend, and the cutest boy she's ever seen!

China's Excellence in Addressing Poverty

Tom Watkins

China, like America, has human rights problems. I have touched on both our countries less-than-stellar human rights record in past columns so I'll not dwell on them again here.

One area where China is excelling and we are failing is in the area of poverty reduction or eradication. Poverty has devastating impact on the growth and development of individuals (especially children), families and society as a whole.

Clearly the Chinese Communist Party has taken many steps to address poverty since the founding of the People's Republic of China in 1949. What the Chinese Communist Party has done in this vein—to lift hundreds of millions of their own citizens from abject poverty to the equivalent of the middle class over the past 40 years—is remarkable and universally acknowledged.

Pres Xi Jinping talks eloquently about "a community of shared future for human beings." President Xi has vowed a "great rejuvenation" to restore China to its ancient prominence and glory. He is equally as clear that the Chinese "Communist Party is the solution to all China's problems and will drive change that will lead to continued progress for the Party and the Chinese people."

2018: 40th anniversary of China opening up

President Xi, in speaking to the Chinese Congress, emphasized that while past leader Mao made China independent, and leader Deng made it prosperous, he would make it strong again – propelling the country into its "new era." This new era is the Chinese equivalent of the policy to "lift all boats." The goal of eradicating poverty is certainly a lofty one.

What Would Confucius Say?

There is a renewed embrace of Confucian thinking in China: Where everyone fulfills their responsibilities and creates a harmonious situation for the whole country to prosper and reach for the "Chinese Dream."

Confucian ideas of agreed upon hierarchies and obedience to authority go back centuries. This philosophy clearly fits nicely with the Communist Party's ideas. Confucius believed that people should do what is right because it was the right thing to do. And, that the sheer act of people attempting to do the right thing would have a cascading, positive effect throughout society.

Chinese leadership—from Confucius to President Xi—are to be commended for seeking paths to eradicate poverty.

The Chinese, both its government and its people, are investing in education, infrastructure, and technology; fully embracing the future. They understand that knowledge, innovation, and creativity are the 21st century currency that will propel them forward as individuals, families and a nation, and are investing heavily in education as a poverty alleviation tool.

As the 1980's unfolded and China changed course, Premiere Deng Xiaoping—the preeminent leader following Mao—and now Chinese President Xi Jinping continue to change the course of the world.

Deng began the process and President Xi has placed it on steroids. They have established policies and practices that have lifted more people out of poverty than any other nation in the world. The number of Chinese that have escaped poverty is double that of America's entire population: over 750 million people.

Today, some argue the 20th century belonged to America and the 21st century will ultimately be led by China. I do not know if their arguments will withstand the test of time. However, I do know that our destinies are linked and we must find ways to live, work and solve problems together or we will surely fall together.

I have traveled throughout China numerous times since 1989, to cities many have heard of such as Beijing, Hong Kong, Shanghai, and Lasha, Tibet. Others less familiar include Lanzhou, Changsha, Beichuan, Bengbu, Changchun, Mianyang, Nanjing, Huizhou, Jurong, Shenzhen, Turpan, Urumqi, and Wuhan. During my travels I have seen the ultramodern as well as scenes that would take

you back centuries.

China, with all its progress, remains—in many parts of the country—a developing nation.

China Has Stood Up

However, there's no doubt that China has soared. Consider:

- 700 million people have moved from abject poverty to a Chinese middle class.
- China has become the world's fastest growing large economy.
- Many Chinese students significantly outperform U.S. students on international tests.
- China is the world's largest auto producer.
- China has become a banker to the U.S., owning more than 20 percent of our total foreign re serves (more than 3 trillion dollars).

There are three underlying facts that make China so vital in world affairs historically and, even more importantly, going forward:

1. One out of every five people on the planet are Chinese;
2. China is the oldest surviving civilization;
3. China was shaken from its historical pedestal as the "middle kingdom" and has spent decades attempting to regain its equilibrium, has clearly arrived or, as Mao said, "China has stood up."

I love the Chinese culture and people and have read and traveled in China enough to know more than the average westerner. Yet, I am careful to ensure that my comments are respectful and do not in any way interfere with the internal affairs of China. I see the country's strengths and weaknesses and have written about both.

China Dream

China will continue to build on its plan to lift the remaining citizens from abject poverty and propel China forward as they reestablish their "fuqiang" (i.e. "wealth and power").

I love America and want our nation and its values to prevail as the 21st century unfolds. Yet, I do not believe we are preordained to be number one— it is something we must earn. China is investing in improving its infrastructure, education (from the cradle to the grave), technology (especially "AI": Artificial Intelligence) and research and development. We, on the other hand, are disinvesting in these areas.

We need a National strategy to assure we remain number one. Whining about China's rise will not prevent our demise. Let me assure you, China is not sitting back waiting for us to get our act together. The individual, family, city, region, state/Provence or nation that chooses to invest in the future will rule it.

We need to stop whining and start investing in our collective future, before it is too late.

As Connections goes to press:

The above article on China's progress in addressing poverty is but one piece of the picture of Chinese culture. Watkins has been traveling and working for three decades in China – the first trip coincided with the Tiananmen Square incident in 1989. On that trip he led a delegation of over 30 CMH professionals.

He has continued visiting and writing about China, including an opinion piece for *The Detroit News* published June 3, 2019: **"30 years after Tiananmen Square, China has modernized, but government holds reins"** [scan code on right]. Taken together, these two articles present a remarkably clear picture of a critical component of our planet's humanity. The recent 30th anniversary of the student uprising in Tiananmen Square prompted Watkins to address their struggle to achieve the freedoms we take for granted. You can connect with Tom by email at: tdwatkins88@gmail.com

Tom Watkins has an eclectic career in both the public and private sectors. He served the citizens of Michigan as state superintendent of schools and director of the Department of Mental Health. He has held leadership positions in higher education, business and behavioral health. Watkins has a passion for in all things China and has written hundreds of articles on the value of this most important bilateral relationship in the world today.

This article first appeared in Dome, *December 21st, 2018 under the title,* "Whining is Not a Strategy or a Plan." Dome *is dedicated to "Covering the People, Issues & Events Shaping State, Politics & Policy." For additional information, see:*

https://domemagazine.com/whining-is-not-a-strategy-or-a-plan/

Adaptive Leadership *(From page 5)*

challenge the purpose of any proposed change to ensure that the outcome will be better than what we can currently produce. An outcome that is the same or worse is not worth the magnitude of change that either the MHP or the CMHSP systems can tolerate.

We've formed valuable relationships with our 298 Pilot partners where we continually ask and balance these questions among ourselves. The strength of the 298 Pilot CMHSPs comes from our collective efforts to balance the need for change, realistic outcomes of the type of change we're discussing, and the ultimate projected outcome of the change. By way of example, financial integration as the context for the Pilot is one of the major barriers we consistently confront with our MHP partners. 298 as a Pilot construct defines the outcome as financial integration. The CMHSPs and the MHPs see financial integration as the vehicle, not the outcome. Financial integration is a "fix" to an obstacle, not a design in and of itself.

In hindsight, we were overcommitted to our own stability and comfort, and under committed to our mission.

The outcome we expect from the Pilot is more clearly and collectively defined in dialogues about care coordination, case management, and even utilization management. Research and experience tell us that the integration we need to support better outcomes for the people we serve lies close to the ground in our communities and within expanded systems of care. Concepts like case management, care coordination, single care plans, attribution models to support assignment of health home, real time data and information sharing are ideas that allow us to collectively expand beyond fixes for barriers to services to an architecture for improved outcomes for people in local delivery systems that support recovery and self-reliance for people we serve. They are also the structures that will result in more efficient delivery of care, lower healthcare costs overall, and decreased morbidity rates for the people we serve.

These are the outcomes that brought WMCMH to the 298 Pilot. These are the outcomes that found us wanting a seat at the table and having hard conversations about how to best improve the lives of people we serve. Collectively, we all want a system that directs more resources to and creates more leverage in achieving efficiency, reduced costs, and decreased morbidity. Few of us believe that the system is working optimally in its current form.

In our leadership work at WMCMH, Jeff Lawrence is working with us around the approach we take to address problems we identify. Our decision to engage is based on the premise that there are two camps ahead of us: *the architects of the future,* and *the obstacles that need to be overcome*. For WMCMH becoming a 298 Pilot is an effort to define a desired future state that is better than our current situation. In Jeff's language, we're becoming architects of our own future. All leaders in our system make this choice a thousand times a day in little ways. Sometimes navigating obstacles is important and a critical part of the work we do to help the people and communities we serve, but rarely is it sufficient to achieve our long-term desired outcomes.

For WMCMH, in focusing almost exclusively on the status quo of separate systems, we were inadvertently choosing to be committed to our own comfort. "Fixing things" allowed us to maintain a certain level of what we called "protection" for our staff and services. In hindsight, we were overcommitted to our own stability and comfort and under-committed to our mission. More specifically, our commitment to "fixing things" and to comfort and safety of our team actually made us *less* safe, *more* vulnerable, and *less* equipped to achieve our mission and vision and outcomes for the people we serve. Even now, we step out as architects in some ways (e.g., 298 and CCBHC) and work on fixing obstacles (process changes, program changes) in others.

I'm not sure if Jeff would agree with me or not, but I believe that there are many ways to be architects. Other leaders in our system have chosen to re-envision their organization's future based upon concepts like Opiate Health Homes (OHHs) or Certified Community Behavioral Health Centers (CCBHCs) or CMHSPs *and* Federally Qualified Health Centers (FQHCs). All are valuable and viable structures and systems to build on that can enhance the strength of the work we do locally to achieve outcomes for the people and communities we serve. The question for each of us as leaders becomes how do we stay vigilant to making sure that we're designing for the future and not just fixing things to stay comfortable?

…how do we stay vigilant to making sure that we're designing for the future and not just fixing things to stay comfortable?

WMCMH's work with Jeff Lawrence has me thinking about my role as a leader differently. Like many of my colleagues, I'm also greatly inspired by Brene´ Brown's work on leadership and vulnerability. A significant part of the work that Jeff Lawrence has done with our organization has called upon all of us to bravely envision/architect a future where we can't control the outcome but where we believe the outcomes we desire for the people we serve can be achieved. This is the essence of being an architect where the clients we design for are the people and communities we serve.

SELF-DIRECTED CARE *(From page 1)*

are different methods for developing a budget, a simple example would be to use the average annual cost of providing mental health services or supports to a person in similar circumstances. The budget will allocate resources to line items consistent with the services detailed in the recovery plan. The individual subsequently is expected to make purchases and monitor expenses on a regular basis, thus assuming personal responsibility for their own actions.

The third element of self-directed care arrangements is ***individual choice***. This is often supported using a "support broker " – someone trained to help individuals purchase mental health services, supports, and other material goods detailed in their recovery plan. A support broker may assist with monitoring the established budget, exploring available community resources, and making purchases. Support brokers may even assist with recruiting, hiring, and employing paid caregivers. In many cases, the support broker may also be someone with personal experiences in the recovery process.

The most common outcome associated with nearly all self-directed models has been high levels of customer satisfaction.

The fourth element of self-directed care involves protecting against a ***conflict of interest***. This typically involves the use of an independent fiscal agent or intermediary who is not a provider or otherwise benefitting from the budget allocation decisions. This fiscal intermediary acts as a third-party administrator by paying for provider claims/services authorized by the individual and processing vouchers for goods and services. The fiscal agent may also be the employer of record for paid caregivers and responsible for payroll, withholding taxes, unemployment insurance, etc. This creates a separation between the individual, service providers, and fiscal agent for management of public funds.

The initial self-directed care models in the late 1990s tended toward implementation with the elderly population and/or persons with physical/intellectual disabilities. These models have gradually been extended over time to projects designed to support persons with other significant mental health conditions. The most common outcome associated with nearly all self-directed models has been high levels of customer satisfaction. This should not be surprising given the amount of authority and control invested in the individual person to purchase non-traditional goods and services related to their overall health and well-being such as a gym membership and transportation. However, more current self-directed care projects are attempting to determine if such arrangements also contribute to sustained health and wellness, community participation, employment, and recovery. The significance of these future results will most likely determine the long-term viability and sustainability of self-directed care.

References

Cook, J.A., Shore, S., Burke-Miller, J., Jonikas, J., Ferrara, M., Colegrove, S., Norris, W., Ruckdeschel, B., Batteiger, A., Ohrtman, M., Grey, D., and Hicks, M. (2010). "Participatory Action Research to Establish Self-Directed Care for Mental Health Recovery in Texas." *Psychiatric Rehabilitation Journal*, 34 (2), 137-144.

Lifting the Roof *(From page 3)*

ever changing healthcare system.

In writing this article I was asked to focus on the high level strategies used to strengthen and improve transparency in the governance of Summit Pointe that may help guide other boards who are likely also challenged by these issues. To summarize the strategy, I think the best analogy would be that in doing this exercise with your organization, you will **lift the roof from your organization and view your processes and policies in action**. Audit against your policies to determine if they are followed and question all processes to ensure the right balance of oversight and monitoring is in place. The process review may uncover areas that are deficient or areas that can be streamlined and keep the board and all of the staff involved in the process. Discuss together what is learned and build effective long-term monitoring that will continue to build on processes and strengthen the organization where needed. In the end, the entire process can prove to build knowledge for everyone and indeed be worthwhile.

Discuss together what is learned and build effective long-term monitoring…

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Hal Madden and Me *(From page 6)*

When I graduated a few months later I learned that I had amazingly been accepted into GVSU despite a 2.3 GPA, and to top it off I got a substantial scholarship that I did not apply for. (Oh, Hal!) At my graduation party Hal Madden showed up to give me a congratulation card and a small financial gift.

I eventually finished working off the hours I owed and then I did not have any real contact with Hal over the next 20 years. When I did run into him on occasion he'd always say, "What's up Hot Shot?" and I always felt like I better say something good. When I took a job for MACMHB I had just turned 40. On the very first day of my employment there, Hal, who was the President of the board, told other board members that I was one of his student/athletes and that if I did anything good for the Association it was because I was a product of the Ludington School System.

Now today, here he is again. I am receiving an award named after one of the most influential people of my life.

In reflecting on my relationship with Hal Madden I realize that he consistently modeled three basic principles to me.

1) There are no throw-away people. Everyone is significant and has value whether they are in an institution or are a pimply faced 15 year-old little orphan kid whose long-term prospects are not very bright. There are no throw-away people.

2) Solutions to most of our problems are local, through relationships and interventions people make to help each other. (I may have been one of the original "wrap-around-kids.")

3) Finally, of course: Always strive to do better, because no matter how good we think we are doing, we can always do better.

I'd like to thank the Association for this award. And The Right Door Board of Directors for allowing me to partner with them for 17 years, and especially my life partner and spouse, Krista Hausermann, for all her support and for the sharing of mutual values, and of course, to you Hal Madden. I have tried to live up to these principles you taught me, and to practice them in all my affairs. Thank You, Hal!