Michigan Association of Community Mental Health Boards

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Connections

for communities that care

Advancing on the New Frontier of Behavioral Health

Linda Rosenberg, MSW, President & CEO, National Council for Behavioral Health

The 50th anniversary of the Community Mental Health Act gives us occasion to celebrate a vision for behavioral health that has been fifty years in the making, and to take it to scale.

The Community Mental Health Act of 1963 was the last piece of legislation President John F. Kennedy signed before his assassination. He encouraged a bold new approach to mental health and developmental disabilities, one in which the "cold mercy" of custodial care would be replaced by the "open warmth" of community. And he called for a community-based focus emphasizing prevention, treatment, education, and recovery.

In the past 50 years, science has brought new knowledge. New medications, psychotherapies, peer support, and other treatment technologies—sometimes even ones that fit into the palm of our hands—have expanded dramatically our ability to treat and support a range of conditions.

Today, a higher proportion of people with a mental illness get treated than at any other time—and they are more likely to be treated in the community than in a psychiatric hospital.

In the past 50 years, individuals with behavioral health conditions have won new rights—the right to be free from coerced treatment, the right to live in the least restrictive setting, and the right to work and play alongside their neighbors.

While science and public policy have taken giant leaps forward since 1963, as JFK has warned us, "The problems are not all solved and the battles are not all won."

We have failed to realize the full potential of community-based care. Financing arrangements, clinical training, and systems of accountability are often misaligned. Mental illnesses continue to be the largest source of morbidity, just as they were in 1963. In fact, a recent analysis of data from the 2010 Global Burden of Disease Study shows that more people are dying or falling ill as a result of addictions and mental illnesses than from HIV, tuberculosis, and diabetes. Worldwide, between 1990 and 2010, the incidence of mental illness has gone up by 38 percent. Jails, nursing homes, and adult homes continue what President Kennedy called "the shabby treatment of people with mental illnesses…in custodial conditions."

Further, we have just begun to move the needle on public understanding and acceptance of serious mental health problems in this country. We still have difficulties talking about it. If we talk about serious mental illness at all, we do so in hushed tones and with a sense of shame. When we suspect others may have a problem, too often we turn away.

Fifty years ago, President Kennedy said, "The new frontier is here, whether we seek it or not." He described the frontier as one of "Unknown opportunities and perils, a frontier of unfulfilled hopes and threats...The new frontier of which I speak is not a set of promises—it is a set of challenges."

In behavioral health, we're standing on the precipice of this new frontier that is only now coming into view. In the new frontier, treatment for mental and addictive disorders has parity with all other health care treatments. The Affordable Care Act will expand mental health and substance use disorder benefits and parity protections to 62 million Americans.

We're entering an era of insurance coverage for all—every state will offer insurance subsidies through exchanges and, in time, all states will expand Medicaid. This will accelerate an already growing demand for *(see* **New Frontier,** *page 2)*

New Frontier *(from page 1)*

behavioral health services and for care on request—anytime, anywhere.

Health homes and accountable care organizations are examples of the public policy experimentation that is taking place nationally and in almost every state. These emerging practice models are the "Home Depots" of health care that offer one-stop shopping for primary and specialty care, care coordination, and patient education and self-management. Behavioral health is becoming part of the new frontier of mainstream medicine, which is driven by science.

Now, it's time to advance into the new frontier. We must revitalize the original intent of community behavioral health —where community resources address and build on community needs. We must embrace scientific advances that promise new discoveries in brain research and advocate for public policies that emphasize prevention and early identification as well as treatment.

We have three decisive opportunities—three current bills in Congress—that advance our mission to reduce the burden of disease and death caused by mental illness and addictions:

- The Mental Health First Aid Act offers education and training to teachers, health workers, firefighters, police officers, emergency services personnel, and other community members.
- The Excellence in Mental Health Act creates Certified Community Behavioral Health Centers to better meet the needs of people currently being served, and those who will seek care as a result of coverage expansion and parity.
- The Behavioral Health IT Act provides financial incentives for the adoption and "meaningful use" of health information technology—the bedrock of improved care and coordination among practitioners—for mental health and addiction treatment providers and facilities.

There will never be a better time to embrace the science of behavioral health. There will never be a more important time to advance public policies that support the most vulnerable among us. There will never be a more appropriate time to reclaim the New Frontier that President Kennedy envisioned—where strong, healthy communities support and empower resilient children, youth, and families. ■

Plea for a Client Driven System

John Walker

In the Fall 2010 issue of Connections, an article entitled, "John Walker: A Quiet, Articulate Voice for Consumers," John spoke of his work to acquire better housing and his desire for improvements in case management.

John has served as President of Kent County NAMI and MACMHB, where he has voiced the concerns of clients and their families for many years. (John has since chosen to use the word "client" rather than "consumer" to speak of those receiving services. It is a way of shifting the perspective from seeing these individuals as "consuming 'our' services" to one in which they are choosing to purchase services that best address their needs. Agency, the power embedded in decision making, is transferred to the client.) Since John remains active in NAMI, I asked him to share some thoughts regarding what clients would like as we transform the future of healthcare services.

Characteristic of John's quiet demeanor, he was both brief and humble. His closing remark was, "I hope this is not too blunt for your audience." His points are clear, let's "walk the talk" and make this a client driven system. – Editor

Clients of the public mental health system need a trusted friend, and stability in their care and lives. Unfortunately, it has been my experience that employee turnover and restructuring—which occurs much too often—defeat those needs. The latest changes here, "regionalization," means new caseworkers and some new office locations.

Some clients who have been around in the system, find that they know more about their own needs and proper treatment than many of the new young professionals.

It occurs to me that too much of what is happening in the system is defined by leadership in Lansing and seems to lack understanding of what the true needs of the client really are. Could we reverse this by finding the true client needs—and how the client feels they might be handled—and then structuring the "system" to respond this way? Planners need to get out on the street to find out what works, and then organize the "system" to do it that way. ■

Through the Eyes of a Social Worker:

looking back over fifty years, and a peek at the future

David L. Neal, MSW, Assistant Professor Emeritus, Department of Psychiatry, University of Michigan

David Neal graduated Lansing Sexton High school in 1956. He then entered the Marines where he served two years in active duty and 4 years in the reserve. Neal enrolled at Michigan State University where he acquired undergraduate and graduate degrees, receiving his MSW in 1964. In that same year he became a caseworker at the Muskegon Child Guidance Center which became the West Shore Child Guidance Clinic in Muskegon. Gifted with a keen mind and a passion for his work, he was destined to carve out a professional career in social work. Two years later, he began what was to become a distinguished career in the Department of Psychiatry at the University of Michigan Medical Center where he was an Assistant Professor of Social Work, being awarded Emeritus stature in 2004. Chances are, if your psychiatrist received his training at the University of Michigan, he learned about the importance of social work from David Neal.

Neal's accomplishments and awards are too numerous to list and would only embarrass him if we did, but a few need mentioning to disclose why he is the consummate person to be writing a brief history of our Michigan experience of providing behavioral health care in the public sector over the last 50 years. His expertise in the role social work plays in the delivery of effective services and the complexities involved when they intersect with public policy and funding have made him a rare commodity, sought after for presentations throughout the United States, and even China. Many times the State of Michigan has tapped Neal to serve in various positions—the Governor's Mental Health Statute and Program Review Commission prior to the writing of the Code in 1974, and the State of Michigan Advisory Council, which he chaired for several years.

Understanding the importance of integrating primary and behavioral health services, Neal became part of Kathy Reynold's Administrative team as the Associate Director of Washtenaw Community Health Organization (WCHO) in 2001, while serving as Director of Social Work in the Department of Psychiatry at U of M. In 2006, Neal became the U of M Department of Psychiatry Liaison to the Washtenaw Community Health Organization, a position in which he still serves. Whereas 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. Yes, he has a family, a church community, six years in the armed services and an avid interest in sports. He has been a Mid-American Conference Football Official since 1983, and a Big Ten Athletic Conference Football Timer and Replay Communicator. But most amazing to me, he consented to write this historical perspective in spite of a scheduled fishing trip to Alaska, from which he just returned as I write. —Clint Galloway, Editor

MENTAL HEALTH CARE IN THE 60's

Prior to 1963 there was very little access to mental health services except for those who could afford to pay. The State hospitals were the primary source for public mental health services.There were approximately 28,000 individuals in 11 State mental health hospitals and approximately 12,000 in hospitals for the developmentally disabled (DD). Today there are 717 individuals in 5 State hospitals for the mentally ill (MI) and none in hospitals for the DD. These hospitals were small communities where people often lived for years. There were a couple of private psychiatric hospitals and general hospitals did not have psychiatric units. In 1963, 90% of the Department of Mental Health's budget supported state inpatient facilities; today it is only 10%.

The State operated a couple of adult aftercare clinics for persons who were discharged from state hospitals. These clinics were primarily to provide medications and there was no therapy or supportive services. There were no case managers, employment programs, residential facilities or housing programs. There was no thought that consumers could ever gain a competitive employment position. Many battles would have to be waged to gain the right for persons with MI and DD to live in community neighborhoods.

Before 1963, there was strong support for providing services to children. There were about 12 child guidance clinics in the larger cities. These were organized through local non-profit boards, primarily financed with state dollars and some local funding. Kids and their families were seen on a sliding fee scale. There were a few children in hospitals; Lafayette Clinic and the University of Michigan Children's Psychiatric Hospital were the best known.

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Eyes of a Social Worker *(from page 3)*

These were more residential settings than hospitals. Kids usually stayed two to five years in these facilities.

After the Community Mental Health (CMH) Act, programs which facilitated individuals being discharged from state facilities received priority funding. Child guidance clinics suffered from this change and their boards often resisted the funneling of their funds through CMH Boards.

Many cities had Family Service Agencies (FSA) that would see individuals and families experiencing emotional problems. They provided counseling and problem solving but no medications. My first field placement was at a FSA and the major issue was whether they should start charging fees on a sliding scale basis.

The only professionals providing services in private practice were family physicians, psychiatrists, and psychologists. There were few medications and they had serious side effects. Psychoanalysis, psychodynamic psychotherapy, and supportive therapy were the approaches most professionals utilized. Professional schools taught that schizophrenia was caused by "schizophrenic mothers" or life events. No one considered that genetic factors could cause mental illness.

Insurances rarely provided mental health coverage. Two years after the CMH Act, Medicare and Medicaid were established. Medicare had high co-pays and limited coverage. Medicaid provided good benefits for those who could qualify with a disability. Today most have some mental health benefits and large employers must provide parity.

CMH ACT: PA 54 (1963) AND MENTAL HEALTH CODE: PA 258 (1974)

The Community Mental Health Act really provided the impetus for changing how mental health services were provided and financed. The focus shifted from the large State hospitals to the community. Legislators thought that they would save money if patients could be discharged to the community. The initial vision was for mental health centers to serve all individuals in a community who needed mental health care but as more and more individuals were discharged from the state hospitals, the focus shifted to those with serious mental illness.

Since Michigan had plenty of money at that time, it instituted financial incentives that encouraged counties to establish CMH programs. In 1964, the child guidance clinic in Muskegon became the West Shore Mental Health Center and started providing services to adults. Detroit and a couple of other communities took advantage of the federal funds that were available to establish community mental health centers. These centers were not required to be affiliated with county government.

Governor Milliken appointed a Mental Health Statute Review Commission which recommended the framework for the Mental Health Code. This legislation was adopted in 1974. The Code provided the legal basis for the county community mental health boards. State hospitals continued to be operated by the Department of Mental Health, and there was nothing administratively in place to require coordination of patient care between the hospitals and CMH agencies. There was a continual struggle with how money would flow from the hospitals to the communities as patients were discharged.

The admission process for hospitalization was one of the more significant changes in the Code. Prior to this change it only required a family member's letter and a physician's recommendation to have someone admitted. The individual had no appeal and there was no continuing review. If the physician in the hospital did not agree to a discharge, the person remained there indefinitely.

The Commission recommended a simple voluntary admission process which it thought most individuals would utilize. Unfortunately, most did not. Unless a person was an imminent threat to him/herself or someone else, it became difficult to have an individual admitted. Even if they were a threat, it usually required a family member to sign a petition and go to court. Two physicians had to certify that the individual needed hospitalization. A court appointed attorney assisted the patient in defending his or her right to resist being hospitalized. This court process is very stressful to all concerned, and often is destructive to patient–family relationships. Research has shown that good patient–family relationships are an important factor to promote recovery. Attempts to improve the process have failed.

Once a patient is admitted to a hospital, there must be continued review to demonstrate that the person still requires hospitalization. This ended the process where persons were kept in a hospital for long periods of time without judicial review and the right for the patient to appeal.

The code established the Office of Recipient Rights within the MDMH, every State facility, and CMH agency. Initially the Office was not openly accepted by professionals in the field. Advocates did not want it established within the MDMH. Politically there was no agreement on where else to place it. A Citizens' Advisory Committee was established to oversee the MDMH's Rights' Office. Local Rights Officers had to report to directors and their work was closely monitored by the MDMH. Today these rights' offices are well accepted and seen as an avenue for consumers to bring their grievances and appeals.

Under MDMH Director Patrick Babcock's direction, the Office of Protection and Advocacy was established, providing another agency to oversee the rights of consumers and to bring action to have problems

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LOOKING BACK AND LOOKING *FORWARD:*

Learnings Since President Kennedy's 1963 Community Mental Health Act That Prepare Us for President Obama's 2010 Affordable Care Act

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Two behavioral health bookends define the past half century. They are President John Kennedy's Community Mental Health Act of 1963 (CMHA), and President Barack Obama's Affordable Care Act of 2010 (ACA). These two Acts are very similar in key respects: badly needed when enacted, basically beneficial for behavioral health; broadly promising for the future. Yet, these two monumental Acts also occurred in very different eras. The early 1960s were a period of exceptional growth and promise—people believed that everything was getting better! By contrast, the early 2010s are a period of much doubt and cut back—many people are fearful of the future! Because of these similarities and differences, we must learn from our 50-year response to the CMHA in order to help us plan effectively for the coming ACA era.

Clearly, the past half century has been very uneven terrain for those directing mental health and substance use services, especially county directors of these programs, who are on the front lines of care. We have gone from soaring heights to sinking depths several times during the 50 year period between 1963 and 2013. The peaks include the CMHA, passage of the Mental Health Systems Act of 1980, President Clinton's efforts to pass the Health Security Act in 1993, the Surgeon General's first-ever Report on Mental Health in 1999, the President's New Freedom Commission on Mental Health in 2003, and the remarkable growth of the consumer movement, which has brought us the promise of recovery.

Arguably, the valleys include obvious failures of deinstitutionalization in the 1970s and 1980s, which resulted in many adult mentally ill persons becoming homeless or incarcerated; the repeal of the Mental Health Systems Act in 1981, which delayed by a quarter century our organized response for adults with serious mental illness; elimination of substance use as a source of disability for Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) in 1998, which resulted in considerable pent-up demand for substance use services; and much angst over organizational and provider reimbursement, as states instituted managed care, and as budgets tightened in the 2000s —especially after 2008—with the onset of the Great Recession.

What have we learned from all of these ups and downs? Here, I will cite several different things that strike me as very important learnings for the future. These items are suggestive rather than exhaustive. You may want to think about this issue and add your own items to my list.

- Lack of health insurance is a huge, perhaps insurmountable, barrier to effective care. Lack of health insurance forces any care to occur in the "cracks of the system," in emergency rooms, in jails, or literally through self-medication. Because of a lack of health insurance today, up to half of those with mental illness, and about 90% of those with substance use issues receive no care whatsoever.
- A majority of persons with mental health and substance use conditions have these conditions as a result of trauma. Such traumas can range from child abuse, to the physical, sexual, and psychological abuse associated with poverty; to the mental and physical trauma of the battlefield. Trauma is extremely pervasive in modern American society, and it plays a major role in generating illnesses.
- "Handing people off" from provider to provider simply doesn't work. The failures of treat–refer systems can be seen in the 25 years of life lost by the adults cared for in our public mental health and substance use delivery systems. Most of these people never receive the primary care that they critically need. Clearly, this dire situation should be unacceptable to all of us.
- Health care services, alone, will not lead to good care outcomes. Many health care recipients also need support services, including job, housing, and social supports.
- Recovery and wellness are required for a full life in the community. In other words, the process of recovering can lead to states of wellness that actually make life possible in the community.

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LOOKING BACK AND LOOKING FORWARD *(from page 5)*

Thus, recovery and wellness must be part of our core mission.

Much as the 1963 CMHA, the 2010 ACA offers us a once-in-ever opportunity to "reset" and to change direction in order to address these fundamental learnings. With no exaggeration, the ACA will produce a dramatic change in how we do health care in the United States. President Barack Obama's ACA is on a par with President Franklin Roosevelt's creation of Social Security in 1935 and President Lyndon Johnson's creation of Medicare and Medicaid in 1964.

Three key features of the ACA are directly relevant to our mission going forward. These are health insurance reform, coverage reform, and service quality reform. Here, I just wish to show how they are relevant to our mission and our learnings. I encourage you to immerse yourself directly in each of these reforms:

- **Health Insurance Reform**

  Through the state health insurance marketplaces and the optional state Medicaid expansions, a wonderful opportunity exists to enroll about 39 million people in health insurance, many for the very first time. We estimate that as many as 11 million of these persons have a prior mental health or substance use condition. With appropriate health insurance coverage, better care will become possible for these Americans. Enrollment begins on October 1. How are you planning to participate in this major enrollment initiative?

50TH ANNIVERSARY OF THE 1963 COMMUNITY MENTAL HEALTH ACT
1963 50TH ANNIVERSARY 2013
CELEBRATING OUR LEGACY

- **Coverage Reform**

  Unlike the past, where health insurance only covered "sick-care" services, the ACA recognizes that it is vitally important to address the social and physical determinants of health, such as reducing trauma, and to introduce population and personal health promotion and disease prevention interventions. These actions can reduce the prevalence of downstream illnesses. Funds have been set aside for prevention interventions directed at populations and health insurance benefits have been adjusted to accommodate personal prevention interventions. Since much of personal prevention, such as smoking and obesity reduction, reducing the impact of trauma, etc., is rooted in behavioral health, coverage reform represents a very distinct opportunity for our field. How are you planning to adapt your programs to incorporate personal and community prevention interventions that promote resiliency?

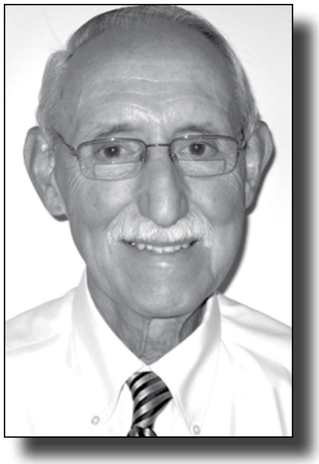
- **Service Quality Reform**

  Reforming the quality of health care services has two distinct components in the ACA. First, a major effort will be undertaken to promote person-centered care and whole health care through the creation of Health Homes which will integrate primary, mental health, and substance use care. Some of these Health Homes will operate out of the primary care sector; some, out of the specialty behavioral health sector. Second, financing arrangements and performance assessments will become adapted to these Health Homes. Financing arrangements will move away from fee-for-service and toward case or capitation rates. Performance assessments will move toward personal evaluations of wellness and health-related quality of life, both of which are of great importance in a context that will emphasize resiliency and recovery. How are you planning to participate in a Health Home?

Thus, these major ACA reforms do fit very well with our learnings from the past half century. In fact, the ACA promotes our core agenda remarkably well. I am sure that President Kennedy would be quite proud of the progress that we have made in the last 50 years, and he would encourage us to undertake the ACA with great "vigor." I can see him smiling right now!

A Personal Perspective: *from George Rouman*

It will become obvious when you read this story as to why I asked George to write a personal account of his life's work serving people with mental illness and disabilities. George became a close personal friend because of his compassionate nature. With a career that stretched from 1958-2005, I begged George to reflect on the events from a deeply personal perspective. He graciously obliged. After reading his story, you will understand why they named the new facilities for CMH of Central Michigan, the "George Rouman Center." – Clint Galloway



This year we are celebrating the 50th anniversary of the signing of the Community Mental Health Act of 1963. This federal legislation had a profound impact on the ways in which mental health services were designed, developed and delivered in the State of Michigan and across the nation. Fifty years is a long time and much has happened during that time to affect and improve the mental health delivery system in Michigan.

Many of the major changes in the Michigan mental health system took place during my career as a clinical social worker, first as an employee of the Michigan Department of Mental Health and later as a director of a community mental health agency. Over that period of 45 years, beginning in 1960, mental health services evolved from a largely institution-based system of care to one rooted in local communities.

I don't really know how I first became attracted to mental health as a career. There is nothing in my family background that would have led me in that direction—unless perhaps, as a child of immigrant working class parents, I was made aware of the needs of others, including their health needs. I know that I was always interested in people and sensitive to their problems. I recall that even as a high school student I used to listen to many of my classmates as they discussed their concerns with me. Later, as a somewhat older Army draftee, I did the same with some of the younger recruits.

I attended the University of Michigan thinking that I would major in mathematics, but instead became interested in psychology. I thought that perhaps I could work as a teacher with children with emotional problems. I received my BA degree in psychology in 1956 and made plans to continue in graduate school, but these plans were interrupted by the draft board. After two years in the U.S. Army, I returned briefly to my home in Escanaba. It was there that I was introduced to the director of the local child guidance clinic. I was very impressed with him and the work he was doing and decided that this would be a good fit for me as well. I decided to return to school and seek an MSW degree.

As a graduate social work student in 1958, I was able to witness and experience the beginning of the end of institutional care as the primary treatment approach for persons with serious mental illnesses and the beginning of community based care. For students desiring to work in the field of mental illness, the placements were often in state hospitals for the mentally ill. I received such a placement. It was obvious, even to a budding social worker, that there was little active treatment occurring on the wards of these hospitals. Although I am sure that the staff members were compassionate and committed to providing the best care they could, it was clear that many of the patients were largely neglected. The hospitals had become warehouses of persons, rather than treatment centers.

Prior to my assignment to the state hospital I had never been in such an institution or seen patients with such serious mental illnesses. Nevertheless I was eager to learn and looked forward to my new setting. I can still recall my first day. I have never been clear if the hospital social work staff was trying to shock me or if they were just trying to help me adapt and adjust to the hospital environment, but shocked I was. I still remember my first visit on the back wards of the hospital. Poorly clad patients, even nude, filled these wards, and the lack of meaningful programming was evident. In fact, even basic human contact was often not available.

One of the first patients to whom I was assigned had not had any visitors for over 10 years. I began to see her once a week, and it soon became apparent how important these visits were. She looked forward to our visits and began dressing up and preparing for our chats. The hospital staff teased her about this. It was evident just how meaningful this personal interest was to her. While she did not recover from her serious mental illness, or even experience a reduction in her symptoms, she now had a more normal week to look forward to, and her physical appearance and mental attitude both improved. I was greatly impressed with how powerful basic compassion and attention were in dealing with persons with mental illness. Just think how much more helpful it would have been if a truly personalized, evidence-based program of care had been available to her – and provided in a warm and supportive home-based setting!

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Perspective *(from page 7)*

The elements of community based care that were sponsored and encouraged by the passage of the Community Mental Health Act of 1963—inpatient and outpatient care, partial hospitalization programs, prevention, consultation and education, and other elements of community based care—were to constitute the basis of state-funded programs of care in the years that followed.

1963 was an important year in Michigan as well as at the federal government. Public Act 54 established the structure and funding for community based mental health programs throughout the state. Every one of Michigan's 83 counties, either alone or in combination with adjoining counties, established a PA 54 Clinic. These clinics were instrumental in helping Michigan move away from primary reliance on state facilities for the provision of care to persons with serious mental illness (and also for persons with developmental disabilities).

Prior to this, in the 1930's, the State of Michigan supported local clinics devoted to serving children with emotional difficulties. These state–local clinics represented a partnership between local communities and the Michigan Department of Mental Health and were located throughout the state. The Central Michigan Child Guidance Clinic began serving children and their families in the central Michigan area in 1960. I joined the staff as director in 1965. These clinics had much to commend them, such as the use of an interdisciplinary team approach (social work, psychology, and psychiatry), an emphasis on prevention and education, a focus on the family unit, close coordination of effort with local schools, and consultation with family doctors. Although our resources were scant and scarce, we worked closely together to provide the best care possible.

However, this system of care was severely hampered by lack of sufficient staff, inadequate funding to meet the community's needs, and an inordinately large service area (in our case 6 counties, later reduced to 4). At one time, the waiting list for service at our clinic exceeded a year. This was a disservice not only to the children and families involved, but to the larger community. The agency also had a narrow mission: to meet the needs of children with emotional and mental problems. Very little attention was paid to adults who had their own personal problems—that is, until it was noticed that often the children referred to us reflected larger issues within the family, or issues of their parents. They often served as the "ticket of admission" to the clinic.

This clinic and the PA 54 clinic merged and gradually evolved into a comprehensive community based mental health center as it strove to meet the needs of adults with mental illness and persons with developmental disabilities. The first several years were devoted to expanding the range of services offered (to both children and adults), and to establishing offices in each of our four counties. This process was facilitated and supported by the availability of new federal and state funding (this cannot be stressed too strongly), and by the need to provide community based services for persons being released from state facilities. Thus was born, a new and stronger relationship between the State and local communities.

Unfortunately, this expansion of services eventually resulted in a de-emphasis on educational and prevention services to children and their families. The press of business in serving a long neglected adult population was one contributing factor, as was the fact that children do not have the same voice and political influence as do adults. At first, funding was readily available from the federal government and a number of pilot projects for children's prevention programs were started, but regrettably, were not afforded continuation funding. For many years our agency placed social workers in our local elementary schools. They provided consultation to the classroom teachers, met with the families of students, and provided limited direct counseling services. This service was avidly supported by the school staff but met its demise as funding withered away.

The process of moving persons from institutions to community care was known as deinstitutionalization. This was perhaps the most dramatic and radical consequence of the changes taking place at the time in the delivery of services to persons with serious mental illness. Three factors contributed to the deinstitutionalization movement: 1) a social–political movement, supported by court decisions, designed to reduce the use of state hospitals for the primary treatment of persons with mental illness; 2) the advent of psychotropic drugs able to manage psychotic episodes; and 3) a financial imperative to shift costs from state to federal budgets. The availability of SSI and the Medicaid program facilitated this shift.

Ironically, a key Alabama court case, Wyatt V. Stickney (1971), unintentionally facilitated the emptying of state hospitals because the judge on the case, in an effort to improve the living and treatment conditions of the patients, imposed such high standards of care—some of which were impossible to meet, particularly high staffing ratios—that Alabama, and soon other states to follow, opted to empty their hospitals and eventually close many of them.

One of the prouder achievements in the history of Community Mental Health for Central Michigan was the transfer of over 180 residents of the Mt. Pleasant Center to our agency, who were then placed in small home settings with both in-house staff support and outpatient/case management services from our agency. The majority of these persons were able to find work, social outlets, friendships, and acceptance in their communities.

Although a court consent decree was required to close one of Michigan's facilities for persons with developmental disabilities, the State was proactive in many areas. In 1974 Michigan's Mental Health Code was revised. Among other things, it included a major chapter on county community mental health programs.

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Person-Centered Active Support

"Our Journey into the Present Moment"

Tammy Unger, Denise Welmers, Nichole Williams, and Brian McLuckie of Bay Human Services, Inc.

When the Connections editorial team decided to commemorate the 50th anniversary by including transformative stories that can shape the future of health care, Robert McLuckie, a member of the team, leaped on board to facilitate the procurement of this article. This is a powerful story in that it describes an emerging theme that has the potential of transforming authentic "health" care, if we understand the root meaning of "health" as being whole. We cannot hope to be cured of every affliction, even if there were inexhaustible financial resources.

Death is inevitable for us all and many disabilities cannot be erased. But achieving "wholeness" in body and mind can alleviate suffering and provide joy and happiness. There is profound resonance in this story with the next article, "Moral Injury." Whereas this article focuses on the interiority of individuals with disabilities, Moral Injury focuses on the interiority of veterans who have served in combat. In both cases, healing comes from awareness of and respect for what is going on in the interior of our consciousness.

Bay Human Services has provided group residential settings for people with severe, often multiple disabilities and significant mental illness since 1982. Our services are conventional—five or six people living together supported by three shifts of support staff. Supporting persons with very substantial disabilities within a group residential model presents many challenges. We'd like to share an approach that is leading us to a better way.

Why We Stay: Many of our staff team members have made a long term commitment. We love this work. Those of us who stay know we "get far more than we give." Not in wages or status; wages are low, and fame and glory—well, maybe someday. We stay because at the core of our work is a great well of compassion and renewal. We stay because this path of supporting people with very significant disabilities feeds the soul and nourishes the heart very deeply.

There are realities associated with supporting people in a group home. Too often we are preoccupied with the "business" of providing services: documenting, reporting, meetings, high staff turnover and filling work shifts, orienting new staff, audits, etc. These ever-present demands are a necessary part of the work. The tragedy is that they take us away from our passion; to support people with disabilities in experiencing the richness and joy of living.

Moving Forward: Over the years we've seen lots of changes. We've deeply appreciated seeing the community service system focus more and more on people as individuals. Person-centered planning helped open us to a greater vision; gentle teaching brought greater sensitivity and sensibility to our work by affirming what we know—that the very personal experience of the person we support, the experience of self-esteem, companionship, and love—is the true measure of our success. Universal enhancement and self-determination taught us how systems dedication to service methods and routines, can too easily overlook the unique and beautiful personhood of those we support. These "transformations" have reaffirmed and reassured.

Our Journey of Discovery and Transformation: We offer this article because we want to share a discovery, one that may seem small, but one that we are experiencing as transformation and revitalization of our capacity to provide true personal support; support that brings joy, and energy, and meaning. We don't have the words to describe how one feels when you know in your heart that you've found the real thing. But, we'll try.

Person-Centered Active Support: In early 2013 we undertook a project of training in Person-Centered Active Support (PCAS). We first heard about PCAS via word-of-mouth and later at the 2011 Michigan Developmental Disabilities conference. We were interested and fortunate to find a consultant/trainer nearby who was a passionate advocate for PCAS. We began a project to incorporate it into our services. The bottom line: Adopting Person-Centered Active Support has breathed new life and vitality into our practice of gentle, person-centered, life enhancing service.

What is Person-Centered Active Support? PCAS is an evidence-based model of care that has been used in community group homes in the United Kingdom and Australia for over a decade. It focuses on one goal: "to enable people with intellectual disabilities to be meaningfully and actively engaged in all phases of their lives." PCAS includes a small set of techniques that support people's meaningful participation. It also focuses on the core skills of "Practice Leadership," those things a manager must do to ensure that training results in using PCAS every minute of the day. For us at Bay Human Services, PCAS has provided the ground, the basic understandings, and tools that help us to better fulfill the promise of gentle teaching, person

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Person-Centered Active Support *(from page 9)*

centeredness, and self-determination. We believe that PCAS has enabled us to support people to own and celebrate their own lives.

A Focus on Ordinary Daily Life: Our training in person-centered active support focused on the routines of ordinary daily life. "Every moment has potential" was the refrain. We talked about how to be in the moment; that everything that arises during the day is an opportunity for meaningful involvement in living. We discussed looking deeply. We viewed many videos of people with very significant disabilities who were actively controlling and actively involved in all phases of their lives. These videos were from group homes in the UK. Two things happened: first, some of our staff lapsed into speaking with a British accent (insert muted laughter here), and...

We Began to Look Deeply and Mindfully: We reassessed. We recognized that we still often talk and think in ways that assume "disability" means "limitation." Together we began to enthusiastically and spontaneously envision change. The core idea behind PCAS clicked! All of us have limitations. We live our lives by "using what we've got." We understood with true clarity that, with the right support at the right time, a person said to have a disability can live within a vast expansive range of experience simply by using what they've got. The possibilities were vast! With lots of opportunities every day, and with the right support at the right time, anyone can have a rich, active life full of personal accomplishment and meaning! Our vision took fire as we began to see the people we support as those in the videos—meaningfully and actively engaged in all phases of their lives.

It's happening, and we celebrate with the people we support!

Five guys live at the Raytown home. It's labeled as a place with lots of behavior problems. The men have gone through an amazing transformation. Joe was bounced from home to home due to aggression, running away, and destroying property. He responded very quickly to person-centered active support. Now he's enthusiastically and meaningfully involved in everything! He plans his day, and relates as a problem-solver when he wishes to change a routine, share an opinion, or negotiate responsibilities. His "behavior problems" have diminished considerably as we've learned to support him in the way he finds to be meaningful. Bill, his housemate, was said to have an obsession with Christmas. We've dropped our attempts to redirect, discuss, and distract him. When Bill insisted on putting up the Christmas tree in the off season we supported his decision. He now has a tree in his room year-round. He's happy and proud.

The entire atmosphere at Raytown has been transformed. When opportunities arise, everyone steps up to participate. It's a place of cooperation and camaraderie. Perhaps the best evidence of the Raytown transformation is Lucky, the dog. Lucky spent much of his time lying low in the back bedroom, coming out to eat and to greet visitors. He was cautious. Now, Lucky, too, is an eager involved guy! He's out and about, active and happy. He's our barometer. Things have changed!

At the Myerson home, the six elderly ladies were chronically unmotivated. Kate was especially sour and she demonstrated her discontent often and dramatically. She didn't want to be bothered. The home manager embraced the person-centered active support approach with enthusiasm. One day Kate was sadly mourning that she'd never ridden on a boat. Rather than see this as part of Kate's routine complaining, the manager saw an opportunity. She approached Kate with gentle active support, "little and often." She responded to Kate's actions as a significant communication and in a way that served to "maximize choice and control" (another active support tool). Together, one small step at a time, she and Kate arranged to ride the tourist riverboat docked down town. Kate was in charge of the process. She determined the pace. It was fun each step of the way. Kate got a taste of going into action. Fast forward—now Kate is up each day ready to go. She looks for ways to be involved in routines. Staff members use simple PCAS methods to focus on enjoying life in the present moment. Some say she's a changed woman, but actually it's just a matter of listening deeply and offering the right support at the right time. The ladies living at Myerson have all adopted the attitude of "let's do it." This has resulted in very active community connections. They're out and about! They've made new friends. Life is rich. Staff members are enthused, re-energized, and infused with creativity. We believe every person has a capacity for joy and compassion, and a hunger to experience life. We know simple mindful support can change lives!

There are so many stories. Chris is proud to be an expert helper with laundry. Everyone at Runyon Street runs the house together: they make the decisions, do the chores, and hire the staff. Dave and Dan actually seem to love doing the dishes; James is "in charge" of filling the napkin holders and he's delighted to be master of the vacuum. Everyone adds their favorite foods to the grocery list and we cook together. John baked a cake for his mom's birthday. Cher is a homemaker,

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MORAL INJURY- A CONNECTIONS INTERVIEW

Chaplain (Colonel) Herman Keizer, Jr., UNITED STATES ARMY, RETIRED

A story in a December, 2012 issue of Newsweek riveted my attention. It described the experiences of a regiment of Marine reservists stationed in Baghdad, Iraq, and the subsequent suffering when they came home. They all returned alive only to face a more devastating affliction. Statistics reveal the reality; every day an average of 22 veterans take their own lives, far more than died in combat. We are beginning to hear of this silent suffering but what caught my attention was what I had not heard before, captured in the title of the story, "A New Theory of PTSD and Veterans: Moral Injury."

One of the leading voices in the nation who has been shedding light on the self-destructive nature of moral injury is Chaplain (Colonel) Herman Keizer, Jr. Chaplain Keizer spent 40 years in the armed services, serving 34 years as a chaplain and 14 years as a colonel. His active duty began in Vietnam where he was wounded twice, in a rocket attack on a fire base in Cambodia and in a 150 foot fall in a helicopter accident. His responsibilities escalated and assignments included faculty member at the Chaplain Center and School; Division Chaplain, 25th Infantry Division; Deputy Director of the Chaplaincy Service Support Agency, Washington, D.C.; Executive Director, Armed Forces Chaplains Board, Department of Defense; and as Command Chaplain, United States European Command, Stuttgart, Germany, where his responsibilities stretched from Norway to South Africa.

After reaching mandatory retirement age in 1998, he was recalled by the Secretary of the Army. In 2000 the recall was extended by the Secretary of Defense. In 2002, after retiring again from the military, he served as Director of Chaplaincy Ministries for the Christian Reformed Church in North America, a position he held until 2009.

On Veteran's Day in 2012, the Soul Repair Center at Brite Divinity School in Fort Worth, Texas was dedicated with Chaplain Keizer named as co-director. His decorations and awards are too numerous to list but include the Purple Heart and the Superior Honor Award from the Department of State. In April of 2010, the Association of Professional Chaplains awarded him their Distinguished Service Award,— the first military chaplain to receive the award. In April of 2012, he was awarded the David C. White Leadership award by the Military Officer's Association of America and the Distinguished Leadership award from the Military Chaplains Association. He is now President of the Army Retired Chaplains Corps Regimental Association. Further recognition is revealed in the interview. This suffices to say Chaplain Keizer warrants our thoughtful attention.

—Clint Galloway, Editor

Connections: Chaplain Keizer, tell us about how you came to be in the armed services.

Keizer: I was the oldest of seven kids from Chicago. My folks were not wealthy. I was the first one from my family to go to college and the first one from my church to go to college in twenty some years. All of the people in that area of Chicago were part of the trucking business. They could make more money working on a truck than one could by getting a degree in anything. But I felt called to the ministry, so I decided I was going to go to Calvin College. In my third year, I went broke and had to take some time off to make some more money. I lost my deferment and was drafted.

How did you come to be chaplain?

Keizer: Well, the first Sunday in Basic Training I went to church and sat behind this woman and her family. I had a good singing voice and so I was singing in the bass parts to the hymns. After the service she turned around and said, "You should be a Chaplain's Assistant." And so I was interviewed by a chaplain and said, "OK." So I became the Chaplain's Assistant and was sent to Fort Belvoir, Virginia. I worked with some really, really fine chaplains—they were good men who were professional and loved soldiers. Since I had three years of college, they asked if I would mind running the youth group. I started out with about fifteen kids and ended up with over 250. They said, "You must think about coming back in as a chaplain." The chaplains were persuasive, so I made the decision that I wanted to go back in as a chaplain.

So, did you have to get additional training?

Keizer: Yes. I finished up college. I had a dual major, philosophy and Greek [chuckling]. Then I went to Seminary. While I was in Seminary, Dr. Henry Stob was the professor of ethics. He was an older professor by that time and had been involved in WWII. My denomination had a lot of chaplains in WWII. In fact, after the war they really became leaders of our church and brought about some changes because "after they've seen Paree" they're not going to be doing things the same way. They really got involved with missions, because they were sent into the military to take care of our boys. In most of the units there were none of "our boys" so they had to take care of all of the soldiers. Professor Stob said, "I'm going to mentor you—I want you to know the 'just

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war' theory upside down and backwards, because there must be a voice that has some moral authority within the military to speak to it as an institution as well as to minister to the troops."

You were fortunate to have that kind of a teacher. So what happened when you went back in as chaplain?

Keizer: Vietnam had started while I was in Calvin Seminary. When I got to my first duty station I worked for two chaplains who were Colonels at the time. The first one that I worked for said, "You're good, and when you go to Vietnam you're going to go to the 1st Infantry Division—I'll make sure." And I ended up with the prestigious 1st Infantry Division.

While I was chaplain for the Third Brigade I started a drug amnesty program for drug abusers. Anybody who was caught "positive" would be able to go down to a place outside of Saigon and the social workers and medics would take care of them, dry them out and then they could come back to the unit. So they weren't getting sent out with "bad" papers in addition to having drug problems. Then the 3rd Brigade of the 1st Infantry Division went home; I was going to be reassigned. The chaplain from the 4th Infantry Division, Orris Kelly, called me; he later became Chief of Chaplains for the Army. He said, "You know I hear you're a good troop chaplain and you're probably kind of tired of bouncing around with grunts, but I have a unit here that's in trouble and I need a good chaplain for that unit." So I went up to An Khe. I had gone down to about 115 pounds and so he said, "My goodness! What have you been doing?" I said, "Well, I was averaging three services a day when the division was going home. There were only three of us chaplains to take care of about fifteen units in the brigade." The Catholic priest and I would go out together every day and we'd have services all over the area of operations.

I believe it was about this time that you were wounded in An Khe.

Keizer: I was wounded in Cambodia when we went into that country which was part of Nixon's strategy in May of 1970. Later on that month I was in a helicopter that was taking off from a new pad. The helicopter pilot made a mistake. He hit high tension wires with the rear rotor blade. Without the rear rotor blade the helicopter begins to whirl wildly, so I was hurled out of the spinning chopper. The pilot told me in the hospital that his altimeter was at 175 feet when he saw me go under the bubble—so they figured I fell about 150 feet. I broke both my arms real badly, but I hit elephant grass and tumbled. Thank God there were not a lot of big rocks in that grass. I broke the wrist, the ulna, the elbow, the humerus, broke this, shattered this, dislocated this and broke that shoulder [pointing to places on his arms], so everything from the fall was absorbed by my arms.

And I understand you were sent home to the Great Lakes Naval Hospital. Tell us about that.

Keizer: When I was at Great Lakes Naval Hospital, where I went for a five month recovery period, I was the only chaplain who had been in combat. The Navy chaplains had been on ships, but had not been in combat. None of them had served with the Marines in Vietnam. They asked me if I would help minister to some of the troops in the hospital. They would wheel me down, with my casts on both arms, to the amputee ward and they'd say, "Hey! Here's the chaplain who fell 150 feet, the 'miracle chaplain.' He's been there like you have." Then the patients would talk to me. I heard some interesting stories and learned a lot about the kind of losses that soldiers experience. Tyler Boudreau, a marine captain, wrote the book, *Packing Inferno: the Unmaking of a Marine*, in which he said, "War is not hell. War is the foyer to hell. Coming home is hell."

And you experienced your own hell in coming home?

Keizer: Yes, I had my own. My son was born while I was in Vietnam, so the first time I came home and saw him, my wife sat him down on my lap. I had both arms in casts, and the poor kid started to cry. She had to take him off my lap, because I was just scaring the heck out of him. Coming home wounded; not being able to blow your nose, go to the bathroom by yourself, feed yourself; you can't do any of that when both your arms are broken. You really question your own manhood and bring up all kinds of questions about who you are and what you are. You know, we don't realize the importance of everyday routine behaviors, like the rhythm of how we eat. I had one nurse who was a potato pusher! I had to eat the spud before anything else, and I got so mad at her I threw a tantrum. One day they had lemon meringue pie, and I said, "I want my dessert first." She said, "No, you can't have it." So I just went $%*&! [I laughed so hard we couldn't transcribe what Herm said! Later he told me, to fill in the blank]. "I pushed my face into the pie and had meringue all over my face." When they finally took the cast off my right arm below the elbow, I was bound and determined I was going to feed myself that night. They had chicken, potatoes and peas. Well I did great with the chicken and potatoes, but the peas—all over the table. The nurse came in and said, "Chaplain Keizer, what a mess. What'd you do?" And I said, "I was so happy to feed myself that I peed all over your floor!" [We're having fun!]

Tell us about some of the experiences that shaped your thoughts about Moral Injury.

Keizer: When I was in Vietnam, I had several soldiers who objected to the war on grounds of conscience. They were not pacifists and did not object to all wars; they objected to the war in Vietnam. I helped them write up their requests for Conscientious Objection, which came back disapproved because the Department of Defense only recognizes pacifists as COs. Several soldiers went to jail instead of fighting. One young soldier stayed, but vowed not to shoot his weapon. He had the opportunity to kill an enemy soldier, but did not. Two of his friends in the unit were killed. This young soldier was a moral basket case. Coming back from Vietnam I always had that sense that there was something more than just a psychological aspect to many of the hidden wounds that soldiers experienced. Craig

Dykstra, who ran the religion program for the Lilly Foundation, said, "Why don't you look back on Vietnam as a chaplain to see if there was anything that you did intuitively that makes more sense—now that you have this concept of moral injury—and write a paper." That was an interesting excursion. I discovered there were two things that I did.

I kept going back in my mind to analyze what I did. After the second week in Nam, I had resolved to serve communion at every service, because with all the brokenness, the question for all of us was, "Where is God in all this stuff?" The sacrament spoke to that brokenness. For me, that was always a part of the Pascal Supper. The account in the New Testament said, "After supper he took a cup." So my sense is that after they went through the Pascal meal, then he takes another cup and says this is a *new* story, or a *new* covenant. So that's the sign of hope. I would always juxtapose the suffering with the new story. That got to be a theme and the soldiers were comforted by that. It acknowledged their suffering and spoke of hope.

Then I also discovered that I used the Psalms a lot. The Imprecatory Psalms are the Psalms where the psalmist is angry at God, he's angry that his enemies are still able to climb all over him and he's trying to invoke judgment, calamity and curses upon them. I would give these Psalms to the soldiers to read and they would read aloud and they would always look bewildered when they got finished, because they got caught up in the emotions. They had the same kind of anger and here's somebody who put it into words for them. So they would close the *Bible* and then look at the binding and then open it up and look and say, "Is this in my *Bible*? This is not a special chaplain's version?" [We're chuckling]

The other Psalms I used a lot were the Lament Psalms—cries of anger, protest, despair and doubt. These Psalms follow a certain kind of pattern: First, you have a problem that you want to address with God, something that is painful. In talking to God you realize that you've talked to Him before in situations like this, and what you came through with was the fact that God is always faithful, loving, kind and merciful. So those memories sort of wash over your present experience and begin a healing process. I used the Psalms a lot that way and those were the things that I pointed out to Craig Dykstra in the paper.

So the soldiers were struggling with issues other than fear?

Keizer: Yes, and their struggles raise the question, "Who's the moral agent in war beyond the soldiers?" When I look back, this is what I was really trying to address, some of the real moral issues that were going on, because what was happening in Vietnam is the same thing that's happening in these wars that we're fighting now. The leaders of our nation are not taking responsibility. Some people oppose funding so they can stand up and say, "I didn't vote for that." There's an abdication of moral responsibility, I think, on the part of our leadership. I think the Vietnam War showed that you should never blame the soldiers who are conducting the war, *for* the war. That's why I believe that the Vietnam guys are the first ones to stand up and greet these kids coming back, they're the ones that applaud at the airport, because they know that these kids are fighting the same kind of war that they fought; the war that's not popular, that seems endless and seems not winnable; furthermore, a war that is fought on the land that you're trying to save, which is crazy. I mean almost all of the damage that we did in Vietnam was in the south – we didn't do as much damage in the north as we did in the south.

There's a good book just out, *Kill Anything that Moves*, by Nick Turse, that reveals that what happened with Lt. William Calley [My Lai massacre], the mass killings of civilians was not an aberration, it was just part of the operational design. We wanted to drive them fearfully into democracy, I guess.

And the nature of war has changed, where combatants are engaging civilians.

Keizer: Definitely, one soldier told me that he was told by his commander to go up on a rooftop and if he saw anything suspicious, he was to shoot it, "engage" it; that means kill it. We have euphemisms for everything in the military. Call it by a different name and it ain't so bad. His friends were going to try and diffuse an IED (Improvised Explosive Device), and so his friends are about 30 feet away and this man walks out of this building with a cell phone in his hand. The young soldier knows that IED's can be detonated by cell phones, so now he looks—and his friends are about 5 feet away—and this man is turning and walking away from the IED and starts dialing his phone, so the soldier shoots and kills him. Then they found out that the IED could only have been pressure detonated. So he says, "I killed an innocent man. He was probably talking to his wife about what to bring home from the market. So I'm a murderer." The commander comes up and says, "No, you did the right thing. You did what you were supposed to do." And the soldier replies, "Everything you've trained me to do is not to take an innocent life and I killed an innocent person and I can't abide that." That's a moral dilemma.

In another incident in Vietnam, I was riding in a "deuce and a half" (2 ½ ton cargo truck), and we were going through this village. A ten year old girl comes and throws a fragmentation grenade in the truck ahead of us. We always had one person who was locked and loaded riding shotgun in each truck and our shotgun shot her head off. Then he looked at me and tears just started gushing. He said, "I have an 11 year old daughter." It reminds me a lot of "Rita's Story" [from the book *Soul Repair*), because every time he saw his daughter he would see the face of that little girl that he blew up.

So to me these were real moral issues rather than simply psychological injuries. The real deep-seated kinds of emotions and feelings where there were feelings of tremendous shame and guilt. The soldier's whole moral universe got screwed up because he knew he had to shoot that girl. One of the things that Dr. Stob said was that if you sinned against your conscience you commit moral suicide. That always stuck with me, because these people really lost their moral moorings. I found out that was true with a lot of them.

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MORAL INJURY *(from page 11)*

Where do you start a moral conversation with someone with experiences like that? Because if you start excusing the behavior, I would say the maximum effective range of an excuse is zero meters. So you can't simply excuse their behavior, you have to take it very seriously if that's what the person really thinks about himself. One of the things that's very different from the folks coming out of Vietnam and the wars now, is the sense of shame. People in these conflicts experience shame more than they experience guilt. Guilt is a measure against some standard or law—of some kind of thing "out there." Shame is about who I am as a person, it has to do with our interior self. If Genesis' story teaches us anything, it really says that the first feeling that Adam and Eve had was shame at their own nakedness. I think that shame is a much more deeply religious problem than guilt.

These stories really help us see the experiences that precipitate moral injury. However there remains a lot of confusion, especially on how we distinguish moral injury from PTSD.

Keizer: I think it took a while for that distinction to become somewhat clear. Jonathan Shay's book, *Achilles in Vietnam: Combat Trauma and the Undoing of Character,* uses the ancient epics and shows how the problems that people experience in war have a moral dimension to them that runs deep within the human psyche. He keeps the two together as he talks about moral injury. But he's really the first one who coins the term "moral injury." Bacha Khan, an Indian philosopher and a close friend of Ghandi—and called the "Frontier Ghandi"—used the same kind of language. In 2009 Robert Lifton et al., wrote a paper examining the construct of moral injury.

The distinction is this: When trauma hits you, you're really not a participant in the sense that it's *your* action that causes the trauma, and although it might be, you're much more passive than when you participate in something immoral, like shooting civilians—then you run into the problem of agency.

In December 2009, Veteran's Administration mental health professionals described, for the first time, a wound of war they call "moral injury." They define it as the extreme distress brought about by "perpetrating, failing to prevent, or bearing witness to acts that transgress deeply held moral beliefs and expectations." They suggest that it contributes significantly to clinical depression, addiction, violent behavior and suicide, and that it may sometimes precipitate or intensify PTSD.

Moral injury is different from PTSD. PTSD is a fear–victim reaction to danger in which your life or serious bodily harm is threatened and has identifiable trauma symptoms such as flashbacks, nightmares, hyper-vigilance, and dissociation. Moral injury is an inner conflict based on a moral evaluation of having inflicted harm, a judgment grounded in a sense of personal agency. It results from a capacity for both empathy and self-reflection. Judgments pertain not only to active behavior, such as killing, but also to passive behavior, such as failing to prevent harm or witnessing a close friend being slain.

Moral injury can also involve feeling betrayed by persons in authority, or significant others in one's life. Even when an action may have saved someone's life or felt right at the time, a veteran may come to feel remorse or guilt for having had to inflict harm that violates his or her inner values. Just having to view and handle human remains can sometimes cause moral injury. And with the way these wars are going, the number of civilians who have been killed is tremendous. People just have problems with how they conduct modern war. The fact that people put grenades and explosive stuff on their bodies and become an instrument of war, causes war to become morally confusing.

In the Newsweek article last December, "A New Theory of PTSD and Veterans: Moral Injury," there were hints that moral injury may account for more of the 22 suicides/day than does PTSD. Could you comment on that?

Keizer: If you look at the power point presentation Rita and I did, that's one of the first things that I bring up [Chaplain Keizer and Rita Brock, Ph.D. are co-directors of the Soul Repair Center at Brite Divinity School in Fort Worth, Texas]. Rita and I have talked about that a lot. It was the clinicians in the VA who began raising this issue. Part of it, I think, is people have to deal first with the physical brain stuff caused by exposure to violence, that which causes the PTSD—which is located in the amygdala, the center part of the brain. This part of the brain is where the emotions are; it lights up in response to startling experiences and becomes overheated when exposed to violence. The brain doesn't get a chance to cool down and keeps being startled by triggering events, and that results in hyperactivity and hyper-vigilance. When this starts to heal, the deeper moral stuff starts to emerge. This response is located in the frontal lobe where your moral reasoning happens and where empathy is. It's kind of interesting that ethical decision making and empathy are kind of together. You have to have empathy in order to deal with people who need forgiveness, and you have to have empathy to seek forgiveness. One of the things that we're trying to look at, is people beginning to get well from PTSD when they hit their moral injury. And when they don't get any help with the moral injury side, that can lead to serious bouts of despair and despondency. Most of what they get in the VA is medication, and almost every one of those are psychotropic and one of the side effects is depression and suicide. I think some people have both—moral injury and PTSD—and some people just moral injury or PTSD. Moral injury, however, attacks and destroys the very core of your self-image; where it can become imprisoned by shame. This is lethal.

This is very informative. Let us turn now to what you have found helpful in addressing these issues.

Keizer: Staying in the military, I think, was one way that helped me. When I retired from active duty, I became the Director of Chaplaincy Ministries for the Christian Reformed Church of North America. I still had to have a tie to the military, and I am still actively involved with the military now. You build a cocoon around you in the military, that's where you feel comfortable.

There was this sniper, a Navy Seal who had 155 kills—I think he was in both Iraq and Afghanistan. He was killed by another soldier suffering from PTSD, whom he took to a rifle range to help him. The Veterans Administration has used exposure therapy as a means of treating PTSD. We [from the Soul Repair Center] were called by the paper in Ft.Worth and asked if I would mind writing an op-ed about this.

The staff read over the details and Rita was saying he wasn't doing a lot of the right things. To take someone who had just been in a mental institution and had threatened to kill his folks and take his own life, that's [a rifle range] not the place you might want to take him. I said, "Well, you've got to read it differently. Read it and see that this guy is still in a military cocoon. He's never been able to get out of it, and this therapy program included real physical stress training, *and* taking him out to a rifle range. It was all centered around some of the things that he found helpful in making the adjustment into the military, but could not "un-adjust" to in coming out. We wrote that as an op-ed and I got calls from some of his friends saying, "You're the only one that hit it right on the head."

I have special concern for the Reserve and National Guard Forces. Fifty-three percent of all of the folks who served in Afghanistan and Iraq are from the reserve component. They come back into a community that has no sense of where they've been and don't have the vocabulary to talk about it. Couple that with the fact that their whole military community of shared experiences and values and ways of speaking about things is gone. Now that we have an all-volunteer force, only about 1% of the whole American population is involved in these wars. So, 99% hardly know what's going on and are not asked to make any real sacrifices for the war.

Once again, this helps us understand the "Hell of coming home."

Keizer: Yes!

Jonathan Shay makes some startling statements when he compares the American and Isreali cultures regarding the military. Everyone in Israel is required to serve in the military and the rate of suicide is non-existent. The Israelis are taught that the other person is a human being, whereas the American soldier is trained to dehumanize the enemy to eliminate that moment of decision before you actually pull the trigger.

Keizer: It was interesting with the sniper who was killed. In his book, *American Sniper*, and in his conversations, he was still dehumanizing the enemy. Research done by the Israeli military demonstrates that snipers keep the enemy human. War for the sniper, though conducted from some distance, is still up close, individual and personal.

So a big part of the problem for returning veterans is culture shock?

Keizer: I think that the transition between civilian life and military life is very difficult, and part of the reason is the military is really a closed organization. In the book *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates,* by Erving Goffman [a key textbook in the deinstitutionalization of state hospitals], he calls it a "total institution." Total institutions have all encompassing characteristics. So when you enter the military you enter this closed system where certain behaviors are okay and can be rationalized. When you come out, all of a sudden you're in another environment where those behaviors are totally wrong. That's why the people who have experienced combat can talk to other people who have experienced combat better than people who have never been there. But sooner or later the narrative of war has to become part of their life story within their families, circle of friends and communities. Otherwise it's always buried in the heart and alienates them from the people around them.

My experience with WWII soldiers is that after about 40 years, they'll open up. We started doing interviews with WWII vets for the Library of Congress. The stories are magnificent, but many of them didn't start talking about it until they had the opportunity to do that with someone who had similar experiences. I remember a doctor, who just passed away at 99 years old. He had been a doctor with an all-black unit. We went through the interview and he told me a bunch of the things that had happened and when we got finished I said, "Did your experience in the war do anything to make you choose the part of your profession that you're in?" He had said he was a baby doctor. And he says, "You know Herman, I've never thought about that. You're right. I was hired to see people die rather than to bring them into life." He finally integrated the stories of his military service and his civilian life.

One of the strategies, I think that's helpful: in the literature, it says that the service member will seek out another service member first, and my sense is that that's true. I stayed in the military after Vietnam and so I was able to deal with some of the survivor guilt that I had— me going 150 feet out of a helicopter and surviving! And then you get soldiers making professions of faith who would never stand in some of our churches, no matter what denomination. They profess, "Your boss was really taking care of you at that point."

So the challenge becomes finding the means of building bridges between the two cultures that are stored on the inside, which involves introspection and sharing. What have you found helpful?

Keizer: One of the things that Rita and I try to do is help people listen deeply. We did a presentation in Kansas City. First participants listened to a panel of vets, then after our conversations, we formed a circle. The first people to talk in the circle were volunteers. When we do this, I'm usually in the circle first, so I can do some modeling. We talked about what we have heard other people say and how that affected us. It was really an amazing session. One of the young women talked about the fact that she walked over dead babies in Afghanistan after the enemy had been pulled out. They killed all of the babies and children before her unit could get into the hospital. Her story, as a woman, was very different than the response that a male would have to that kind of thing.

Towards the end of the session, a former Navy chaplain came in and sat down, and he said,

(continued on page 16)

MORAL INJURY *(from page 115*

"I feel I need to just share something that I haven't shared before and that has been bothering me. I was going up to An Khe; we were on the road and got hit by an ambush attack, and we were told to keep going, because you don't want to stop in an ambush. On our way back the MPs and the medics were still working with recovering the bodies from the trucks that had been hit and I got out to help. I've have never forgotten picking up body parts and putting them in body bags. It was obscene!" The tears started rolling down his cheeks.

I think law enforcement people experience the same thing. One of my young chaplain friends who was going into Special Operating Forces needed a top secret security clearance, and the young chaplain used me as a reference. The Special Operating Forces sent an investigator to interview me. We finished the interview within ten minutes, and then the man asked, "Colonel Keizer, what did you do when you retired?" I told him about my moral injury work, and he said, "You know, when I was a young cop in Texas, a car rolled over and started burning. The young man was underneath the car and was on fire. I couldn't get to him. He yelled, 'Shoot me, please! Kill me, please!' The former policeman said, "I couldn't do that!" Tears just started rolling down his cheeks, and he said, 'I gotta' go.' I said, "Now is not the time to go. Maybe it's time that we talk about that." And he opened up. It was amazing! That's the kind of strategy that I think needs to happen.

You have alluded to some of the personal attributes to which soldiers respond who are suffering from moral injury. Tell us more about that.

Keizer: Yes. One of the things that I think is helpful is to remember that people who are struggling with their conscience are basically healthy people. Their brain is working in the right way, because they are feeling guilty and they are feeling shame. The only people who don't feel guilt are sociopathic or psychopathic. You probably won't see too many of those coming to you with problems of guilt. What you're going to see are people who really need to be talked to with non-judgmental warmth and positive regard for them as human beings.

You need to be able to really listen deeply to their moral injury. You can't make judgments. The people who really need to forgive them are the ones that they've killed. But if you don't treat them as humans they stay in their shame. That moral hurt needs to get out from being buried so it can be dealt with. Like naming your ghosts—once you name them you'll never need to be afraid of them again. This is something that we really need to pay attention to and start dealing with because the psychological and therapeutic communities don't necessarily have the tools to handle moral injury. Furthermore, it has to be acknowledged as a life-long process, because you continue to revisit those things. You never know what will trigger them.

The church is one place that keeps you from cradle to grave and participates with you in all kinds of great incidents in your life that have a lot of moral choices, including making marriage vows and stuff like that. That is why Rita and I thought the real place to begin to help would be the religious community. That is how the Soul Repair Center at Brite Divinity School in Fort Worth, Texas got established. We received a $650,000 grant from the Lilly Endowment Fund to conduct research and training, public education and recovery on moral injury and to assist veterans and their families.

We not only have a team that does research but we also hope to develop curricula for theological schools, liturgical materials, training programs for communities, churches, and their leaders. We want to develop materials that enable members of the public to support recovery from moral injury. While our current focus is primarily on veterans, we will also be addressing aspects of civil society such as law enforcement, prisons, medical care givers, and international post-conflict situations. The nature of moral injury begs that our churches become informed and involved.

In 2009, Brett Litz, et al. published an article, "Moral Injury and moral repair in war veterans: A preliminary model and intervention strategy." Their work has been recognized by the VA. We adopted part of their protocols as being appropriate for Soul Repair. It is not surprising that they fit with the culture that is found in many of our religious communities, such as engaging in a dialogue with a benevolent moral authority and engaging in rituals that provide reparation and forgiveness and making amends. They also discuss the importance of fostering reconnection, intimacy and vulnerability, and putting your experiences into a larger/longer perspective. Although this doesn't need to happen in a church, and for many it won't, we need to better equip our churches so they can provide this kind of support.

Chaplain Keizer, the scope of your work and wisdom cannot begin to be exhausted in this interview; I only hope we have stimulated the compassion of our readers to help alleviate suffering our soldiers endure. What words would you like to leave us with?

Keizer: Hope! One of the things that I'm hopeful about regarding this work on moral injury is that it will bring the religious community to the table. One of my hopes is that it awakens in the American public a dialogue about our own national militarism—focusing in on what this really does to the human beings and human society that fights in war and how damaged people and institutions come out of wars. These problems that already exist are going to be with the United States for the next sixty years. ◆

Moving Forward

If you wondered why "Moral Injury" was included in this 50th Celebration issue of Connections, what better way to honor the past than by embracing transformative practices that enhance the future it has made possible. The healing of moral injury is one of those promising practices that challenge us to rethink our understanding of post traumatic stress disorder that afflicts so many, especially veterans.

Person-Centered Active Support *(from page 10)*

doing chores, baking, cleaning, decorating, and having a great time all the way. Mary's a shopper who hits the Dollar store every week; she's purchased a pink cowgirl hat that matches her cheerful persona. Bill has taken up golfing; Judy is a devoted church member with friends in the congregation. When we go out we make it a point to meet people. We're not shy and we've made some lasting friendships.

So many stories! They are about people living ordinary lives, fully and meaningfully. The stories are about the heart and soul of living day by day, but also about a vision of possibility and a service model that has transformed our lives. Person-Centered Active Support opened a door and empowered us to go beyond providing services toward living with vitality right here, right now, where we are, in this moment. We see people experience joy and meaning within the small moments of life. This is a life not of program or routine, but life rooted in the deep interior experiences of individuals. Ordinary life lived with meaning.

Looking back, it seems so simple: You might say, "Well this is basic. We all know this stuff. This is nothing new." And you might be correct. The key for us, however, seems to be that we now "see" differently. The training in PCAS—this "nothing new" approach—showed us basic tools and ideas that opened our minds to possibilities. This new way of seeing may have been there all along. That's the beauty of it; it was not a matter of discovering some new concept or skill. It was like looking at where we were, and seeing that place for the first time.

We were too accustomed to being occupied first with the superficial business of providing services. We have come to be mindful of the value of the ordinary experiences that are the substance of life. This has led us to the center of life where the heart thrives, smiles bloom, and people are fulfilled within the simple moments of ordinary magic.

It's a Journey we are just beginning; but already, the people we support are more active, happier, more enthused, and more deeply involved in a far broader array of life experiences. People's feelings and preferences are heard with more sensitivity. This has resulted in a natural growth in their having more authority and control all through the day. Staff members are more energized, more focused, more nurturing, and more optimistic. This is why we stay. This is how we thrive.

To quote Teilhard de Chardin, "Do not forget that the value and interest of life is not so much to do conspicuous things, as to do ordinary things with the perception of their enormous value."

We wish to thank Ellen Albrecht, and the support team at Bay Arenac Behavioral Health Authority. They've encouraged and supported our journey into more direct and more genuine ways of supporting people. They are wonderful fellow travelers on this rich journey.

> ***"The present moment is filled with joy***
> ***and happiness.***
> ***If you are attentive, you will see it."***
>
> *— Thích Nhất Hạnh*

MORE ABOUT PERSON-CENTERED ACTIVE SUPPORT

Person-Centered Active Support (PCAS) is a model of care that enables and empowers persons with intellectual or developmental disabilities to participate fully in all aspects of their lives; at home, in relationships, and in the community. An evidence-base, verifying positive outcomes, has been established via research on the use of PCAS by direct support professionals in group residences in the United Kingdom and Australia where PCAS has been in use for over a decade. The University of Minnesota Center for Excellence in Developmental Disabilities is conducting a longitudinal study of PCAS within group homes in the United States.

The PCAS approach focuses on what is needed on a day-to-day, moment-to-moment basis to provide effective support which is integrated and supportive of other person-centered approaches such as person-centered planning, gentle teaching, and positive behavioral support. PCAS is particularly effective with persons with severe disabilities and those with communication difficulties.

For more information, contact Brian McLuckie at 989-846-9631.

Eyes of a Social Worker *(from page 4)*

addressed.

CMH board members, under board member Hal Madden's leadership, formed a Board Association and hired Dave LaLumia as their executive director. The directors formed their own organization and met separately. It took several years of negotiation before the two organizations came together to form the Michigan Association of Community Mental Health Boards.

MEDICAID AND MANAGED CARE

In 1980 a major recession hit Michigan. Facing major cuts in funding for CMH agencies, Patrick Babcock, then Director of the Department of Mental Health (MDMH), adopted the policy to use Medicaid funds. This was the beginning for Michigan becoming dependent on Medicaid to fund mental health services. With the implementation of the Affordable Care Act, it is anticipated that Medicaid will be funding most of the CMH services.

In the early 90s, the State began Medicaid capitated funding for physical health. This was controversial, but proved to be successful. Capitated funding for CMH agencies was the next step. The majority of directors supported this movement as it provided for flexibility in funding and organizing services. Michigan is now a leader in the nation in having capitated funding arrangements for public services.

> **"...the public more than ever recognizes that mental illness and substance use problems affect all families and that they are serious health problems."**

Full management by CMH agencies was first brought in as a pilot but soon became state policy. This was a major step in the process of CMH agencies becoming responsible for the total care of a consumer. In 1996 Senator Beverly Hammerstrom provided leadership to revise the Code, which allowed CMH Boards to become authorities. This freed the Boards from county policies, enabling them to provide a more efficient delivery of services, although with the County Commissioners continuing to appoint the CMH Board members, it did not avoid dealing with county political issues. From 1989 to 2005, these changes enabled the State to close approximately 20 facilities and transfer the funding to CMH Boards.

CONSUMER FOCUS AND STIGMA

Richard Wellwood, co-founder of the Justice in Mental Health Organization (JIMHO), was a consumer who led the fight for consumer run programs. Today there are consumer run programs across the state. Peers are now becoming important staff members in the delivery of services. The revised Code required that primary and secondary consumers have representation on a CMH Board. This established the precedent for consumer participation in making policy decisions. Today consumers have a much stronger advocacy role in deciding how mental health services are organized and delivered.

With the hope of community based programs for persons who were mentally ill, a few strong willed families had the courage to establish the National Alliance for the Mentally Ill. Local chapters grew, and the Michigan Chapter was established. Today this organization provides an important voice for family members and consumers.

Families of persons with developmental disabilities had for many years been well organized and strong advocates for their loved ones. Participation in this movement was probably a major factor in President Kennedy's support for the Community Mental Health Act in 1963. Their strong political support has led the way for the development of community based supports and living arrangements.

DD advocates in Michigan initially wanted to have their own separate Department. They were never able to obtain the political support for this to occur. Michigan is one of only a few states in the country to have DD and MI services within the same Department. Being able to use Medicaid funding for these services in a flexible manner has been a significant asset.

Through the years, there has always been a concern that CMH services vary significantly from one county to another. Until recently there was little political will to address this issue. State policy was to let each county determine how best to grow and serve their consumers. Today consumers and others are demanding to receive similar services in all counties. Requiring CMHs to form into PIHPs was one attempt to address this concern. While some of the disparities were addressed, this continues to be a concern.

Stigma has always been a problem faced by consumers and family members. Fifty years ago, families never acknowledged that they had someone with mental illness. Persons were sent far away to state hospitals. Since consumers and families are speaking out, the public more than ever recognizes that mental illness and substance use problems affect all families and that they are serious health problems. I suspect that stigma for mental illness is not greater than it is for a number of physical health problems.

ADDRESSING SUBSTANCE USE DISORDERS

The relationship between substance abuse (SA)—now referred to as Substance Use Disorders (SUD)—programs and funding and MI funding has been a continuing issue. Initially SA advocates wanted a separate state department. When this was not possible, Substance Abuse Coordinating Agencies were formed which established separate boards, but more importantly separate financing. Traditionally SA and MH interventions have had different philosophies of treatment. In the past, Alcoholics Anonymous (AA) was the organization that provided most of the treatment for person with substance use disorders. They would not support using any medication. This conflicted with mental health interventions which usually included medications for persons with serious mental illnesses. Statistics showed that fifty percent or more of persons with MI had some substance use problem. Directors as far back as Mr. Babcock have said that SA and MH treatments need to be better coordinated. A few CMH agencies took on the role of being a Substance Abuse Coordinating Agency. The latest legislation requires the SUD funding and MH funding to be under the same regional structure, but it remains an issue. A SA Advisory Committee will also continue under the new regional Board. Time will tell if this arrangement brings about better coordination of clinical care.

SUD programs have always been under funded. SUD was removed as a disability which qualified for Medicaid. Things are now looking up for SUD funding. The federal parity act includes SUD. When Medicaid expansion occurs, significantly more individuals will have SUD coverage.

A PEEK AT THE FUTURE

Michigan has been blessed in that community based services have been strongly supported by both political parties. Michigan governors have appointed directors who have been strong leaders in developing the community based system of care. Jim Haveman is one who has had the longest tenure. He spent eight years as the CMH Director for Kent County, several years on the State Mental Health Advisory Council, twelve years as MDCH Director under Governor Engler, and one year under Governor Snyder. When he has not had an official office, he has been an advocate behind the scene.

I was talking with Patrick Barrie shortly before his death. He said, “CMH agencies have really achieved the mission they were established for, closing state hospitals.” The new challenge is finding a cost-effective administrative structure which can provide financial incentives to groups that provide needed community resources to assist consumers in achieving recovery. Patrick was considering many options to find a new structure to achieve this goal.

Our current system of each county having a CMH Board has many positive advantages, but it also has some serious limitations. Small boards cannot provide the full array of services that larger boards can. It also increases administrative costs. Time will tell whether the new PIHP regional structure can maintain the advantages of the local structure and achieve more efficiency between county programs.

Cost will continue to be a serious concern. Health care cannot continue to consume a higher and higher portion of the GNP. The Affordable Care Act with its expansion of health care coverage must be paid for. Will prevention programs and better coordination achieve the savings that will be required?

How will future funding occur? Change is in the wind. Will Accountable Care Organizations—along with outcome based and/or population based funding, or some other strategy gain favor—or will traditional fee for service and capitation continue? CMHs will probably have to deal with a combination of different models until more experience is gained.

It has been well documented that persons with serious mental illness do not receive appropriate physical health care and die earlier than the general population. Appropriate physical health care is critical for our consumers to achieve full recovery. What is the best model to coordinate the physical health care consumers require with needed behavioral health services? Many models are being tested. There is probably no single model that fits all. Each community must find the best fit.

The Department of Education, Department of Human Services, and the Juvenile Justice System all control significant funding and services for children and adolescents. The MDCH has received grants to develop a “Systems of Care Model” in a few communities, and has met with some success. Much work needs to be done to better coordinate services for children. In addition children deserve coordinated physical health services as well.

The Affordable Care Act will expand health care to many low income individuals who do not currently have coverage. Physical healthcare providers are learning that many of their consumers have behavioral health problems which need interventions. Most of these individuals will not qualify for traditional CMH services. CMH providers appreciate the importance of addressing both basic and social needs individuals have when seeking health care services. If these are ignored, consumers often do not benefit from the services that are provided. Physical healthcare providers are beginning to learn about the importance of addressing multiple problems in persons with complex needs, which are their most expensive clients. CMH providers have much to offer our physical health colleagues in addressing these concerns. Boards should not ignore this need and participate in a dialogue with other providers and payers to find solutions to meet all of the individual’s healthcare needs.

In the past, recovery was not even considered possible. Today there are consumers who have achieved recovery and others who have made significant progress. More can be accomplished in helping consumers pursue their dreams. With gene therapy on the horizon, what can we hope for? Are there possible cures?

Looking back over 50 years gives me great pride in what has been achieved. I have faith that the next 50 years will bring about even greater accomplishments. ■

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Perspective

(from page 8)

A mechanism was established that allowed for the submission of an annual funding request that permitted the establishment of a comprehensive range of mental health services. Many community mental health agencies, including ours, developed strong group home and case management services which tried to meet the promise of community-based services that provided active treatment and support.

It was this combination of a new approach to the treatment of persons with mental illness and access to federal and state funding that allowed community programs to assume the primary responsibility for the care and treatment of persons with serious and persistent mental illness, and to provide this care in their home communities.

There are some critics who believe the Community Mental Health Act of 1963 was a mixed success. They say that while it facilitated the release of state hospital patients who were not receiving active treatment, but were merely warehoused, the lack of adequate funding has left many of them without the services and support that they need. Some ended up homeless or without appropriate housing, especially in large cities, and many of them without the mental health care they need. This funding shortage remains with us to this day and presents major challenges to community agencies trying to provide the necessary care and treatment of persons with serious and persistent mental illness. It is disheartening that as our understanding of mental-illness has increased dramatically over the past 50 years, the financial support essential to taking advantage of this knowledge has not kept pace.

Nevertheless, it is no exaggeration to say that many, if not most, of the positive changes and improvements in our mental health services over the past 50 years and in our understanding of the needs of persons with serious mental illness stemmed from the vision of President John F. Kennedy and his commitment to the needs of persons with mental illness that led to the passage of the Community Mental Health Act of 1963.

It is only now, in retrospect, that I can fully appreciate the fundamental changes that have taken place in the field of mental health. During the time these changes were occurring we were too busy doing our individual jobs, implementing improvements as we could, trying to keep up with managed care challenges, and learning new and better methods of consumer care, such as evidence-based practices, to fully recognize the systemic changes taking place around us. While the current system is far from ideal and requires continued improvement, it is markedly better than the one in which I began my career 50 years ago.

I cannot imagine a more satisfying career than the one I chose. The opportunity to help persons with debilitating mental illnesses and disabilities, the chance to work alongside creative and committed colleagues, the ability to make lifelong friendships, and the gratification of a career of service cannot be overstated.