CMHA
Community Mental Health
Association of Michigan

Connections
for communities that care

WINTER 2020

INTEGRAL HEALTH CARE BEGINS WITH CONSCIOUSNESS

Clinton Galloway, Editor

Although I have a body, I am not that body.
I am a conscious being, not a thing.
The only way you will know me is to listen.

The World Health Organization defines health as a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity. Integral is defined as that which is essential to make a whole complete. With this understanding, health care is best understood as integral care and begs an understanding of what constitutes being human.

Arguably the most important subject that needs more open discussion, especially in healthcare, is about the fundamental nature of a human being. Simply put, "What am I?" What is it that we are trying to heal? The relative absence of discussion may be attributed in part to the fact that academia and large for-profit corporations have influenced our world view to their advantage, assuming the conclusions have been determined and align with what they are providing. There is no need for debate. Ultimately, they have decided, we are *physical/biological organisms*, albeit enormously complex ones. That's it. Consequently the most vigorous research is occurring in the neurosciences, centering on the complexities of the brain. As such, only the most sophisticated intelligentsia has the ability to comprehend what we are. What was once the territory explored by philosophers and religions, stories meticulously catalogued by mythologists like Joseph Campbell, wisdom exchanged by common folk and passed from generation to generation, is now the prerogative of an elite group of scientists including, but certainly not limited to, biologists, chemists, neuroscientists, and physicians who work in laboratories where the "real stuff" can be measured and verified. The consequences of this shift have produced many modern "miracles." But it also has impacted how we address our well-being; some of the consequences are devastating. In a recent study, the health status of people living in the United States ranked 35th in the World and was declining. Populations within Cuba, Croatia, Estonia, Chile and Costa Rica fared better.* It's not for lack of money; we have by far the most expensive healthcare system in the world.** It doesn't have to be this way. (To read more on the performance of our healthcare system, there is free access to the Peterson Center on Healthcare and KFF (Kaiser Family Foundation) which has partnered to monitor how well the U.S. healthcare system is performing in terms of quality and cost.) *https://www.healthsystemtracker.org/about-us/.*

We have come to identify our *self* with our body—how we look and especially what we do. A historical marker was the 1898 publication by Albert Marquis of *Who's Who*, which soon became a common colloquialism. Albert Marquis has been forgotten, but everyone recognizes the phrase "who's who." The shift towards thinking of our *self* as being fundamentally a physical body has been a gradual one, spanning centuries during which the physical sciences have overshadowed traditional wisdom as the mediators of truth and what is really real. Relevant to our focus on healthcare, it is noteworthy to recall that Marilyn Ferguson published and edited the well-regarded science newsletter, *Brain/Mind Bulletin*, from 1975 to 1996. I think of her as the sage that recorded the events taking place after academia had adopted the physical organ of the brain as the defining characteristic of *Homo sapiens*. But Ferguson didn't make that mistake; although fascinated with the brain, she was more excited about the potential of our mind that was unfolding. She became a founding member of the Association of Humanistic Psychology. While academia had adopted materialism and physicalism as its reigning philosophical position, she was chronicling a significant cultural change taking place in the widely popular book, *The Aquarian Conspiracy*, published in 1980. The sub-title best captures the contents, "Personal and Social Transformation in the 1980s." As the title suggests, she was focusing on what was happening in our minds and

(Continued on page 16)

About This Issue

Clinton Galloway, Retiring Editor

This being the last issue for which I am responsible as Editor, I am very pleased and excited to announce that Lois Shulman has consented to take on those responsibilities for the future. I firmly believe Lois has the skills, knowledge, values, connections and passion that are essential for the continual evolution of *Connections*! In conversations with Lois, I've become confident that the potential of this communication venue will be taken to a new level. For those who don't already know Lois, you will catch a glimpse of what Lois brings in an article she has written for this issue. To acquire a much richer appreciation, you need to meet her in person.

One of the first requests Lois made was that I write down my vision for *Connections*, thus you are being subjected to an atypical dose of my thinking in this issue. I apologize. Fortunately, you won't be dumped on like this in the future! However, it would be disingenuous to deny that I have appreciated the opportunity to share with you a peek into my world. (I've enjoyed the dump!) My closest companions are frequently the authors of the thousands of books that have helped me find direction and meaning during my lifetime. I am constantly amazed by the knowledge of countless people. I find myself living in exciting times!

It is difficult to find words that convey my feelings when I reflect on my involvement with the evolution of *Connections* over the past 13 years. Make no mistake, they are very positive feelings! Having pursued an education that would hopefully equip me to serve people as an ordained clergyman, I believe my work within the public community-based mental health system has provided me incredible opportunities to do just that. For me, a sense of meaning and fullness was never about having the right beliefs; it was about doing the right thing amongst those of us who have the least. "God"was never a concept I carried around in my head; it is more like a sense of a presence deeply felt in acts of compassion. That was what I learned when I attended graduate school at Boston University School of Theology, sitting at the feet of the same teachers Martin Luther King, Jr. had sat a few years earlier. Part of my education there was pastoral clinical training in a Massachusetts State Asylum, a challenging experience! The text was *Client Centered Therapy,* by Carl Rogers. All in all, I was initiated into the work of social justice coupled to a realization that we are all equal and interconnected. Is it any wonder that the title for this publication became *Connections for Communities that Care*?

There have been many who have played a very important role in *Connections* over the years; perhaps the best way to acknowledge them is to invite you to peruse the contents of the back issues on our website. [https://cmham.org/resources/connections/]

However, I must call attention to one. This issue contains a piece written by my closest ally throughout this adventure, Cindy Chadwick. I first became acquainted with Cindy's husband, Bob, when he became the CEO of our local CMH in Ionia. Some years later, Bob was working part time at the Association where he learned of my desire to initiate what became *Connections*. He knew I needed to meet Cindy and arranged it. Cindy and I came bearing an armful of stuff accompanied by a head full of possibilities. They fit like hand and glove and the rest is history. One thing about our connection is the realization that what we each brought was essential to the future success—whereas I was responsible for acquiring the material, Cindy fashioned it into a form that caught our attention. Presentation is imperative for success. *Connections* would not have survived beyond a few issues had Cindy not worked her magic! Of that I am certain.

Finally, an individual who has played an increasingly important role in the evolution of *Connections* is our CEO, Bob Sheehan! I have undoubtedly been inspired in watching Bob's tireless efforts in providing leadership for what seems, at times, like the impossible job of salvaging decades of work spent building the complex community-based networks that are increasingly being proven as the most effective and efficient systems for population health. The efficacy of these systems is directly attributed to the principles that have been creating them; he articulates them in this issue. They are the self-same principles that you see at work in Bob. I regard him as my brother.

Of course, integral to *Connections* are the stories, and this issue is no exception. With Lois at the helm, you are assured of a continuing stream from the heart of our work. ■

Integral Health Care Begins with Consciousness:
Response by David Neal, in Conversation with Clinton Galloway

David Neal has had a distinguished career in the Department of Psychiatry at the University of Michigan Medical Center as an Assistant Professor of Social Work. His accomplishments and awards are numerous. And while Neal's work has been recognized by numerous professional organizations, those honors do not capture the complete picture of why he is so effective.

His life revolves around many centers that comprise his social networks, understanding that every life has multiple facets and we will not be successful in our work until we help the individuals we serve make numerous connections. Neal has a family, a church community, six years in the armed services, an avid interest in sports, and is now a certified tree farmer.

The following dialogue between Clint Galloway and David Neal was in response to the essay [see front page] Galloway penned, entitled "Integral Health Care Begins with Consciousness."

Galloway: The purpose of writing "Integral Health Care Begins with Consciousness" was to advocate for giving primacy to our subjective experiences, believing that healthcare has become skewed by a limited focus on our physical bodies. This orientation has produced some remarkable successes which serve to reinforce the underlying bias—the ontological primitive of our humanity is physical.The current healthcare system has definitely been tilted by the accumulating weight of this bias. We now refer to physical care as *primary* care. Attention to our subjective experience of care has been relegated to second class status—*mental health*. Add to this the recognition of dismal progress in population health compared to other developed countries; there is a growing realization that something is desperately wrong in our current system of healthcare.

***Neal**: I wish that we had more time to talk about your paper. You are always challenging us to consider different approaches to health. From my experience of working in health care, I do not think the system is capable of moving as far as you are suggesting. I think that the system has made significant progress understanding the importance of integrating behavioral health services and respecting the person receiving services.*

When I joined the Department of Psychiatry at the University of Michigan Health System in 1966, psychiatry was not respected by the medical community. The Department of Psychiatry received a direct appropriation from the State of Michigan which the medical school could not touch. This was the major factor which allowed the Department to become a leading program in the country. Today the medical school understands that psychiatry has an important role in developing integrated healthcare services. This shows how far physical health providers have come in accepting/integrating behavioral health services.

Galloway: This reveals the powerful impact of policy and funding. Comment further on the development of integrating primary and mental health.

***Neal**: In 2000 when we started the WCHO (Washtenaw County Health Organization) and the University of Michigan joint partnership to integrate physical and behavioral health services, there was little interest from the physical health care providers in the University. Other CMHs questioned why we were doing this. It was only after the research showed that mental health consumers died 25 years younger because of poor physical health care that interest increased.*

Galloway: So in this case, research was an important factor; what happened next?

***Neal**: The WCHO had to be dissolved because of the county's financial situation. The University and Saint Joseph Mercy Health System wanted to continue a relationship with CMH to integrate physical health services and obtained seats on the Board. There was an understanding that it was necessary to treat the whole person and not function in separate silos. I understand that now all primary care clinics and most specialty clinics in the University system have a social worker to address behavioral health needs and social determinants. The younger doctors see the value of these services. Look what progress has been made in developing integrated care in twenty years! Everyone is on board, the question is what should policies be and how should it be funded. It has only been twenty years and now all CMHs and most health systems have some form of integrated services.*

Galloway: You were an Assistant Professor of Social Work at the University of Michigan Medical Center. Share with us some insight into the history of the role of the social worker.

***Neal**: In the 70s social workers were not seen as competent to provide mental health and substance use services, and were never reimbursed. By the turn of the century, social workers were providing more behavioral health services than any other discipline and became licensed to diagnose and do therapy. Counselors just received this recognition in the legislature this past year. Funding is now available to these disciplines although it can still be a challenge in some settings. I share this because I have seen significant progress in the acceptance of the importance of meeting the need for behavioral health services.*

Galloway: What does social work education contribute to the healthcare team?

***Neal**: Social work education includes a focus on the individual,*

(Continued on page 4)

Neal Response

(continued from Page 3)

their relationships, and social determinants affecting their lives. Master degree programs for nurses have developed programs that are very similar. I think that this is moving more towards your concept of consciousness. Time and financial pressures do not allow providers to fully understand someone's consciousness. The system of care has moved to include the consideration of multiple factors that affect one's health.

Galloway: This is helpful in understanding the attempt to treat the whole person. What other positive trends have you seen?

Neal*: I have seen a major change in how individuals are treated. Fifty years ago, everything centered around the doctor's schedule and recommendations. Persons receiving services either accepted or rejected what they were told. Now they are involved in the decision-making progress. Appointments are coordinatated, individuals are told the diagnosis and given the pros and cons of treatment recommendations, and the final plans are made by the person served. This is a bit idealist, but it is the goal for progressive health systems. As an individual receiving service, I find it refreshing when this occurs and very frustrating when it idoesn't.*

Galloway: This seems like a step in moving toward the first of the Triple Aims Don Berwick, et.al. identified in 2008—"the experience of care." As this gains momentum, I believe we will see progress on the other two aims: population health and the cost per capita. This is part of the reason I believe we should begin with consciousness. I would think that the core principles of self-determination and being person-centered that have emerged in behavioral health would also have efficacy in primary care.

Neal*: I appreciate that in talking about consciousness you are expanding the concept beyond mental health and substance abuse services. I do not disagree with your paper, but I do not see docs, or people being served, as really being supportive of moving in that direction. I just saw my primary care doc and he shared the pressure they are under to do more with less. I do not see funders moving to have health care professionals spend time dealing with consciousness. Also, I do not think most health care professionals are trained to do so. Individuals receiving services are equally a challenge. When you are sick, most folks just want someone to take care of them which often means getting some pill or medical procedure.*

Galloway: I agree; when it comes to *next steps* we need to be both realists and pragmatists. The system we have is not equipped. Being somewhat of a dreamer, I have always sought orienting generalizations that can help me understand where we need to go. "Integral Care Begins with Consciousness" was written to fulfill that function. However, your experience and wisdom keeps me grounded. What are some of the things you see taking place in the immediate environment?

Neal*: I am part of an e-mail exchange with faculty in psychiatry. A concern has been raised nationally that training and research is more focused on the biology of individuals and illness, rather than the unconscious and relationships. Gradually life events and social determinants have been included in the discussion. Only a few years ago they would not have been. There has been acknowledgement that behavioral health research has not integrated key factors that must be included in delivering behavioral care. Suicide is an example where no progress has been made. On the other hand, there has been lots of progress in cancer, cardiology, etc. Financial support will naturally go where the most progress is being made.*

There is no question that biological research has made some very significant gains in treating medical conditions. I believe that this has been achieved because of the technology available to them to identify and evaluate different biological aspects of individuals. This type of research is held in high esteem and it has drawn behavioral health researchers to start focusing on the biology of illness while other factors have received less attention. We do not have the tools to easily assess the severity of depression, anxiety, and other conditions. As you note in your paper, consciousness is subjective. Most believe that there are unconscious factors affecting who we are but we have not done well learning how that may occur.

I just talked with a state senator who said that mental health is a big focus for legislators. They know that they need to do something but they are not sure what to do. The 298 pilots are a good example about how some progress has been made but there is no agreement on what the policies should be nor how integrated care should be organized and funded with CMH agencies.

I also have seen articles by physicians delivering physical health services discussing what their role should be in the future. They recognize that health care has become very specialized and complex. It has become necessary to involve providers from several disciplines including behavioral health. It has already changed significantly from the doctor working alone or in a small group practice. How will health care in the future be organized and funded? Will it address your concern about how health care providers can really get to know their consumers as you suggest in your paper?

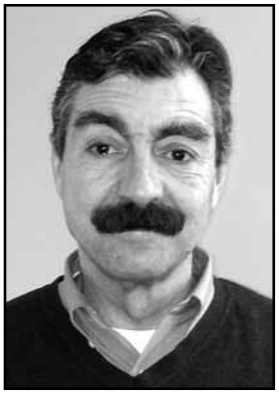
Galloway: These are indeed significant concerns that are stirring the waters! However, this conversation illuminates one important fact that has promise—dialogue speeds up the process of understanding and consequential change. And as the feedback loops expand, the pace of change accelerates. The technological innovations of modern media, especially the ubiquitous cell phone, have enabled our networks to circumscribe the entire planet. This factor is impacting every dimension of society; we see it pronounced in the transformation of political structures which represent the geographical coalescence of the power of people.

Neal*: I agree. Our new communication networks have shrunk the world. I believe that it is positive in that fewer people in the world*

(Continued on Page 19)

CMHA's System Integrity and Design Principles

Robert Sheehan, CEO, Community Mental Health Association of Michigan



Michigan's public mental health system, the envy of the nation, is a system for which creating and nimbly responding to change along all of its dimensions-–clinical, fiscal, structural, statutory, regulatory, governance, and partnering dimensions-–are part of the system's DNA.

Recently, in addition to the large number of innovation-related changes that Michigan's public mental health system is leading and to which the system is responding, the State's CMHs, PIHPs, and providers are now responding to proposals from State policy makers to redesign the state's public mental health system.

As has been the long tradition of our system, the changes that we have sought and our responses to externally driven changes have been grounded in a solid value set. The system's response to the current system redesign proposal is no different. The set of values that are driving our system's advocacy work around this most recent system design effort were recently captured in a set of system integrity and design principles passed unanimously by the Executive Board of this Association in December of 2019. These CMHA principles and design elements are summarized below:

System design should:

1. Always start with what is best for those served by the system.
2. Be built on a set of core values that are so fundamental to Michigan's public mental health system, that they do not need explanation beyond their listing: an individual's right to self-determination, person-centered planning, full community inclusion, a recovery orientation, cultural competence in the services, and supports provided them.
3. Recognize and build on the current system's strengths, building on the nationally recognized strengths and accomplishments of the State's leading edge public mental health system.
4. Foster real primary and mental healthcare integration and coordination via clinical integration (where the client/patient receives services and supports), and build structural and financial supports from there.
5. Ensure strong local county government-based public governance in the managed care, provider, and collaborative convener roles of the State's public mental health system remain local and public, embedded and linked to the counties served by the system.
6. Ensure that the persons served are mandated members of the local governance bodies and the governing bodies (not only advisory bodies) of the public-private partnership that may be formed to manage the behavioral health care benefit.
7. Protect and strengthen the full set of roles played by Michigan's public mental health system—driven by a commitment to the common good, public interest, population health, social determinants, and community collaboration:
    - Organizers of care – Providers, purchasers, and managers of a well organized comprehensive array of services and supports across a network of proven and experienced providers.
    - Community conveners and collaborators – initiating and participating—often in key roles—collaborative efforts designed to address a broad range of social determinant-related needs of individuals and communities.
    - Advocates for vulnerable populations and a whole-person, social determinant orientation.
    - Sources of guidance and expertise, drawn upon by the public, to address a range of health and human services needs.
8. Ensure adequate and sustainable funding to the public system to ensure that it is sufficiently strong to meet the growing demand and expectations for access to mental health services by all Michiganders.
9. Ensure that the State of Michigan retain its long-standing statutory (i.e., Michigan Mental Health Code) and constitutional risk sharing role in the State's public mental health system.
10. Use competition as a design element only when it benefits the persons served and the communities in which they live.
11. Provide for foundational and standard risk management tools, including:

(Continued on page 18)

THE *MISSION* OF *CONNECTIONS*

Clint Galloway

Connections, like the "Weekly Update" (formerly the Friday Facts) is a communication publication of CMHA, however, their primary missions differ. Over the past decade-plus (the duration of the *Connections* publication) the mission of each has remained somewhat constant while the substance has significantly increased, especially in the Weekly Update. I think it is time to reflect on the unique mission of *Connections* a little more closely, enabling us to effectively move forward. There is no doubt that there is growing need for the production of the Weekly Update, given its mission and the increasing complexity of the system the CMHA represents. What is less obvious is what I perceive as an equally demanding need to expand the scope and content of *Connections*, enabling it to better address the complementary role it plays in the CMHA communities. What is that complementary role? In a nutshell, it is to explore the interiority of our system, the subjective experiences of those providing and receiving services and thereby strengthen the underlying force that creates an integral system of healthcare.

From my perspective as Editor of *Connections* since its inception in 2007, the Weekly Update is an essential, pragmatic source of information assisting members in performing their tasks. It focuses on the effectiveness of the system of care and provides resources to that end. If you want to know what is happening "on the ground" or "under the hood," you can do so by keeping abreast of Weekly Update. As such, it provides an exterior view of our public community-based systems of care. *Connections* is more focused on the subjective experiences of both those providing and those receiving services; it provides an interior perspective, primarily utilizing first person stories which communicate the values and motives that are the heart and soul of our work. Instead of focusing on system structures, the subjective experiences that constitute the moment-by-moment consciousness of the people served as well as those providing services become the subject matter. As such, they are two quite distinct sources of information. Whereas the increasing complexifications of the structures of our community-based delivery system are obvious, the incredible, accumulative force, and consequent impact of the band of sisters and brothers who show up every day in acts of compassion along and beside those who are seeking care is somewhat hidden; yet, it is this force that ultimately creates an authentic system of caring. To see it requires an introspective orientation; the stories come from within and are accessible only by interpersonal sharing. The mission of *Connections* is to illuminate and strengthen these threads that bind us together as we strive for wellness. Any individual who is cultivating and expanding their self-awareness realizes, there is a tremendous proliferation of material that addresses both this personal and social transformation. It is a resource-rich territory! Tapping into it nourishes us all.

One way to frame the daunting task that the Weekly Update addresses is: How do we provide structures that keep the doors open for, and expand this band of sisters and brothers in fulfilling this mission of compassion? That is a challenging task in a culture that has nurtured an appetite for material goods. If we are to have integrity we cannot ignore this battle; it is present inside every one of us. *Connections* illuminates this struggle by addressing the question of **why**. This is a very personal question. It becomes increasingly poignant if we attempt to be person-centered, or advocate for self-determination and self-directed care. Furthermore, it becomes sheer hypocrisy to invite those seeking services to reveal their interior selves if we do not do likewise. Why have we chosen this field of work?

Most of the stories in *Connections* are stories that are navigating this interiority of consciousness, revealing experiences on the journey to wellness. Focusing on personal experiences provides more room to take a deep breath, enabling us to grasp a clearer vision of who we are and why we are involved in this system of care. It provides a crack in the door to grasp a wider perspective, to catch a glimpse of the "big picture" in which we are operating, to take note of cultural shifts, expanding opportunities for personal and social transformation, the burgeoning field of the neurosciences, and the proliferation of philosophical treatises that focus on the nature of mind. (A review of current influential philosophers found that 60% identified their work as a philosophy of the mind.) How well do we understand not only our **self**, but the nature of that which we profess to heal? Perhaps the greatest benefit of pausing to reflect is to take stock of the myriad of mixed motives that are pushing for change— what are the benefits and who are the beneficiaries in the systems for which we work? How do the cultural changes in which our systems are embedded impact the individuals we serve, and the communities in which we live?

(Continued on Page 18)

Our Dreams Empower Us

Lois Shulman, Incoming Editor

Much of what follows was delivered at the CMHAM Member Assembly on June 11, 2019. What I shared at that time is relevant as I excitedly follow my chosen path. My journey has brought me to this joyous moment, being selected as the new Editor of Connections for Communities that Care.

Martin Luther King had a dream. You and I have dreams. I dream of a humanity where all people are seen as valuable, where all people feel hopeful and empowered to seek their joy, and where listening with kindness and working together uplifts and encourages us all.

In 2008, the door to Oakland Community Health Network (OCHN) opened to me. I proudly found a home on the organization's board. I immediately became aware that I had entered a beautiful magical garden where people come first; where the mission is to inspire hope, empower people, and strengthen community. The OCHN staff, providers, and the individuals served were joined in spirit to protect and promote the public mental health programs for people.

Along my wonderful journey with these courageous people, I have sought to understand the dynamic, complex CMH network with all its twists and turns, I have strived to identify my strengths to nurture and share with the people I've served, and I have experienced happiness upon each discovery of how OCHN's staff, its providers, and the board positively impact the lives of the valued people we serve every day and night.

Through my position as an OCHN board member I had the honor of attending the Community Mental Health Association of Michigan conferences. I met lovely people from around the State, including fellow board members, executive directors, persons served, vendors, and CMH staff. Their trust to share their stories; their voices— full of struggle and laughter—of lived experiences, of challenges within their agencies, and their thoughts, were humbling. I came to understand that to work together with one voice, we must advocate for the CMH network safety net with legislators and state leadership.

Their words changed me for the better forever. My dream was shaped by a deep desire to participate to my fullest to make their voices as strong as possible. Seeing miracles all around me, I am reminded of my commitment to myself and to the people served by the public mental health system, to fulfill my choice to show up, speak up, and provide support to people wherever and whenever I can. That is how dreams are realized.

Clint Galloway, *Connections*' creator and Editor since 2007, shared with me his story and his dreams. His words, full of wisdom and hope, shined a light on my path and on my dream. When asked, I chose to serve as the Editor of *Connections*. In this position, I will seek, see, listen, and hear all valuable voices together, one person at a time, one community at a time, to experience the connections I feel listening to their stories. I am humbled by the honor, ready to work to fulfill my commitment to lead, advocate and write with respect, compassion and kindness. Through the words shared in *Connections* I will advocate for the right of all people to lead self-directed lives. As I continue to listen to people, seek to be aware of the miracles all around me, I am strong in my purpose as I take this position as Editor.

My journey has brought me to this joyous moment, being selected as the new Editor of *Connections* *for Communities that Care.*

Regardless of the uncertainty and chaos around each of us, like you, I am strong in my purpose to put people first; to inspire hope, empower people and strengthen community. We may not be able to clearly see the immediate path before us nor even the next step, but we can feel the power that will enable us to find a path.

My cup runneth over with abundance for this opportunity. My feelings for those I have served and worked with here at CMHA and at OCHN will light my path. My dream, forever and always, will fill my heart and direct my actions.

I express my appreciation and gratitude to the amazing individuals at the Association and OCHN. I commit to you that I will be present with passion, kindness and grace; to always see, hear and strive to understand. And now, once again, a door has opened! I have been selected as your Editor of "*Connections* for Communities that Care." ■

Editorial Staff note: *In addition to the new responsibilities of Connections Editor, Lois has remained involved at OCHN as a member at large on the OCHN Recipient Rights Committee, Chair of the OCHN Citizens Advisory Committee, volunteer driver for Freedom Road Transportation, and member of the OCHN Advocacy Workgroup.*

My Life With Cerebral Palsy

Renee Uitto

I was born with cerebral palsy, a condition that affects most of my body. People have a difficult time understanding my speech sometimes, and I cannot walk. It is also hard to move my arms. I was diagnosed at nine months old. Life has been a challenge for me, but I always try to have a positive attitude about everything. I am not afraid to try anything.

If I was born twenty years earlier, I would have been in an institution most of my life, if not all.

My parents enrolled me in school before I was three years old so I could have physical, occupational, and speech therapy. If I was born twenty years earlier, I would have been in an institution most of my life, if not all. My mom wanted me in classes with the regular kids, but my special education teacher said no. She didn't think I could handle it. I started going to regular classes when I was in fourth grade.

My mom advocated for me when I was in school. A lot of teachers didn't want me in their classroom because they didn't think I would do well or I'd be too much of a burden to them. But my mother talked to them and convinced them otherwise. I ended up getting good grades in their classes.

I started going to community college in 1989. I only started going part-time, just to see how well I'd do at first. I had two professors that did not want me in their classroom because they didn't want to hear me talk. *Really?* I was sick of dealing with this. Both of them were old and were strict. One of the professors asked my mother, "Does she have it up here?" and pointed to his brain. That was the worst comment I've ever heard! My speech may be hard to understand sometimes, but I am a smart person. I got my Associate's Degree in 1993 and then transferred to Oakland University. I wanted my Bachelor's in Journalism. I got through my classes pretty well. I only had one problem with a professor. He was an older guy and didn't want me in his classroom. The class was Law of the Press and it was so hard! I had to read all these cases and understand them. I left the class after I failed the mid-term exam. I took it later with another professor.

I lived on campus for my last three semesters of college. I had learned to be more independent. I was patient and taught myself how to get dressed, put on shoes, and had easy-to-put-on shirts and pants. I learned to get in and out of my wheelchair by myself, take myself to the bathroom, and get myself into bed. I made more friends. I loved being on campus. It was a new freedom for me.

Four weeks after I graduated in 1997, my father passed away. It was a hard time for me because I had just graduated from college and I didn't know what I was going to do. I had sent out a lot of resumes but no one was calling me for interviews. I was just sitting at home with not a lot to do. I sent 100 resumes and got two interviews. My first real job experience came about ten years later when I started working at a mental health agency and participated in different meetings. I prepared a PowerPoint presentation that explained self-determination and how it related to my life. I felt like I was contributing to something and I was good at it. I was even the chairperson of one committee. I went to meetings where we discussed recipient rights, state and local issues, and advocacy; I learned how to contact my federal, state, and local officials to advocate about a transportation issue. Some of the legislators even wrote me back and sided with me. When I started at the mental health agency and Community Living Services of Oakland County, I wrote articles for their newsletter. I wrote from my personal experiences about using public transportation, going out into the community, and how self-determination worked in my life.

I had two professors that did not want me in their classroom because they didn't want to hear me talk...

When I first moved out on my own, I lived with my partner, Mike, who also had cerebral palsy. He was also my caregiver. We were best friends and had a lot in common. We loved to travel, go out to concerts, and have long talks. However, our relationship had a lot of ups and downs. I wanted to get married, but he didn't. He didn't accept his disability. I tried to encourage him, but that didn't always work. I also felt like

(Continued on page 15)

RIDE OF A LIFETIME

William S. Slavin, MA, LLP, LMSW

Boarding the CMH train in 1976, I rode to my final station climbing off in December of 2018, having experienced the ride of a lifetime. At my graduation time, CMH in Michigan was still relatively young, and fittingly, the director of the Department of Mental Health was a pediatrician. I knew I wanted to work at CMH and I knew I wanted to work in rural northern Michigan. I had also interviewed at a State facility, but when I got the call from North Central in Cadillac I knew where I was headed. I called the State Hospital to let them know of my decision and the medical director there was supportive but warned me he didn't think CMH was going to be around for long. This was only the start of the many surprises to the system, and change became the norm rather than the exception.

Working in rural settings requires some degree of flexibility and adaptability and in the early days we were all generalists to some extent although my initial classification was as a child and family outpatient therapist. Even then I knew that it was all about relationships—in therapeutic settings, with coworkers, community providers and administrators, commissioners and board members. Based primarily in Cadillac, I shared a lot of responsibilities with other therapists and each of us was assigned a half day per week to conduct two intake assessments and simultaneously cover crisis duties for that office. Intakes were dictated and service plans and case notes were hand written. I soon learned the value of editing transcripts, finding reference to "*old factory* hallucinations" in one of my documents.

Clinical staff all participated in the after hours crisis program as well, covering four counties at that time. This meant four jails, four probate courts (each run differently) and two hospital emergency rooms in our region. One was assigned coverage on weeknights from five PM until eight AM, and weekends from eight AM Saturday until eight AM Monday. Maps and key phone number contacts were provided and two agency vehicles were available for travel to remote locations. Cell phones were still well in the future as were pagers, so on call meant sitting home by your land line waiting for the answering service to call. Calls were common, most requiring only phone intervention, but inevitably a call would require an on-scene response. Crisis intervention in rural settings is ninety percent showing up, quickly. We logged many dashboard hours at night.

Voluntary hospitalizations were fairly common and when families were unable to transport, on call staff were expected to accommodate. There were some rules: You never transported anyone who was an imminent risk of harm to themselves or others, and you never transported anyone alone. This often meant calling a co-worker, rousing them from slumber and appealing to their sense of duty to join you on a midnight ride. We often drove significant distances to get to an inpatient unit and coworkers were not reimbursed. No one ever refused. If a male staff person was transporting a female consumer, a female staff had to be called upon.

The call came in late one night in the fall. The weather had been drizzly all day and a dense fog had set in. A resident of a foster care home in a remote corner of a neighboring county had broken some windows and the police were on scene. The client, well known to us and invariably cooperative, was willing to go voluntarily to the State Facility in Traverse City (voluntary admissions were not uncommon in those days), and my supervisor was willing to ride along. Neither of us had ever visited this home before and GPS was still science fiction in those days. We followed the directions the home operator had provided us and found ourselves on a desolate gravel road on the edge of nowhere. A rusty mailbox provided a clue but the only driveway nearby was a two track wandering into the fog along a pasture. No house could be seen from the road. Courageous CMH workers that we were, we ventured onto the two track and after crawling along in the dense fog for what seemed like miles (in reality fifty yards) we came face-to-backside with the first of a series of Holsteins who had knocked the fence down in order to graze on the greener grass in the yard of our destination. We met with our fare, found him to be most amiable and interested in a nice ride to Traverse City and proceeded with our mission.

Upon arrival at the hospital we had the attending physician paged so that he might conduct the admissions interview before we headed home. The doctor arrived in sartorial splendor, bedecked in T-shirt, cut offs jeans and cowboy boots. Admission was approved.

Many things have changed since those days. Arnell Engstrom opened and closed. Deinstitutionalization changed the entire public mental health landscape. AIS homes were developed (sometimes with considerable and totally unwarranted community resistance). Medicaid became a primary funder of services and supports, bringing with it piles of regulations, requirements and red tape. ACT was launched in Michigan, EBPs, AFPs, PHPs and PIHPs became part of the alphabet soup. Accreditation became essential along with person-centered planning, full community participation, and other long overdue improvements. With all the changes however, it was and is still

(Continued on page 15)

‘I know what they’re going through’:

From Muskegon’s woods, Cowboy builds bridges between the city’s homeless and housed

Thomas Hardy, also known as Cowboy, was homeless his entire life until 2013, when he was 54 years old. Cowboy was a drifter from birth, his father moving the family of five children around the United States to find work or escape the law. The family would occasionally come back to Muskegon County, where Cowboy’s maternal and paternal grandmothers lived, to visit. As Cowboy came of age, he continued to live the life he was brought up in, working odd jobs, collecting scrap metal and sleeping in the woods, until his health finally gave in and he had to seek stable housing.

Today, Cowboy puts his life experience and his passion for the homeless and vulnerably housed to use in Muskegon County. Cowboy’s on call around the clock working to connect homeless and vulnerably housed individuals to community and much-needed resources. Cowboy first came back to Muskegon to be close to his family in 2013; he joined Sacred Suds as a volunteer and soon after found permanent housing in the city. Cowboy has lived in Muskegon since 2013, the longest he has ever lived in any one place.

“I will continue working what I do, to help someone out that is in the same position that I grew up in, homelessness,” he says.

Cowboy sees the obvious solution to easing homelessness as affordable quality housing, and local steady jobs that pay a livable wage. He dreams of a day when his experience will no longer be needed, but, until then, he will continue to help those in Muskegon County who are living the life he once had. ▼

Cowboy shows a picture of himself at around six months being held by his mother. Cowboy thinks that by the time this picture had been taken, he had already traveled through most of the southern United States, and some of Mexico, before heading to Muskegon County, where his parents’ families were based.

Cowboy poses in his bedroom for a portrait, “The last thing I have of my father, except for my height, is my looks.” Cowboy’s father believed that God had come to him in a vision and had commanded him to physically and emotionally abuse his children. Cowboy has finally been able to accept the abuse that he suffered at the hands of his father, even being able to forgive him, but he will never be able to forget. His experiences as a child have deeply shaped who he has become and the work he now does.

Cowboy drives a scooter donated by a member of the Muskegon chapter of Rolling Thunder, a local veterans biker group. The Scooter is Cowboys main form of transportation until the snow gets too heavy, then he relies on the help of friends and family to get around.

Cowboy suffers from arthritis, emphysema, and epilepsy. The three health conditions combined finally pushed Cowboy to accept help in finding housing. If he hadn't sought out housing, Cowboy thinks he would have died on the side of the road from a mixture of the three conditions.

Cowboy comforts a friend seeking housing resources at a weekly community breakfast offered by United Church of Christ (UCC) in Nelson, Muskegon County.

Within the homeless community, there is a lack of trust of anyone housed; most homeless people have experienced physical and verbal abuse from housed people based on their current life situations. That lack of trust leads people to further isolate themselves and not go looking for available help. To add to this, the bureaucracy that surrounds housing people is so complex and slow-moving that it often leaves homeless people feeling even more ignored. Cowboy often finds himself acting as cheerleader, urging people mired in the system to stick with it.

Cowboy jokes with a volunteer at the UCC community breakfast during the winter of 2017. He has become a small celebrity among the homeless community due to his openness and humor.

The average story Cowboy comes across within the homeless community is that people lose their jobs due to the economic climate: businesses close, move or downsize; or people lose their job due to ill health, leaving them unable to pay their rent, leading to eviction. With an eviction on one's record, it is very hard to find another place: many landlords now enforce policies that renters must be eviction free for a number of years. This leaves many people facing homelessness, with very little help in finding housing. ▼

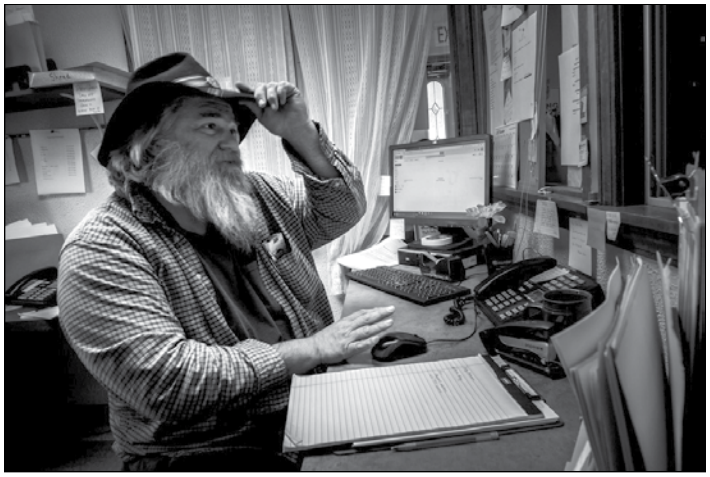
An old friend from Sacred Suds and the UCC community breakfast embraces Cowboy.

"The Good Lord allowed me to go through what I went through; which is 54 years of homelessness, a recovering alcoholic, and cross-addicted drug addict, and being physically abused growing up to work with and minister to the street homeless. I know what they're going through; I've been there; I know where to go looking for them," Cowboy says.

(Continued on Page 12)

Cowboy stands next to the north branch of the Muskegon River. Cowboy's last camp site before finding housing was next to the Muskgon River in 2013. Every morning, he would wash in the river before heading into town to volunteer at Sacred Suds, a local community center offering laundry and shower facilities—as well as internet access and community space to socialize. Cowboy loves the outdoors. When he was homeless, Cowboy would set up camp in wooded areas, to keep away from housed people but also to enjoy the peace and quiet nature provides. Cowboy misses the freedom of being a drifter, being his own boss, and being free to live the way he wanted.

Due to the mistrust and fear many homeless people feel towards the housed, numerous individuals will often camp out in the woods to be left alone, just like Cowboy once did. Due to this, Cowboy tries to make contact with people camping in the woods so he can build trust with them and connect them to services they may need.



Cowboy works with local agencies to get people into the housing system and connect them to needed resources. In his work he sees major issues that need to be addressed if homelessness is going to be tackled in a meaningful and systemic way. There needs to be more locally situated jobs that pay a livable wage, decent opportunities to make a career, and more affordable quality housing.

Cowboy visits with a friend at the Patriot House, a homeless veterans housing unit he once supervised. Between 1977 and 2013, Cowboy worked odd jobs to support himself. In that time he became a recovering alcoholic and cross-addicted drug addict, lived on the highway, rode boxcars, and hitchhiked. ▼

Connections would like to thank ***The Muskegon Times***, the original publisher, and **Pat ApPaul** the author and photographer, for permission to reprint the "Cowboy" story here.

A documentary photographer from South Wales, UK, Pat ApPaul is now based in Muskegon, Michigan. He is interested in exploring and sharing the stories of people on the edges of society in western Michigan. ApPaul's work can be found at www.PatApPaul.com, and he can be contacted by e-mailing Pat.ApPaul@gmail.com.

Additional photographs can be found at www.patappaul.com/cowboy. Also a videographer, Mr. ApPaul has made a video about Cowboy, which can be found at:

https://youtu.be/K6fLEpr3uC0.

To view this article as it originally appeared in the Muskegon Times (with larger color photographs), scan the QR code below. We also extend our thanks to Mr. ApPaul for trusting us to edit the sizes, and convert his photographs to black and white for printing.

COMMUNITY CORNER PUBLIC BROADCAST TV SHOW

Community Mental Health Association of Michigan

2019 Jim Neubacher Media Award Winners

David DeWitt Taylor • Ryan Nicholas Gray • Aaron Castle

The **Community Corner TV** show is hosted by David DeWitt Taylor, Ryan Nicholas Gray, and Aaron Castle. The show first aired in October of 2007, after these three young men (students at the time) enrolled in a video production class at Community Media Network (CMN) in Troy, MI.

Community Media Network offers classes for individuals interested in the taping, directing, filming, and editing of cable broadcasting. These classes are open to anyone in the community. David, Ryan, and Aaron were the first people with intellectual and developmental disabilities to enroll in the class.

They were pleased to learn that the CMN class instructors were very welcoming of people with all ability levels in their classes. Being a part of such an inclusive experience is positive for all involved, not just the students with disabilities and their families who witness this exceptional community-based learning environment, but also for other enrollees in the classes, fellow CMN staff, and those who volunteer time to help along the way. The Video Production classes meet the needs of all their diverse community attendees and serve as a role model of the benefits of community inclusion.

The **Community Corner** production moved from CMN TV in Troy to ONTV in Lake Orion with episode 65 in February of 2013. Joe Johnson, the guys' original class instructor from 2007, transitioned from CMH TV to ONTV in Lake Orion to continue as the Studio Director of the Community Corner TV show.

Each month, David, Ryan, and Aaron invite guests on the show for personal interviews to discuss community resources and issues that affect the lives of people with disabilities. Hosting this show has allowed David, Ryan, and Aaron to use their talents and passion to increase awareness, reduce stigma, and make a difference in our community.

They have recorded 128 episodes and have had a range of guests that contribute significantly to improving the lives of individuals with disabilities. Their guests have included Jane Porter, of Leader Dogs for the Blind; Roger McCarville, the creator and producer of the PBS show "Disabilities Today"; plus many more guests from advocacy organizations; hospitals and service provider organizations; Oakland County Community Mental Health; and even Karen Drew, Investigative Reporter and Anchor from the Channel 4 WDIV News.

The three gentlemen have wonderful on-air personalities and are engaging hosts. The Community Corner Show is impressive and successful. It is an asset to our community, and the commitment of these three young men is highly commendable. I know receiving an honor such as the ***Jim Neubacher Media Award*** from the Community Mental Health Association of Michigan was a tremendous honor for them and their families.

To watch the YouTube presentation, enter this URL of the Special 100th episode special into your browser window:

https://www.youtube.com/watch?v=yOalmBmCw4I

CHAD'S STORY

Catherine Kellerman, Newaygo County Mental Health Center, CMHAM Secretary

Chad and Catherine

This is the story of a boy/man named Chad. It is also the story of a broken family—mom, dad, brother—and their journey through the world of divorce and mental health. Mental health disorders can affect anyone at any time. Mental health disorders can tear down, and also build up; can separate and bring together. You will experience failures and triumphs. The binding factor is love and perseverance. The journey through the field of mental health can achieve great outcomes if we hold on, embrace hope, and never give up.

Chad was adopted by a young couple at the age of three months. He was a wonderful, remarkable infant, toddler, child, and young man. I am/was his mother. Unfortunately I had married a man who could not hold a family together; a self-centered, self-serving man who only cared about seeking his own pleasure. As Chad grew through his teen years, his adoptive dad looked more toward outside pleasures and chose not to be involved in the needs and desires of a child, especially when he approached puberty. It is a time when a son should be able to look to his dad as an example of manhood, fatherhood, and marital accord. This did not happen and Chad suffered as a result.

As this family fell apart, Chad was affected in ways that brought a latent mental disorder to the forefront. A young teen's feelings are very tentative as he traverses through the world of growing into a young man; hopefully he has a father who can show him the way. This was not the case for Chad.

When Chad was 10 years old I brought another child into this world, thinking we would be a wonderful, loving family. Little did I know that the dad in this scenario was finding pleasure elsewhere to the detriment of his family's well-being. Chad was an extremely intelligent and intuitive boy and recognized what was happening before his mom did. He could not handle the deception he saw everyday and finally brought it to his mom's attention. Chad began to rebel—breaking rules, and causing problems as the family disintegrated. Mom attempted to seek help through a bevy of counselors, doctors, and rehabilitation programs that hopefully would keep Chad, mom and baby brother together as a family unit. Eventually Chad was diagnosed with juvenile diabetes, and bi-polar and anxiety disorders

Once the root of the problem was diagnosed, and the proper help secured, Chad began to make many strides to recovery as did his mom, brother, and new stepdad through counseling and outpatient services. This did not happen all at once, but took many years of counseling and working through issues. Eventually his adoptive father recognized the needs of working with mom, Chad and brother along with mental health experts. The best help came through a local CMH in the city in which Chad lived. For the first time we saw improvements in Chad's frame of mind and he began a road to recovery.

In some respects, this story did not ultimately have a happy ending. Over the years, Chad's juvenile diabetes took a toll on his system, especially during his rebellious period when he did not take care of his physical health as prescribed. At the age of 46, after the ravages of diabetes, rebellious behaviors, three years of dialysis for kidney failure, two heart stents, serious retinopathy, and a leg amputation took their toll. Chad succumbed to death on August 3, 2018 while in hospice care. However, Chad did end up with a passable, love/hate relationship with his dad, and a warm and connected relationship with his mom, stepdad and brother. I have Genesee County CMH to thank for the last several years of a wonderful, close relationship with my wonderful son. Chad recognized, and often commented on the fact that I never gave up on him, even during his most trying behaviors. Love is the most important emotion during times of trials and troubles; mine was strengthened by the knowledge that my son was a wonderful person underneath all the emotional turmoil.

I will always remember the love that shone from Chad's eyes the day my husband and I went to the doctor with him, offering to give him a kidney if we matched. We learned that we were too old to donate, but the fact that we offered meant the world to him. I know he left this life feeling thoroughly loved. It was his decision to call hospice. I told him I knew he had been fighting to hold on just for me, so I told him I would certainly honor his decision. This is what I said to him when he asked me to call hospice, "I have loved you from the first moment I saw you; I have loved you all your life. When God calls me home my soul will find yours and I

(Continued on back cover)

RIDE OF A LIFETIME

(Continued from Page 9)

all about relationships.

I remember fondly the interoffice softball games and bowling tournaments. The men's league softball team (we won a championship), our basketball win over the staff at the Regional office (played at the gym at Arnell Engstrom), the agency Christmas parties, and the friendship and cohesion of staff. Dedication to a common mission. I found this everywhere I went. Relationships.

Looking back (and I often do) I realize how generous these years have been to me. I am amazed at the number of extraordinary people I have met. Courageous clients, dedicated case workers, doctors, law enforcement officers, EMTs, commissioners, judges, community providers, family members and board members on both sides of the bridge I crossed so many times. All about people, never profits. Committed to communities and full community participation for all. I made the right choice years ago and am a wealthy man. Wealthy in experiences and relationships and a trove of wonderful memories I will always cherish.

Bill Slavin pursuing one of his favorite activities.

I would not trade this for anything.

More about the author: *Born and raised in Howell, Michigan, William Slavin earned a BS from Michigan State University, and an MA in clinical psychology from Western Michigan University.*

He began his career in public mental health as a children's outpatient therapist for North Central CMH. Over time his clinical and administrative responsibilities were expanded and he served in a variety of clinical supervisory roles, and as CEO of NorthCare Network until his retirement in 2018.

Slavin is the President of the Critical Incident Response Team of Northern Michigan, and former Vice President of the Michigan Consortium for Healthcare Excellence. He has served on numerous committees at the PIHP and MDHHS. He also served on the Executive Board of the Community Mental Health Association of Michigan.

He is spending his retirement years enjoying time with family, friends, and pets and in the relentless pursuit of trout fishing (catch and release, of course).

My Life

(From Page 8)

he put me down a lot because he didn't like what I was doing. He went out with other people and one day I asked him to leave. I had to get caregivers to help me a few hours a day. I needed help with preparing meals, grocery shopping, laundry, and personal care.

I have been fortunate to live in an area near a mall, a lot of shopping centers, a movie theater, and restaurants. One of my favorite things to do is to go to Panera Bread, Tim Horton's, or Starbuck's, and get a snack and read a book. That is so relaxing for me!

In the summer of 2017, I had my left hip replaced. It had a lot of arthritis and I crawled all the time to get around the house. I had the surgery on a Tuesday and went to a rehab center on Friday. It was more like a nursing center than anything else because people were living there for a long time. I was there for three months. I got physical and occupational therapy so I could get stronger. It changed my life since I no longer had to crawl. Instead of needing about 12 hours of help a day, because I had needed help with transferring, I now only needed a few hours a day.

> **There's a lot of stigma around nursing homes. People told me I wouldn't be happy in one.**

I moved into a nursing home a couple years later. I was having problems with caregivers. They were leaving me alone too long and I stayed in bed because my morning caregiver fell asleep and didn't hear me when I wanted to get up.

There's a lot of stigma around nursing homes. People told me I wouldn't be happy in one and all my rights would be taken away. That simply isn't true. I get to be showered, something that I wasn't getting at home, and I get to go places, out to Wal-Mart, and to Panera Bread. They encourage me to speak up when things aren't going right. They remind me that this is my home and I have rights.

I feel very blessed with the life I have. I feel fortunate I have the support of my family and friends. I am thankful for every day I have.

A note by Lois Shulman: *Renee moved from Detroit (where she lived in her own apartment and hired her own staff), to a nursing home. Her lived experience of this transition is invaluable to leaders, decision makers, and her peers. She has gained the insight and understanding of how these two living situations function to serve those in need of the services provided, her concerns, and her vision. She enjoys writing and wishes to share her lived experiences, and wisdom gained.*

Integral Health Care

(Continued from Page 1)

the consequences for our relationships. By that time, Ferguson already knew who and what was dominating the way we think about ourselves; contrasting it with what was really important in our lives. For us to journey inside and develop our potential as human beings, it would require a conspiracy at the ground level. Chapter 8, “Healing Ourselves,” (pp. 241-277), is even more poignant today than when it was written. What follows are quotes from the first and last pages of that chapter: “The autonomy so evident in social movements is hitting the old assumptions of medicine hard,” (p.241) and “Surely historians will marvel at the heresy we fell into, the recent decades in which we disregarded the spirit in our efforts to cure the body. **Now, in finding health, we find ourselves**.” (p. 277)

The question that arises is; what is this “self” that I’m trying to find?

Rene Descartes, widely regarded as the father of modern philosophy, in his *Discourse on Method* (1637), stated that there is one incontrovertible fact that still stands today, “I think, therefore I am.” A moment of introspection verifies this truth; I have consciousness; more accurately, “I am consciousness.” *It is this first person phenomenon of awareness that constitutes my fundamental existence.* **This subjective, interior *experience*** is more fundamental than my physical body, including the most complex organ, my brain. To repeat, consciousness is the only incontrovertible experience common to every human being! It is a first person phenomenon. Being an interior, subjective, unique experience, we simply do not have the ability to directly know what another person is experiencing. The dominant world view of materialism, without any means of proof, has reduced our first person experience to a physical, material process; an epiphenomenon of the brain. Our consciousness is undoubtedly enabled and correlated by and with the brain but there remains a categorical, qualitative difference between the object (my brain) and my subjective experience. The implications are profound!

In healing the whole person, we must begin with the subjective experience of consciousness.

In healing the whole person, we must begin with the subjective experience of consciousness. Let me provide a personal story that may help clarify the issue. Having been deaf in my right ear since birth, I became aware of one of those miracles produced by this dominant scientific worldview, artificial cochlear implants which restore the pathway for sound waves to be received by the auditory nerve and transmitted to the brain, enabling me to experience sounds on my right side for the first time in my life. Before attempting this procedure, the surgeon ordered an MRI, an image created by a machine using a magnetic field of resonance. This is a physical process that is capable of producing an image of my physical brain. The experienced technician that looked at these pictures provided an interpretation to the surgeon. His experienced opinion was that the biological mechanism I had between my ears (brain) had the capacity to process sound waves. I was a viable candidate for implanting an artificial cochlea. (And importantly, I was qualified by the standards established by the FDA to be eligible for coverage by Medicare.) However, neither the MRI interpreter nor the surgeon had any idea of what my conscious experience was when I was inside that noisy contraption! What they were perceiving and interpreting was an *extrinsic* picture of a physical brain that correlated with an *intrinsic* experience of my consciousness. They were looking at a physical structure but they had no direct access to my mind. We need to distinguish between the ontological primitive of reality that is consciousness and the correlating activity of a physical entity, be it quantum, biological, chemical or neurological. As we learn to do this perhaps we will see the wisdom of giving a lot more credence to the first person *experience of care* which is an attribute of consciousness.

Let’s expand on the implication of granting primacy to the experience in consciousness with another personal story. Self-directed care is already a reality for some of us who have the resources. Some years back, having entered my sixth decade, a physically active lifestyle, coupled to a genetic predisposition, had exacted a toll on my left hip, requiring daily dosages of extra strength Tylenol to manage the pain. I sought out an orthopedic surgeon who had a stellar reputation for hip replacement. Sure enough, after viewing the x-rays, he assured me I was a candidate for a titanium hip which hopefully would resolve that conscious experience of pain. I signed up!

Then came the stack of literature that has become common place with such interventions, the list of “what ifs,” limitations and waivers that will hopefully provide some cover for the surgeon should my *experience* not be what I was led to believe it would be. Fair enough. However, it was the limitations that snared my consciousness. Upon reading what I should not do, ever again, I reasoned my quality of life (ongoing conscious experiences) would be worse than it was with my daily regimen of Tylenol. I went back and cancelled the surgery. The surgeon was gracious and understood, “Come back when you are ready.” Several years later I decided it was time. I needed more than Tylenol to keep the experience of pain at bay that was intruding into my consciousness. I believe I made the right decision both times; both were driven by my interior experience that correlated with an exterior condition of my physical body. It was that subjective experience that directed the surgeon to step back at first, and years later to step in and apply his skills. Self-directed care is a critical dynamic if we value the experience of satisfaction as a criterion of quality. Granted, it requires knowledge of available resources, informed decision making and assistance in navigating the possibilities, but it remains as ultimately being an activity of consciousness.

Another implication of acknowledging the priority of the individual subjective experience (consciousness) is the realization of the critical role social determinants play in our well-being; quality of life is not limited to the condition of our body. A moment's reflection on what is essential to our quality of life—and by inference, to our wellness—quickly identifies numerous factors not addressed in the doctor's office. Do I have a place to live, do I feel safe, do I have friends, do I have adequate income, transportation, education, availability of healthy food, and embedded in a healthy environment? We know that the stressors of poverty greatly diminish our well-being. Needing to address all of these social factors is a cornerstone of the foundation of integral care; again, integral means including everything that is essential to my quality of life. When we start making a list of all the essential factors for being a whole (healthy) person, a couple categories emerge that seldom are addressed by our primary care physician unless we are about to completely fall apart: relationships, and the quality of my interior/subjective experience. The multiple array of services, coupled with case management available in community based services, comes closest to providing access to the essentials of wellness. Can this be called "integral care"? Well, not quite, but it is a huge step in the right direction.

With healthcare being dominated by the bias for conflating our identity with our physical bodies, physical health has become regarded as primary. In spite of some amazing benefits this has developed; as we saw earlier, it has acquired very disappointing results in the outcomes of the triple aim: population health, experience of care, and the per capita cost. Why?! Many reasons are presented, but one that is seldom acknowledged is our cultural bias that puts misplaced value on material/physical realities. One place we can make a significant difference is by challenging the bias in healthcare that focuses primarily on physical interventions such as drugs to alleviate our conscious maladies. A recent issue of the *British Medical Journal* cited a review of 148 studies that concluded "the influence of social relationships on the risk of death are comparable with well-established risk factors for mortality such as smoking and alcohol consumption, and exceed the influence of other risk factors such as physical inactivity and obesity," and that "physicians, health professionals, educators, and the media should take social relationships as seriously as other risk factors that affect mortality." We all know this intuitively; yet we shy away from a deeper discussion of why this is so. Let's be honest; it is difficult to monetize social solutions within the current structures of primary healthcare. [https://www.mentalhealth.org.uk/publications/relationships-21st-century-forgotten-foundation-mental-health-and-wellbeing]

Social determinants and relationships are but a couple of the myriad of factors that surface when we shift our primary focus from our biological bodies, balancing it with first person accounts. It is time to seriously challenge the efficacy of the culture that has invaded the offices of our primary care physicians—leaving minimal time for first person stories—primarily because they are not billable units. There is hope. The importance of telling our stories is the basic theme in the emerging practice of Narrative Medicine. [https://www.narrativemedicine.org/about-narrative-medicine/]

The dominant system of healthcare which is responsible for generating the alarming statistics of quality and efficiency is suffering the affliction of misplaced concreteness. The primacy of individual experience-—our consciousness—which should be the concrete fact that is being addressed, has been relegated to second class status of behavioral health with the failures hopefully being gathered up in a public safety net which has become increasingly strained by lack of funding. The scope of resources needed to address all of the essential components of integral care is not expedient for existing primary care providers to pursue. The time frames in which they are operating are often dictated by the demand for *timely* reports by their shareholders. The drive for integral care must arise from the people being served— the public. It will not arise from the desire to gain monetary profit by a privileged few. Coupled with the worldview that we are fundamentally physical beings, the desire to accumulate material goods has acquired considerable power. A materialistic worldview nurtures greed. The primary motivation of integral care is compassion, focused on the well-being of the individual being served, guided by their subjective experience. Integral care treats the whole person, beginning with an assessment of their experience. To paraphrase Descartes, "my interior experience is who I am"; when I enter your presence, see me. Care of the *heart* and *soul* is what we all desire at both the beginning and end of the day. Somewhere along the way our healthcare culture seems to have become confused; identifying with material compensation, the physical body, and discounting the primacy of our interiority. Who do they think they are? ■

---

*https://www.bloomberg.com/news/articles/2019-02-24/spain-tops-italy-as-world-s-healthiest-nation-while-u-s-slips

** https://specials-images.forbesimg.com/imageserve/5d4be2265040990008805ab0/960x0.jpg?fit=scale

CMHA's SYSTEM INTEGRITY

(Continued from page 5)

- State financing of risk reserves
- Sub-capitation payments to the CMHs and the ability to retain savings; with incentive and shared saving structures.
- Sharing of savings across the physical-mental health care line.

12. Retain and expand the groups served by the public mental health system to include:

Current groups served by the system:

- adults with serious mental illness
- children and adolescents with serious emotional disturbance
- children, adolescents, and adults with intellectual/developmental disabilities
- children, adolescents, and adults with substance use disorders

Groups to be added to responsibility of the public mental health system:

- children, adolescents, and adults with mild to moderate mental health needs

Guided by this set of system integrity and system design principles, CMHA, in partnership with its members, persons served, advocates, and community partners, will continue its work with policy makers to refine and redesign Michigan's public mental health system.

MISSION

(Continued from Page 6)

What and who all are involved in our well-being? Evidence shows that the circle of care encompasses a far greater expanse than we are accustomed to thinking. A question that needs exploring by all healthcare providers is: Do we have the means to address these multiple relationships that are essential for our wellness in today's society? Has our specialization blinded us to the complexity of the individuals we are serving? *Connections* explores the impact of a multiplicity of relationships from the inside through personal stories.

After the first couple years or so, as Editor of *Connections*, someone remarked to me that they never thought it would last that long. Now, a dozen years later, my deepest concern is keeping abreast of what I truly believe is the burgeoning potential. It has become apparent that a key part to its success lies in plain sight, the healing function of storytelling; stories that resonate within the heart and soul of countless people which constitute our communities that care. Isak Dinesin said, "To be a person is to have a story to tell."* The diversification over the past few decades in the field of psychology is a reminder that our stories have countless chapters with many dimensions. We are far more complex than the systems that treat us, and everyone is unique!**

I firmly believe that the primary factor that will shape the efficacy of healthcare in the future is an appreciation for this complexity. A positive trend is the recognition of the importance of the experience of care which requires an entirely different set of skills than those of the neuroscientist studying the brain. A quick glance at their respective pay scales reveals what's driving our current system. Nevertheless, the cumulative impact of the experience of care will ultimately shape the efficacy of our systems; the question is how much needless suffering will occur as we tinker with our current structures with their competing motives? Meanwhile, the mission of *Connections* is to tap into and share the fathomless depth of compassion that lies at the heart of the subjective experiences within both those providing and receiving the care that impacts our well-being. These are the stories you will read. This is the force that will endure.

> **"To be a person is to have a story to tell."**
>
> **— Isak Dinesin**

*Isak Dinesin, a Danish author, is considered one of the greatest story tellers to have lived. *Out of Africa* is one of them.

** https://www.medicalnewstoday.com/articles/154874.php The above article is but one that addresses the bewildering proliferation of various fields dedicated to a study of the mind/consciousness. Perhaps the most revealing statement was made by Sonu Shamdusani, widely regarded as the leading Jung historian at work today, "I think one has to look first at how psychological concepts are actually used and were developed in a task to complete the scientific revolution. The notion was that psychology was to be the master science that would underpin all other sciences. Well, this clearly didn't work. We've got as many psychologists almost as there are people. And one thing that I think all psychologists have in common is that they don't agree about anything, apart from that they use the word 'psychology.' So you have to ask is this a science?" *Lament of the Dead: Psychology after Jung's Red Book* pp. 11-12.

Neal Response *(Continued from Page 4)*

are isolated and we are more knowledgeable about different cultures. This can be threatening to some people and promote conflict and divisiveness. Unfortunately, the political debates and many talk shows are people yelling at each other. I always wonder what examples they are for our children and our future. We need to learn to listen.

Galloway: Yes! I firmly believe the underlying drive on our planet today is the quest for autonomy, and to have a voice. Facilitated by the wireless technology of communication, memes develop networks overnight! Our world has not only shrunk, it is rapidly changing. The collective force of the innate push for recognition is powerful; as a result, hierarchical structures have been eroding fast. We live in virtual chaos. I believe that the systems that endure will be those that are rooted in and guided by these grassroots' networks.

Neal: *Agree again. The individual desire of many people to be free, to be themselves, and do better is the hope for the future. There are always some individuals who are willing to join groups. Most people like to feel a part of a group. Some are fringe groups that create more conflict in the world.*

Galloway: This brings me to a deep concern that arises from recognizing the complexity of our consciousness. There is an assumption that we are being person-centered when we offer individual choice. That seems, at best to be a half-truth that can become a screen for the vested interests of those making the offers. Let's consider choosing your health plan. The choice is only a true and valid choice if (1) the individual is being offered what represents the best care available for their affliction, and (2) they understand how their choice will impact them. Those are two big "ifs." We know the power of persuasion employed by vested interests. Individual choice must be protected by eliminating the interference of vested interests. What is your experience in enabling people to make good choices?

Neal: *It seems that you are raising two issues. I agree that giving choice to the patient and attempting to make their treatment a positive experience is far from understanding their consciousness. For me it is a start at beginning to involve the patient and respect that all individuals are not the same.*

The question of what is the "best care available" and how it should be organized are major issues for providers and the individuals served to determine. Your example of first declining the hip replacement is an example of how you were not ready for the surgery even though it was available. Think of the number of people who do not have a funding source and access to it. Should every individual have access to "best care"? If so, how should it be funded? I am not sure that the "Medicare for All" that is being proposed would provide funding for everyone to have access to the best care available.

Galloway: There is one issue we haven't discussed that arises as we focus more on our subjective experiences—how do we, as a system, handle that information? I recently asked a psychiatrist what change would help him the most for improving the integration of care. His response was immediate and simple; "Open access to all the patient's records." He made the point that you could have both physical and mental health services in the same building and it wouldn't help if those attending the care did not have access to what others were providing.

Neal: *This one hits my career. When I started at the U of M, Psychiatry had its own record room. No one outside of the Department could have access to the records. Records are now fully integrated with access to any provider who needs to know. It is possible to track who accesses an electronic record so it is very difficult for it to be abused. Before electronic systems, records were sent around in grocery carts; there was no way to monitor who read them. However, if an individual goes to providers in different systems, they are dependent on the providers sharing their information. This often does not happen. It takes time to send info or to make a call. In the past, persons served were never told their diagnosis or even what the professional thought their problem was. Now most of that information is available to them via a personal portal.*

On a related note, I did a lot of group therapy. I had each member write a note from their last session; I also wrote one for each member. We would then begin the next session with each member reading their note and then I read mine. The goal was to help each individual, including the therapist, to be open and not keep secrets. They were encouraged to share their inner thoughts and feelings which allowed members to develop supportive relationships. Even in this setting it was often difficult for members to reveal their consciousness.

Galloway: Interesting! We've made a lot of progress in record keeping but perhaps we need more of the work you did in group therapy.

Neal: *I really respect the challenge your paper on consciousness raises for the health care system. Providers are not close to achieving what you are suggesting. I do believe that significant progress has been made by mainstream health care providers— and that they are moving in a positive direction—but there remain many obstacles both internally, in the system, and externally that challenge progress.* ◆

To read more of Neal's thinking, see "A Peek at the Future of Healthcare" at https://cmham.org/wp-content/uploads/2018/06/Fall-2017-Connections-web.pdf

Community Mental Health
Association of Michigan
426 S WALNUT
LANSING MI 48933
Telephone: 517-374-6848
www.cmham.org

Online editions of *Connections* can be found at: www.cmham.org: select "RESOURCES" on the home page, and choose "*Connections*" from the pull-down menu. Committed to diversity and inclusion, *Connections* is pleased to include authors of a variety of beliefs, opinions, and interpretations of facts and events. We do not make the determination of print-worthiness based solely on agreement with the *Connections* Editorial Board or the publisher, CMHAM. Individuals interested in contributing to *Connections* are invited to contact the editor at: loisshulman@comcast.net.

Connections is published by the Community Mental Health Association of Michigan • All Rights Reserved

CHAD'S STORY *(From Page 14)*

will love you through eternity." At that point he gave me the greatest smile which I hold in my heart and mind to this day.

Mental disorder should never succumb to stigma as a reason for not seeking help. Mental disorders are no different than someone who has cancer, heart disease, or any other ailment of body or soul. As a parent, relative, or friend, you just need to continue to search for the treatment that will work. Yes, it does take perseverance, vigilance and hard work to combat mental illness, but it is totally worth it—no matter how long it takes—when you see your loved one totally invested in the road to recovery.

I miss my son every day, but I know that he revels in the fact that we never gave up on him. His life is a testimony to the positive results of good mental health programs. Please do not be ashamed to recognize and work toward mental health recovery. We all have gifts to leave to this world and those working through mental illness are no different. A little support can bring out talents and hidden accomplishments that we would not know about if we did not engage with these recipients and help to highlight their talents. So please take an interest in your local mental health programs or club houses to learn where you can be of service and uplift the lives of others.

Who Took My Fine Tooth Comb?

Cindy Chadwick, Connections Designer

In 1971 and fresh out of MSU, I was somehow hired and working in an Adult Activity Program. I loved it and believed I'd found my forever career. Well, I'd found the *first* one. Other jobs followed, and in the years after 1986, I held some wonderful positions in human service organizations, but I still missed my CMH days.

By the time I met Clint Galloway in 2007, I'd had my own consulting and design firm for several years. Clint was looking for a "graphic design/print layout specialist, with a knowledge of mental health, kind of person" who could help him put together a MACMHB newsletter. And just like 1971, I was offered a job not quite knowing what I was getting into but very happy to be back "home."

The past thirteen years of working on *Connections* have been exciting, rewarding, and sometimes—well, sometimes just teeth-grindingly difficult. But I've been blessed to be a part of it, and just like leaving CMH in 1986, I'm going to miss all of you once again. I will especially miss working with Clint, one of the most generous and supportive individuals I have ever known. Fortunately, my contract states that he must remain my friend after retirement.

New people with passion, fresh thoughts, and big ideas will now guide *Connections* as it continues to grow. And to each of you who have ideas to share and stories to tell—*Connections* is your vehicle; get in and take a drive! *(Just be careful not to run over any excess comas, dashes, and semi-colons on the way. I haven't finished picking them up yet.)*