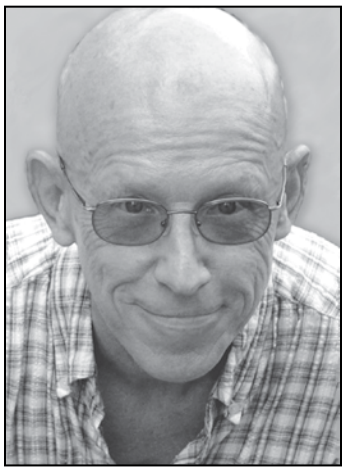
Michigan Association of Community Mental Health Boards

SPRING 2009

Connections

for communities that care



THE ONE TRUE THING

Bob McLuckie, Executive Director, Alternative Services, Inc.

From the Editor: "Direct service is the foundation of Michigan's community mental health and substance abuse treatment system." This is the very first affirmation of the Provider Alliance in its declaration of beliefs. They represent people on the front lines who actualize the principles and values established in our board rooms. Our effectiveness as board members is only as good as the quality of services they provide. They are indeed the foundation of our deliberations. Our connections need to be a two way street. What are they thinking? What do they value? What do they believe is essential to providing effective services? What can we learn from those who engage in the face-to-face encounters with the very people we serve and support?

Connections asked the president of the Provider Alliance, Bob McLuckie, to share his insights of this perspective from the front line. We believe you will find his report very affirming and inspiring!

For over thirty years, the mission of our company has been to help people engage in life-affirming ways within their chosen communities. Lives are enriched through exploration and discovery. People grow from forced dependence to empowerment: a 'home of my own', a job and a paycheck. Some thrive while others struggle. Through it all, we in the helping professions carve out roles, set goals, define processes, measure outcomes, and seek continuous improvement. We're rarely finished; there is constant movement and many meetings. The pace can be exhausting, and there is always the demand to do it better, use a promising new approach, achieve better outcomes, etc., etc. Frankly, it gets pretty hectic here in the trenches of direct service.

I began my career in 1971 at a large state institution. On my first day, the supervisor walked me to the end of a long hallway in Cottage 3, unlocked a heavy steel door and hurried me in, securing the door behind me. Here I was greeted by a rush of about 40 boys and girls, ages 4 -7 years. The children smothered me with clutching, hugs, and much clinging. It was here that I discovered the *One True Thing*.

I met John Henry in Cottage 3. A short stocky boy of five with a constant runny nose and a tenacious muscular grip, his strapping two-armed hug around my leg was unyielding. John Henry held on so tight as to become part of my own body, never letting go until I reached down to pick him up and carry him as I moved about the day room. John Henry showed me the One True Thing and taught me perhaps the most important lesson I've ever learned–that living is essentially about Connection with Others; living is about relationships.

Beneath the flurry of interventions, programs, service plans, goals, and outcomes; beneath the urgency of philosophies and the reach for the purity of best practice, it is connection with another, affection freely given, a sense of human kinship no matter how simple or unembellished, that builds and sustains us as persons. Human connection is the direct service provider's most valuable gift.

Lessons Learned

1. The customers' encounter with the service provider is fundamental, defining, and precious.

~ My friend Dan lives with paranoid schizophrenia. His home is a supported independence arrangement shared with several others. Dan does very well when he stays on his meds and when the Doc doesn't adjust them. My provider agency supplies staff to Dan. As the Executive Director, I visit to see how things

(continued on page 7)

Inside This Issue...

e-connections 2
Lori's Story.....2
ARR Navigation Guide 3
The Last Flip.....4
Creative Minds Art Auction.....4
Clinical Interventions for Consumers with Developmental Disabilities.....5
Walk A Mile Rally.....6
Spring Conference Highlights.....8

e-connections

It's worth your time to check these sites...

- **http://www.macmhb.org/Provider%20Alliance/ProviderAlliance.html**

  This site will give you access to information about the Provider Alliance including who they are and what they believe. Of particular interest is a white paper they produced entitled, "A Time of Opportunity: Five Practical Cost Effective Ways to Help Michigan's Community Mental Health System Now". A statement from this paper: " It's very simple: The Community Mental Health system should focus on the needs of the person seeking services."

- **http://www.michigan.gov/documents/mdch/ARR_final_2_10_09_266727_7.pdf**

  Here you will find the final version of the Application for Renewal and Recommitment.

- **http://macmhb.blog.com/**

  Livingston County is where Lori's Story originated. Her story was part of an article about the remarkable success Livingston CMH has had in bringing together various community partners to address the multiple needs of kids. We have posted the entire account of this remarkable achievement on the Board Member CMH Blog site concurrently with the publication of this issue of Connections.

- **http://www.thenationalcouncil.org/cs/about_us/national_council_magazine**

  "Lori's Story", referred to in the previous "e-connection" first appeared in a special edition of the National Council Magazine on Kids. This special edition of National Council Magazine portrays the current landscape in children's mental health and addictions. The magazine outlines the challenges in funding, policy, and practice; and highlights innovative and effective community services and supports that are increasingly available to children and youth with behavioral health challenges and to their families. It points to what still needs to be done — with all of us working together — to provide a better future for our young people. The magazine speaks to our progress and also to the possibilities that lie ahead.

- **http://www.cbsnews.com/stories/2009/03/22/60minutes/main4882450.shtml**

  It's not too late if you missed it! "This is one of those urban fables that happens to be true. Steve Lopez is a newspaper columnist for the Los Angeles Times; Nathaniel Ayers is a troubled man with a brilliant past. They met by chance on the streets of downtown L.A. - an encounter that would change them both. The story of their friendship is a tale about madness, redemption, and the mysterious power of music." (If you Google this story, you will find video versions of this amazing story of a person with serious mental illness!)

- **http://www.soloistmovie.com/**

  The "60 Minutes" story referred to above has been released as a movie entitled "The Soloist". This is the official web site of the movie.

How it All Comes Together: Lori's Story

Lori, age 14, was referred to wraparound by her probation officer. The court was considering placing her in a residential treatment facility after repeated incidents of physical aggression toward her mother. Although Lori had received mental health treatment and special education services, these, along with a variety of court interventions, including detention stays, were having little impact on her escalating behaviors.

Lori's wraparound team focused on two complementary strategies. The team recruited a behavioral psychologist to develop a plan targeting the antecedents of physical aggression and implemented that plan with in-home behavioral coaching for Lori and her mom. Concurrently, the team encouraged and supported Lori's interests in arts and community activities through flexible funding. Psychiatric evaluation with medication treatment, in home family therapy, and respite opportunities for Lori's mother supported both strategies. During this period, Lori also reestablished her relationship with her father, who joined her wraparound team.

Regular team meetings allowed for real-time modifications to the plan, kept the key players on the same page, and provided the court with needed oversight. As Lori's behavior stabilized, the team supported her in developing friendships, participating in school activities, and holding a part-time job. Lori completed her probation terms, "graduated" from wraparound, and continues to use some limited mental health and special education services to support her ongoing family and community successes.

There have been challenges along the way. The ability to commit the time to attend regular team meetings has been an ongoing issue for busy professionals (and families). Sharing decision-making responsibility with a team is easier for some professionals than for others. The team process can take time to yield results– therefore many teams now start with "quick wraps" to address safety concerns first. The overwhelming feedback, however, is that families and staff benefit from the support and unity of purpose that come from working together as a team.

Human services leaders in Livingston County look at their children's system now and like what their vision for wraparound created. The financial commitments of the partners remain strong, based on the goal that services should deliver good value.

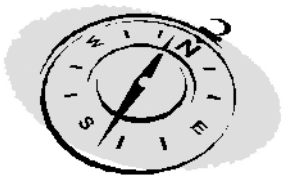
Clinical outcomes have focused on helping children improve their functioning and remain in their home, school, and community as a result.

The wraparound partners selected the Child and Adolescent Functional Assessment Scale as their primary tool to measure outcomes. The CAFAS is sensitive to overall improved functioning, and its subscales (school, community, etc.) address the specific concerns of the partner agencies (e.g., schools, court). Child functioning on the CAFAS has shown consistent and significant improvement.

Over the past 5 years, the CAFAS scores of children served by wraparound have decreased by an average of 40 points, which is twice the level of improvement seen in our traditional services. Also, in each of the past 5 years, between 70 – 90% of the children served have been maintained in the community and have avoided costly out-of-home placements. Local success with wraparound has sparked additional collaborative initiatives, which currently include a trauma-informed system of care initiative and a model court plan for child abuse and neglect.

In Livingston County, Michigan, we know community collaboration is here to stay.

Reprinted with permission from the *National Council Magazine*, Fall 2008, "Toward a Brighter Future: New Opportunities for Children and Youth."



APPLICATION FOR RENEWAL AND RECOMMITMENT

–Navigating through the MDCH Medicaid Waiver Renewal Process

Robert Sheehan, Executive Director, Clinton-Eaton-Ingham CMH Authority

We at Connections believe that the decision by the Michigan Department of Community Health to use the "Quality Improvement" option to renew the Medicaid waivers provides a unique opportunity for all boards to review their principles and values as they address the eleven sections in the Application for Renewal and Recommitment. (ARR) This is the essential role of governance. We asked Bob Sheehan to provide the following article which will enable individual boards to discuss these eleven sections to identify their strengths, weaknesses, challenges and opportunities as well as establish strategic plans to meet objectives for improvement. Thanks Bob!

As many of us know, Michigan's Medicaid mental health and substance abuse system operates under a number of federal Medicaid waivers. These waivers must be renewed periodically through a process which requires the approval of the federal Centers for Medicare and Medicaid Services (CMS). As a part of this process, CMS works to assure that those who hold the contracts to manage a state's Medicaid benefit – in Michigan's case, the Medicaid mental health and substance abuse benefit is managed by 18 Prepaid Inpatient Health Plans (PIHPs) – are fulfilling the intent of the Medicaid program and the waiver. As you know, each of Michigan's 46 CMHs are PIHPs or are affiliated with a CMH who serves as the PIHP for the affiliation. This assurance process can take one of many forms, including: a bid-out process, a compliance review process, or a quality improvement approach. For 2010, the Michigan Department of Community Health has taken a quality improvement approach, by requiring that each of the state's PIHPs submit an Application for Renewal and Recommitment (ARR). The ARR process requires that each of the state's PIHPs respond to questions in eleven areas, with each response providing an environmental scan of the PIHPs performance or work in the area and its plans for improving performance in the area. The 11 key areas of focus identified in the ARR are outlined below, along with a short description of the importance of each section to the quality of the state's Medicaid mental health and substance abuse system. The full set of ARR requirements can be found at http://www.michigan.gov/mdch. Thank you to the Mid-Michigan Affiliation partners for their descriptions.

1 Partnering with Stakeholders in the Design, Delivery, and Evaluation of the Public Mental Health System.

"Stakeholders" is defined as people who receive public mental health services, their supports (family, friends, and advocates), providers, and other interested groups. Stakeholders have for years been involved in a variety of ways in the design, delivery, and evaluation of the public mental health system (on Boards of Directors, on advisory councils, in workgroups, etc.) The focus in this area is developing "innovative methods to recruit, support and retain stakeholders" and "ways to involve stakeholders so that they feel their participation is meaningful."

2 Improving the Culture of Systems of Care.

This area looks at how the public mental health system provides a culture of care that is the most conducive to ensuring optimal outcomes for persons served. It includes:

- *Ensuring a welcoming and caring culture, from the front door and throughout the service experience.*
- *Promoting a "culture of gentleness" wherein positive supports, interventions, and approaches are used, regardless of the challenges a person may present, and better learning to interpret behavior as communication about that person's experience.*
- *Working with a "trauma-informed system of supports," with the organization supporting staff training and agency policy in recognizing and understanding how past experiences with trauma and stigma affect a person's life and support and service needs.*
- *Ensuring an integrated system of care for families with children with SED or DD.*
- *Promoting a culture that recognizes and values recovery of persons with SMI.*
- *Promoting a culture that is recovery oriented and strength-based for persons with substance use disorders.*
- *Working with partners and stakeholders to reduce stigma within the mental health system and in the community.*

3 Assuring Active Engagement.

Regardless of the level of supports and services for persons with DD or where they reside, they must be provided with opportunities to engage in activities that are chosen by them and are meaningful to them, and provide them with opportunities to have involvement and participation in the community and with friends and family, to be productive, and to be independent at the highest level of personal capacity and interest. This area requires the system to assess the extent to which individuals with DD participate in chosen activities outside of their home, and how to improve this.

4 Supporting Maximum Consumer Choice and Control.

Supporting consumers to choose and control their supports and services is critical to Person-Centered Planning and Self-Determination. This area assesses current practices and plans for improving the Person-Centered Planning process, the implementation of Self-Determination, and the utilization of Fiscal Intermediaries and External Facilitators for planning meetings.

5 Expanding Opportunity for Integrated Employment.

Employment is seen as a critical factor in the opportunity for individuals to not just gain an income, but also to engage as a member of the community and develop a capacity to choose and control their life direction. This area focuses on the public mental health system

(see *"Renewal"* page 6)

That Last Flip!

John T. Fryer II, Certified Peer Support Specialist,
Project Stay Associate Director, JIMHO

Since my early 20's, when I was first diagnosed with paranoid schizophrenia, I have lived a very full and proud life. Recovery back then took some time and patience. I was a struggling thespian and had broken my foot doing naked back-flips down the streets of Los Angeles, running from the voices in the media. Nobody understood the panic and danger I was living in at the time. I had nothing to lose so I decided to surrender myself to the cruel world in my mind that was no longer making sense to me. How in an instant can one's life change forever? And then to be left with no comprehension of reality due to a chemical breakdown in the brain that was silencing like death and at the same time creating a truth within which I was living.

I decided to surrender myself to the cruel world in my mind that was no longer making sense to me.

Doing back-flips was nothing new to my life. As a child I performed in many parades in the Lansing and Detroit areas, was a Michigan State Junior Olympian, and even performed with "Sparty" during halftimes at MSU games. Gymnastics was a big part of my life. I remember calling my talent agent and telling him that they were talking about me on television and that I was scared, and at that point he told me to go to the nearest church. So I ran out of the apartment in my boxer shorts to a church just around the block. I got there and the doors were locked. I had nothing left for which to live; I was a totally lost soul that thought the world was after me. Trust was non-existent. I threw my shorts off and began doing the only "right" thing in my life–back-flips. Imagine it! I was in L.A. where this was no big deal. People were counting rather than concerned for my welfare. On the last flip, I landed wrong and broke my ankle. So now I was crying in pain and required medical attention and was prepped for cardiac arrest. I covered myself under the white sheets as they wheeled me out of my apartment building thinking that I was in a body bag, afraid to make movement or noise. Immediately they took me to an emergency room and at that point the nurses saved my life. They told me someone wanted to talk to me and treated it like an audition: "Tell him you are hearing voices and that you are in your 70's." I did so and landed in what was to be the first of a many psychiatric hospitals.

My family brought me back to Michigan and connected me to Community Mental Health. For some years after the initial onset of diagnosis my life was a constant juggling act–sometimes trying to conceal my illness to save my dignity and other times just trying to sustain sanity. For a time I was also self-medicating, which did not help matters. Dual-diagnosis is very difficult to treat. It takes diligence and hard work. Once I finally admitted that I had a problem with drugs and alcohol I was able to mature into the man I am today. For one year I was sober and regained my life. I even got a plant to take care of in my new apartment after being homeless twice. After battling this dual disease for nearly four years, I now take care of a beautiful cat named "Hugh Hefner."

The services I received helped me gain the independence that I have today. I received housing assistance, food assistance, medication assistance, and college assistance just to name a few. I always knew that I could overcome this illness. Denial was probably the biggest setback for me. Once I realized that medication could manage the symptoms and that I could live a healthy life I was on my way. Certified Peer Specialists played a big role in helping me get all these needs met. Many of them have become my mentors, friends, and associates through not only my place of employment but also around the state. I feel fortunate to live in a state that adheres to supporting recovery through employment services which are an alternative to traditional types of treatment for mental health. We are growing in numbers and our voices are starting to be heard. That in itself is recovery working!

Somewhere in the mix of all of this I was also diagnosed with HIV. Today I am blessed to say that I am a survivor. I look at life as a positive experience in which I am lucky to be cast. There is no time to dwell on labels of misfortune. Recovery begins when I wake up each morning and realize I have another day to live life to the fullest. Educating the public about these illnesses is the best gift that I can give. Once I see people becoming more open-minded about health and wellness and wanting to ask me questions I realize this is being proactive in the journey of recovery.

At this point my greatest accomplishment is my current position at JIMHO (Justice in Mental Health Organization) as a Certified Peer Support Specialist. Knowing that my life's experience is what is valuable to my job gives me power to advocate for others. I have met some of the most honorable and courageous people through the peer support initiative. I will always remember what was told to me early on in recovery: "that I can do anything and be anyone who I want to be." And in my job today I strive to inspire others to do the same. ■

MACMHB & THE PUBLIC RELATIONS WORKGROUP
Proudly Present...

Traveling Art Show Online Auction
October 6 -19, 2009

Since its first appearance at the MACMHB 2007 Fall Conference, this exhibit has been making appearances all across the State. The final appearance is scheduled for the 2009 Fall Conference at Grand Traverse Resort.

The art show pieces will be auctioned off – ONLINE – from October 6 -19, 2009. For information, including a slide show of the artwork to be auctioned, go to www.macmhb.org and click on "Traveling Art Show" under Member Information.

Clinical Interventions for Consumers with Developmental Disabilities: "It is a Matter of How not What"

Michael Brashears, Psy.D, Executive Director, CMH Ottawa County
Betty O'Rourke, MA, CCC-SLP, DD Program Supervisor, CMH Ottawa County

Editor: This is our fifth issue of Connections. In reviewing the contents of previous issues, we realized that we had neglected to address the needs and voice of those with developmental disabilities and their families. We were made acutely sensitive to this omission by the resolution from Ottawa CMH that focused on this very issue. Therefore we asked Dr. Michael Brashears, CEO of Ottawa CMH, to provide the first of what we hope to be several articles that provide different perspectives on this population. In subsequent issues, it is our intent that you will hear from both individuals with disabilities and from family members who often provide much needed supports for those who are more severely disabled. We are indebted to Dr. Brashears, Betty O'Rourke and the Ottawa CMH for their excellent contribution to this discussion.

Over the past 10 years the philosophical underpinnings for conceptualizing and providing services for the developmentally disabled has changed drastically. Philosophical concepts and active theories for change such as Self Determination and Gentle Teaching have shifted the focus from the acquisition of specific life skills to freedom of choice and natural support development. In addition, the Michigan Department of Community Health (MDCH) has issued the Application for Renewal and Recommitment (ARR) which places heavy emphasis on the concepts of active engagement, community inclusion, and meaningful employment for all consumers in the public mental health setting.

Understanding these concepts is vital in both developing a service array and defining the role of service providers, families, and consumers in the change process. In fact, the very definition of change itself can be challenging to conceptualize when applied to the above stated philosophical concepts. For example, is change a process to achieve specific, individually identified goals chosen by the consumer, or is change focused on modifying one's environment to develop a role and function for persons with a developmental disability within a given community? This issue and others will be presented in a series of three articles focused on the areas of clinical intervention, family and consumer perspective, and board member advocacy as related to services provided to consumers with a developmental disability. The intent of the articles will be to briefly present the variables and tensions associated with the provision of services for the developmentally disabled population. This first article is focused on identifying the variables associated with clinical intervention.

Defining Intervention

The concept of clinical intervention implies that a Consumer with a developmental disability somehow has an issue or need that is in need of "an intervention." Furthermore the word "clinical" can suggest that the intervention should be provided by one who is clinically trained. The way the consumer and service provider define these terms is vital in understanding the role and function both have in defining clinical needs and methods.

MDCH, via the Medicaid provider manual and other source documents, has provided a list of clinical interventions that one may utilize in the provision of services for those with a developmental disability. The list includes, but is not limited to, the following:

1. Support Coordination
2. PT, OT, Speech therapy services
3. Community Living Supports
4. Skill Building
5. Supportive Employment
6. Micro-enterprises
7. Mental Health Services

These core interventions can be utilized to address the basic needs of life, such as shelter and the ability to care for oneself independently. Ultimately the goal is for the Consumer to develop the skills and supports needed to sustain a self selected set of desired outcomes. In fact, the desired outcomes selected by the consumer become the rationale or context within which clinical intervention should operate.

Medical Necessity and Consumer Choice

A key tension point can be defining the relationship between medical necessity and consumer choice when the consumer does not select or cannot select services that may be deemed medically necessary. These services may include PT, OT, and Speech services and medication services. Defining what is medically necessary can be as complex as a group of clinically trained professionals defining what is needed to address identified medical or clinical needs, or as basic as identifying with the consumer what interventions could be helpful in obtaining self-selected outcomes. At issue is who gets to choose the clinical intervention utilized and goals and objectives of the person-centered-plan. The consumer, caregiver, and clinical staff–during the person-centered-planning process–need to struggle with this issue with an honest dialogue on the best way to obtain the consumer's self selected goals and objectives.

It Is Not What Interventions Should Be Utilized But How They Are Delivered

The central tension point related to the provision of clinical interventions is not just what services are going to be provided but how the services will be delivered. This has become a central issue for many Community Mental Health services providers as the philosophy of self determination has become the primary theory within which services must operate. At issue is the method and location of services such as Community Living Supports. Should CLS be provided in the consumer's home, congregant living situations, in a

(see "*Interventions*" page 6)

Renewal (continued from page 3)

providing the most comprehensive, best-practice, employment opportunities for persons with disabilities/illnesses, including improving partnerships with other employment providers for resources, staff training, and how to improve a focus on competitive employment.

6 Assuring Opportunities for Needed Treatment for People in the Criminal Justice System.

This area focuses on the need for the public mental health system to partner with law enforcement and the justice system in jail diversion, prisoner re-entry, mental health courts, drug treatment courts, and community-based inpatient psychiatric treatment of prisoners, and in-jail mental health services. This collaboration is to ensure that individuals (both adults and youth) are properly screened to determine their need for mental health or substance treatment and are provided appropriate treatment, regardless of the results of their offense.

7 Assessing Needs and Managing Demands.

Public mental health agencies are required to continually assess the needs of the community. The focus of this area is to improve the ability to determine the needs, characteristics, and interests of those un-served and under-served, and identify trends in access to and utilization of mental health services. Following this identification, the mental health agency needs to be able to address risks and vulnerabilities in being able to meet those identified needs.

8 Coordinating and Managing Care.

This area assesses the public mental health system's strengths, challenges and opportunities for improvement in ensuring that care management and supports coordination adequately address the needs of persons with multiple, complex, and persistent needs, such as persons with DD who have co-morbid conditions, children and families who are involved with multiple systems of care, and persons with SMI with substance use disorders or persons with dementia. Coordination of care with other agencies and with primary care providers is extremely important.

9 Improving the Quality of Supports and Services.

The public mental health system is to assess its current practices for monitoring outcomes and quality of services. This includes the monitoring and management of its providers; ensuring the use of evidence-based, promising, and best practices available; improving the effectiveness and response to critical incidents and sentinel events; and ensuring that services are ultimately helping consumers achieve their outcomes.

10 Developing and Maintaining a Competent Workforce.

A stable, competent and sufficient workforce is critical to consumers to achieve their outcomes. This area has agencies assessing their current staffing capacity, training, and competence in the areas of leadership, supervision, and direct service staff, as well as current recruitment and retention strategies, and identifying challenges and opportunities for improvement in all areas.

11 Achieving Administrative Efficiencies.

The challenge to the public mental health system is how to operate in an increasingly efficient and effective manner while maximizing the funding available for providing supports and services. Agencies are to identify opportunities for improving administrative efficiencies, and identify simplification or consolidation of administrative processes or functions. ■

Interventions (continued from page 5)

day program, or other community settings? Should a CMH provider make all of these options available for the consumer to choose from, or should CMH providers limit the choice to reflect a desired method of service delivery?

Another example of this is in the area of Supportive Employment. The clinical intervention of self sustainability via employment can have varying methods in meeting this desired outcome. Can supported employment include competetive employment, sheltered workshops, and volunteerism, or is competitive employment the only acceptable definition of employment?

To address the above stated questions, one may utilize the concept of "least restrictive" or "more independent" as the desired method of service delivery. Defining these two terms may lead one to believe that CLS services in the community and competitive employment are less restrictive than day program based CLS services and sheltered workshop activities. One could argue however, that certain dimensions of a consumer's experience–such as relationships with peers at a day program or sheltered workshop–may be less restrictive than negotiating new relationships in other settings.

The philosophy of Self Determination via the process of Person-Centered-Planning is primarily focused on choice and self direction. This acknowledges that having a wide range of intervention methods–such as community based CLS and day program CLS–is really at the core of consumer choice. To limit the method of service to only include one desired method takes away the consumer's ability to choose, in favor of the mental health system's choice of "what is best" for the consumer. To ensure true consumer choice, the consumer and their caregivers should be presented with and have access to a variety of service delivery methods. This will allow for consumers and caregivers to develop a true Person-Centered-Plan when full menus of service methods are offered. In essence, the method of delivering clinical interventions can be more important than the intervention itself. Key areas of the consumer's experience such as health and safety, relationship development, and sustainability of new skill sets, need to be addressed by utilizing a variety of settings and methods and not restricted to a singular setting or method.

After all, it is about choice. ■

5th Annual Walk A Mile in My Shoes Rally

Tuesday, May 12, 2009 • 1:30 PM
State Capitol Building, Lansing

May is Mental Health Awareness Month!

Go to www.macmhb.org
click on "Walk-A-Mile Rally" under COMMITTEES.

One True Thing (continued *from page 1)*

are going. Dan and I found a personal connection when we learned that we both were staunch admirers of a popular musician and writer. Our relationship began by discussing our favorite songs and concert stories. Today, in addition to our formal roles as service provider and customer, we share a warm personal connection. Music is our common interest, but our connection is much deeper. Dan knows I care for him and that I value him as a friend. I benefit from the warmth of his company and I respect his knowledge as a collector of music. We share a connection that sustains and nurtures both of us. Together we experience the One True Thing.

~ I am in a meeting of our frontline management team. These people supervise our residential services where treatment and support are provided 24 hours a day, 7 days a week. Most of their work time is spent with people who experience severe disabilities and staggering disadvantages. These professionals are truly some of the most important people in our customer's lives.

The place where the customer encounters the direct service provider is potent and defining.

Someone opens a discussion about helping people connect: "We should be careful not to do too much 'for' people. After all, it's their life. We shouldn't live it for them."

There is discussion about how life is actually composed of the small things: "It's like the Buddhist thing…the realization of happiness and meaning in the small things…you know, 'Chopping wood and carrying water'…cooking dinner and doing the dishes. These small moments can be the rich healing times…."

"Yeah, you can 'be with' people in their daily lives in a way that helps them really connect with their experience, no matter where that might be or how small it may seem. You help them connect with themselves."

Someone tries to describe the magic of "being in the present moment" with the customer: "Just be calm, settle in, and let the moment carry you both. It's 'being with' rather than just 'doing' something together or 'acting out' the role of a support person. Yeah, it's like you connect…like 'what' you are doing is not that important …it's about connecting…being real…being together…being part of each other."

The discussion continues. These people truly get it. They understand that relationship, the human connection, is the One True Thing.

2. The places we inhabit each day are fundamentally important. 'Place' either limits or empowers. The Good Nurturing Places are those that feed relationships and build community.

~ Larry works at K-Mart. He no longer needs the Job Coach. He's been employed there over five years. Sure, K-Mart is his employer, but it's also one of Larry's Good Nurturing Places. He takes out the carts and cleans the parking lot. His co-workers are some of his best friends. They tell the same old familiar jokes that everyone knows just so they can laugh together. They watch out for Larry and remind him not to push too many carts at once. Larry makes sure he's there to help others when it's time to lift a box or clean a spill. Larry's mental health disability is not invisible…his co-workers have simply forgotten it's there. Larry belongs. He knows this is one of his Good Nurturing Places.

3. Enabling the customer to build relationships and community is perhaps the single most important contribution the direct service provider can offer.

~ Betty and Leo. Betty has a severe chronic mental illness. She's also challenged by an intellectual disability. For years, her life has been laced with anger and sorrow from (as she describes it) "not having a place in the world." Betty meets Leo at the Day Treatment Program. Leo is a scruffy homeless man with a kind, timid nature who also lives with a mental illness. He comes in mainly for the meals. Leo used to live under the band shell in the park, but now lives in the shelters.

Over time, Leo and Betty develop a connection. Their relationship is protected and respected by the staff. They come together on their own. They find love. Their time together brings deeper meaning into their lives. They announce intent to marry. Betty's family is deeply concerned, but the staff encourages them to keep an open mind and get to know Leo. The family soon happily embraces Leo. The marriage is a true celebration.

Betty and Leo move into an apartment just blocks away from the CMH center. Betty cooks big meals for Leo and sees that he "looks sharp like a gentleman." Leo watches over Betty with gentle affection. He walks her to the clinic for an appointment whenever she begins to see "the men" peeking in their third story apartment window. Betty and Leo's relationship is the center from which their new world grows and expands. The One True Thing— it's about relationships!

~ Howard and Cil are seniors. Both live with severe intellectual disabilities and both survived many years of institutional living. Years ago, they chose to enter a partnership as roommates. They share an apartment and spend most of their time together. Their relationship is platonic, but Cil refers to Howard as "My Man." When another woman looks at Howard, Cil tells her straight-out and loud, "You stay away from my man!" They have formed a deep and warm partnership with each other and a community with best friends. Their life is built around enjoying their relationship and caring for each other. It's about relationships!

Ubuntu: The word has its origin in the Bantu languages of Southern Africa. In very simple translation it means you can't exist as a human being in isolation. More poetically, "I am because we are."

The place where the customer encounters the direct service provider is potent and defining. Warm human connection, the *One True Thing*, is essential to our thriving. ■

For more information about affiliate members of the Provider Alliance, see e-connections on page 2 of this issue.

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2009 Spring Conference Highlights

May 19-20, 2009 • Radisson Plaza Hotel, Kalamazoo, Michigan

PLENARY SESSIONS

Conference Welcome Address
Bobby J. Hopewell, Mayor, City of Kalamazoo

Taking Stock of Michigan's Public Mental Health Transformation: Successes & Challenges Ahead
Irene Kazieczko, Director, Bureau of Community Mental Health Services, MI Department of Community Health
Judy Webb, Director, Division of Quality Management and Planning, MI Department of Community Health
Consumer Representatives

Pathways for Moving Forward and Sustaining Transformation
Dean Fixsen, Co-Director, National Implementation Research Network and the State Implementation of Scaling-up Evidence-based Practices Center; Co-Principal Investigator and Co-Director, National Early Childhood Technical Assistance Center

Best Practices: Changing a State's Culture of Care from Control to Support
Chris Heimerl, Office of Behavioral Services, New Mexico Department of Health

Key Issues Update from the Michigan Department of Community Health
Michael J. Head, Director, Mental Health & Substance Abuse Administration, Dept. of Community Health

National Council for Behavioral Healthcare Briefing on Mental Health First Aid
Lea Ann Browning McNee, Outreach & Development Officer, National Council for Community Behavioral Healthcare

Pre-Conference Institutes: May 18, 2009

Ways to Link Practice, Organization, and System Change

Boardworks 2.0: Board Member Orientation & Update

Motivational Interviewing