Insights and Innovations in Community Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

The Erich Lindemann Memorial Lecture Committee presents

THE FOURTEENTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Social Ethos, Social Conscience, and Social Psychiatry: Community Mental Health and the Cycles of Psychiatric Ideology

Lecturer

David G. Satin, MD, Department of Psychiatry and Division on Aging, Harvard Medical School, Coordinator, Colloquium on the History of Psychiarty, McLean Hospital and Harvard Medical School; President, Geriatric Health Resource, Inc.

Discussants

Danna Mauch, PhD, Consultant on Public Policy, Massachusetts Association for Mental Health; Princial PDM Health Strategies

Robert L. Porter, EdD, MPH, Northeast Director of Corporate Psychological Centers; Director, Delphi Economics International

Moderator

Robert Evans, EdD, Executive Director, Human Relations Service, Inc., Wellesley, Massachusetts

Friday, April 26, 1991, 2:30 – 5:30 pm

Massachusetts School of Professional Psychology
221 Rivermoor Street, Boston, MA 02132

Introduction by Robert Evans, EdD

The program for today involves a small roleplaying in which I get to stand here as host and the person who normally stands here as host will speak. This is sort of like entertaining people in someone else's home, in that I will, in a few moments, have the chance to introduce David Satin, who is the remaining member of the Lecture committee I haven't mentioned, and who will be our speaker today. Most of you don't know me. I am, I suppose technically, Erich Lindemann's administrative heir, in that I am the director of the Human Relations Service in Wellesley, and I have been for nearly 11 years now. And I am not a substantive part of the program today, but I am to prepare the ground a little, and I have a couple of small thoughts to share with you at the beginning.

The first is that on the day before, in March, the day before David Satin called me to review the details of today's program, the State Department of Mental Health beat him to the punch and called me up to complete the elimination of it's funding of the Human Relations Service, a process they began 18 months ago and accelerated smartly this spring, and in 1969 the Human Relations Service was already 21 years old, and joined the partnership network that the state of Massachusetts had created, which had an irony all of its own because in a sense that whole notion of community mental health that the state was building in fact was the kind of activity that had been created at the Human Relation Service, and that is associated with the name of Erich Lindemann. So for about 20 years, a little longer than that, we enjoyed that association, and now in the current context of things, in which not only are dollars shrinking but priorities have changed, we find that the department has eliminated its resources from us, as from many other agencies. This, needless to say, provokes a variety of thoughts and reactions, but it made my discussion with David, and succeeding talks with him also thought-provoking for me, because we all know that history, as it's an old adage by now, history is written by the winners. It is not clear at this point, I guess, in the end whether there will be winners or losers in this struggle, and who they will be, and whether in the long run those of us who are interested to even be here on an afternoon like this about a topic like this, Social Ethos, Social Conscience, and Social Psychiatry: Community Mental Health and the Cycles of Psychiatric Ideology. Those of us who work in community mental health, whether we will look in retrospect like keepers of a precious flame, or just fossils-to-be, who didn't know that is what they were heading for. I'm looking forward to David's sharing some thoughts with us about that.

I had one last one, sort of an analogy that I wasn't sure was entirely appropriate or relevant, but I couldn't shake it, so I thought I would share it. In a lot of his novels, John Le Carre writes about figures who are out of time. Very often in a lot of his books there are figures who are left over from the Second World War and the Cold War, and who

cherish a dream of a certain kind of return to power or prominence or freedom, whatever it may be, which, as it happens in the course of those stories, is unrealistic and doomed. And some of his most powerful portraits of characters in his books are people who are caught, as it were, out of time, and not even really aware that that is true. I have wondered increasingly, as the director of the Human Relations Service, whether that is true of me and my staff and the people who still labor in the community field, and whether we will turn out like that. Then I realized the other day that of course in some of those books some of the people who are most out of date are Baltic exiles who cherish a dream somehow that they will be free from Russia, and, lo and behold, we don't know what will happen, but they're still working on it. I didn't know whether to take heart, or whether we're heading for another round of disappointment.

But, in any case, I think that it is clear that whether we turn out to be fossils or not when somebody else rewrites history, it ís also clear that for lots of us there is at this point not just a set of beliefs and a database and knowledge base that we are confident of, whether others pay attention to it or not. There is also a tradition at this point. For me, the Lindemann legacy actually is expressed by Betty Lindemann, who is the one that I know and have worked with. But I think more broadly what we might think of as a Lindemann tradition or legacy, though it is one that is harder to sustain these days, is one that has inspired and animated a large number of us.

Indeed, even the person in the Department of Mental Health whose job it was to call me up and tell me they had eliminated our money has worked in the field for 25 years and was reflecting on what he has seen happen in that time, and the contrast between his priorities and values and interests and the job he is currently needing to do. By chance last night I found, at the bottom of my briefcase, a scribbled piece of paper with a quote I had come across a couple years back when I was reading *Habits of the Heart*, and it is this: "Whereas tradition is the living faith of the dead, traditionalism is the dead faith of the living." I think that it is important for us to find a way to sustain a tradition, not become traditionalists.

David G. Satin, MD

Department of Psychiatry and Division of Aging, Harvard Medical School; Coordinator, Colloquium on the History of Psychiatry, McLean Hospital and Haravrd Medical School; President, Geriatric Health Resource, Inc.

Introduction by Robert Evans, EdD

I like to think we're here today, looking for some further perspective about our dilemma and looking for a way to sustain the living faith of Erich Lindemann, and for that I'm delighted to introduce to you now Dr. David Satin. Bear with me and I'll tell you a little bit about him for those who don't know, and then we'll move on to our program.

He is currently the director of the Community Geriatrics Program at the Harvard Medical School, of the Geriatric Mental Health Program at Newton Wellesley Hospital, and president of Geriatric Health Resource, Incorporated in Wellesley. The list of things he has done in mental health, as it is for each of our panelists today, is long and remarkably varied. He has had a variety of teaching and clinical and consultative positions, and he is currently assistant clinical professor at Harvard Medical School, and has been on the faculty of B.U. School of Medicine, and the University of Aberdeen in Scotland. Over the past 35 years he has been on the staff of or consultant to mental health agencies, hospitals, neighborhood health centers, settlement houses, and has even been an honorary assistant psychiatrist in the northeast region of Scotland. He has published in a wide range of topics, from the allocation of mental health resources in air force settings to motivational factors in geriatric rehabilitation, and recently edited The Clinical Care of the Aged Person, published by the Oxford University Press. He has coedited, with Betty Lindemann and Jean Farrell The Lindemann Legacy: 10 Lindemann Memorial Lectures, and his topic today is Social Ethos, Social Conscience and Social Psychiatry: Community Mental Health and the Cycles of Psychiatric Ideology. David.

David G. Satin, MD

Introduction

I am honored to be selected as the fourteenth Erich Lindemann Memorial Lecturer. It allows me to participate in honoring Erich Lindemann: a creative, synthetic/inductive mind; an exponent of the historical approach to psychology and a researcher in the case study tradition; a humanist and moralist; a true Guru, in the sense of teacher and role model.

I also appreciate the opportunity to formulate and reconsider my ideas about the history of community mental health and psychiatry, a project I have had in hand for

some years as the biographer of Erich Lindemann and of the Community Mental Health Movement in the twentieth century United States. This project grows from my own experience as a student, teacher, and, above all, steadfast practitioner of community mental health over the period of its late flowering and then when it withered and was plowed under. Perhaps when one feels unable to rescue one's ideals from the onward sweep of history one can at least seek to understand that sweep of history.

The agenda of my lecture will be simple, though the contributing influences and interrelationships are complex:

1. a frank look at mental health practice and ideology in the late 1980's and early 1990's;
2. placing this reality in the context of cycles of psychiatric ideology and societal values;
3. a proposed explanation of this cycling: the phases and sequence of the cycle, and the factors that trigger movement from one phase to another;
4. the social and moral implications of mental health practice and ideology.
    1. I would be grateful for comments, criticism, and ideas that will enrich this perspective.

I. The State of Mental Health Practice and Ideaology at the end of the Twentieth Century

1. Governmental Policies

Over the 1970'S and 1980's governmental policy in the United States—surely reflecting society's philosophy—has pressed toward a reduction of social services and resources. This is true of other western, industrialized societies as well, even those which were pioneers in and committed to social welfare programs, such as The Federal Republic of Germany and Great Britain. Reduction of funding for and entitlement to physical health, mental health, vocational, and pension programs was progressive and a part of political party platforms. Such "reforms" represent only one aspect of a general shift of emphasis and resources from expenditure for human care and services toward conservation for the advancement of private business and the individual. I do not mean to overlook the existence of vigorous advocacy and support movements addressing such issues as the civil rights of minorities, abuse of certain groups, and even the health and welfare of the mentally ill and retarded. But these constitute, significantly, private undertakings seeking to influence government policy or redress the loss of governmental/societal resources, and have limited effect.

To address support for mental health services let me use the example of state government programs. These observations hold true also for my own state, the

Commonwealth of Massachusetts—formerly a leader in innovative treatment approaches (the psychopathic hospital, the child guidance clinic, the court clinic, the community mental health center), research into the causes and cures of insanity and mental illness, and public generosity in support of these efforts (and, in the period under consideration, still offering one of the highest levels of service and expenditure on health and welfare of all U.S. states).

The budgets of state departments of mental health (DMH) were steadily reduced. Local Mental Health Areas and even the grouped Regions, developed under Federal community mental health centers legislations to bring mental health services and control closer to communities and their residents, were first combined and then entirely abolished. Community residents' voice in setting policy and in planning, and even their access to administrative information, were eliminated.

State hospitals—and the later additions to their numbers, mental health centers—became the government's main mental health resources. Even these offer mainly in-patient treatment, and even access to this is stoutly resisted. In Massachusetts the "Crisis Intervention Services"—an Orwellian "newspeak" title—became the agency responsible for preventing the use of DMH resources: inviting applications for help, and then turning applicants away to private agencies or regreting its inability to help due to a maze of policies and procedures. In fact, it is outraged when patients actually appear at its doors for help!

State services are substantially limited to the social support of the chronically and incurably mentally ill, especially those discharged from and to be kept from returning to state hospitals, and qualifying them for federal support such as through Medicare and Medicaid. In the 1970's and 1980's it was government policy to discharge most patients from state mental hospitals regardless of their clinical needs and without adequate alternative resources or plans for their care. The result was multitudes in the community existing just above or below the subsistence level, a shift in the population of (ill prepared) nursing homes toward residents with major mental illness, and a large contribution to the "homeless" population. Euphemistically this was termed "deinstitutionalization"; in a vengeful irony it was trumpeted as the adoption of community mental health policies, and its disastrous consequences were used to discredit that ideology.

The acutely mentally ill—often trivialized as "the worried well"—may be treated if resources are available, but this means never as budget and staffing are continually reduced. Staffing is structured to emphasize ever less qualified workers: Originially psychiatrists were the mainstays in clinical, supervisory, administrative, and planning roles. Currently they are primarily limited to writing prescriptions and authorizing insurance claims; nurses and social workers are the main administrators and

supervisors; casework aides, "mental health workers", or "counselors" are the caregivers to patients and their families; and those with training in "public administration" or "community service" or without human service background of any kind are often selected as facility superintendants and central office program directors. Massachusetts was one of the only states which required that its Commissioner of Mental Health be a trained physician, while some other states filled this position with untrained political appointees. In Massachusetts first this requirement was modified to accept anyone with a terminal degree in a mental health profession, and now there are no education or skill requirements. It is expected that all state staffing for direct services will be ended, they will be contracted out to private agencies for medication and social maintenance and funded at a much lower level, and the DMH will act as a policy-making, contracting and auditing agency only. The service contactors include health maintenance organizations, which have traditionally minimized costly services such as mental health and excluded heavy service users in order to avoid financial losses. The federal courts have rejected the Commonwealth of Massachusetts' plan to reduce funding for mental retardation services, citing this as an avoidance of state responsibility.

State mental health and public health facilities are being closed and sold. The Erich Lindemann Mental Health Center in Boston has long been the target of sale to private condominium developers, use by other state departments, or closing. Presently clinical programs have been moved or phased out, and it is used substantially for office space (including the DMH's central offices), saving money at the cost of the community's mental health. (Were the Lindemann Center's carefully planned occupational therapy and physical therapy suites, library, gymnasium, swimming pool, indoor reception area, and outdoor plazas *ever* used for the community's mental health as intended? They are now broken up for office space, house the homeless, moved, shrunken, or abandoned.)

Needless to say, prevention of psychosocial disability, much less the enhancement of mental health, is beyond consideration. Previous Erich Lindemann Memorial Lectures—"Cultural Factors in Mental Health" by John Spiegel, "Social Justice as a Mental State" by William Ryan, "Generating Social Settings for a Public's Health" by James G. Kelly, and "Healthy Cities: From Wellesley to W.H.O." by Leonard J. Duhl—do not apply to present public services in Massachusetts, the United States, or the western developed countries in this time of economic and political reactionarism.

The federal government is similarly concerned with economic austerity and limiting obligations. St. Elizabeth's Hospital in Washington, D.C.—a federal center for research, training, and clinical care—has been closed, sold, and broken up. Funding of the various institutes of health have been restricted. Even the sacred Veterans Administration—the federal government's largest health care undertaking—is being reduced in services, manpower, and funding. However, demands for the solution of national social problems

are focussed more at the federal level. To navagate between these pressures the federal government has the interesting option of mandating state assumption of new programs and expenses while pressing for the shrinkage of the federal bureaucracy.

2. Clinical Practice

The federal Community Mental Health Centers acts guidelines required the development of catchment areas and local community mental health centers to qualify for access to their massive funding. The Erich Lindemann Mental Health Center was one of the earliest state facilities developed in Massachusetts. Dr. Lindemann had observed its conception and tried to influence its character. He was gratified by this concrete (sic) recognition of his work, though unhappy with its massive, institutional embodiment rather than the model he pioneered of an informal program blending into the physical and social structure of the community it was to serve. It is symbolically significant that this and all the new Massachusetts facilities were labeled "mental health centers" and not "community mental health centers": a mark of the professional aloofness and institutional isolation that they perpetuated.

In the early days of community mental health professionals were heavily involved clinically and academically in community mental health centers, much service was community-based, the community was often strongly involved in the direction and use of the centers, and consultation and education (preventive) services were well developed. Despite the (relatively) low income and governmental bureaucracy, community mental health was an exciting and attractive field that offered creativity, pulblic support, and moral satisfaction. Later budget and staff were progressively reduced. The focus became almost entirely the chronically and severely mentally ill and maintaining them in community residences. Minimizing the use of state and local facilities and expense, and maximizing the use of federal and private benefits (including Medicaid and Social Security Disability Insurance) became a high priority. Preventive, health enhancement, and social research activities were relegated to the "when resources are available" category.

From time to time psychiatrists are taken to task for "abandoning" public service and the severely mentally ill because their numbers in public and community programs has diminished and this is no longer a popular career choice. In fact, psychiatrists have been extruded from public service both because of their expense and as a result of inter-discipline competition (discussed later). They are currently preferred as consultants for specific tasks, such as evaluating patients only in terms of medication treatment, monitoring them only briefly in groups, and prescribing medications for patients whose treatment is carried over from other settings or is recommended by non-physicians

whether or not they are personally examined by the prescribing psychiatrists. There are even examples of psychiatrists being pressured to sign blank forms for commitment to mental hospitals to be used later for patients seen only by other staff members. This exploitation of psychiatrists, in violation of ethical principles, licensing regulations, and law, has been recognized in the American Psychiatric Association's cautionary "Guidelines for Psychiatric Practice in Community Mental Health Centers"i. Doctoral-level psychologists also are hard put to find a place in the public mental health system, since their sophisticated diagnostic, treatment, and training skills exceed those needed for basic care and institutional maintenance. Social workers and nurses often occupy supervisory and directorial positions, partly because they traditionally deal with physical and social maintenance issues, and partly because they are so much less expensive. Direct clinical care—not only maintenance support but also emergency evaluation, intervention, and disposition—is increasingly given by ill-defined and variably trained paraprofessionals, with more highly trained mental health professionals acting as advisors or filing official documents sanctioning the actions of the less trained.

It has both symbolic and practical significance that the first two superintendents of the Erich Lindemann Mental Health Center were psychiatrists with extensive experience in and dedication to community mental health. They also held academic appointments to the Psychiatry Service of the local Massachusetts General Hospital and Harvard Medical School—the institutions in which Dr. Lindemann held high rank and from which he did his pioneering work in social and community psychiatry. Thereafter the superintendents had masters degrees in public administration or no relevant education, and came from state administration, volunteer services, and penal institutions. They implemented the goals and policies dictated from above (including proposals to close the Mental Health Center itself without plans for alternative services), and employed as clinical directors mental health professionals who gave a veneer of professional respectability and disciplined subordinates who challenged convenient goals and practices. Attempts have been made in vain to recruit psychiatrists: both the policies from above and the impossibility of high quality and interesting professional practice have discouraged them.

Other mental health centers have had similar experiences. The Boston University/Dr. Solomon Carter Fuller Mental Health Center began in the same era of creativity and governmental and professional committment. When financial and ideological support fell away professionals, academia, and community forces drew back from one another. Non-professionals came to dominate the staff, and factional interests—based on ideology and personal ambition—caused internal and external conflict. The quality of care deteriorated so that the community and referral agencies shunned the institution. The staff fared no better, with financial mismanagement and

diversion of staff benefits until exposed to the state Department of Labor. Only after a number of patients died while in the Mental Health Center's care was it investigated, its administration replaced, and more competent staffing arranged. Since then the quality of mental health service and acceptance by the lay and professional communities have improved.

The betrayal of community mental health responsibility and practice is now officially recognized in federal investigations by the Office of the Inspector General of the Department of Health and Human Services, the Director's Office of the National Institute of Mental Health, and the General Accounting Officeii. The issue is failure to use federal community mental health center planning, construction, staffing, and renovation grants to actually develop comprehensive services—including consultation and education—as mandated in the Community Mental Health Centers acts. In many cases academic, clinical, and local government institutions turned to this great trough of funds to support their traditional programs rather than creating and implementing community mental health programs. It is only the agitation of community activists and conscientious program monitors that spurred these investigations long after both ideology and policy have changed. It comes as no surprise that the investigating government agencies discourage expectations of significant findings or retribution.

3. Political Economics

The debate about economics and human services invariably starts with the assumption that too much is being spent: the U.S. Social Security Trust Fund, the government treasury, the working middle class, the country are being bankrupted. The discussion then turns immediately to reducing services. And this is made into a virtue: "cutting fat out of the budget"; excluding and punishing the "cheats"—both the recipients of services who are lazy and fraudulent, and the providers of services who are greedy and fraudulent; exposing unjustified and absurd expenditures; streamlining wasteful, inefficient, and overly padded bureaucracy (that bureaucracy heaped up by the government spokesmen who now righteously decry it). The system will be leaner, the benefits to those in need will be undiminished, and only the greedy and lazy and dishonest and well-provided will be deprived. And yet simultaneously the needs of the mentally ill, aged, homeless, AIDS sufferers, abused and neglected children, and newly-discovered malnourished appear in the next column or the next page or the next edition or the next conference. Even those government officials who formerly labeled themselves "liberals", championed the care of the needy, and saw government as the instrument of human service, with all-too-brief apology, agree to the need for reform, efficiency, and cost-cutting—although trying somehow to be more kindly, discriminating, and regretful.

As an example, a Massachusetts State Senator, acknowledged as a long-time friend of psychiatry, recently addressed the Massachusetts Psychiatric Society on "The Future of Mental Health Care in the Commonwealth"iii. She pointed out that the drastic decrease in funding from both federal and city/town sources left the state with a critical gap between revenues and expenditures. The public will not tolerate increased taxation, so the state must resist new human service programs, drastically reduce the number of state employees, and address the three largest items in the state budget: Medicaid, state employee pensions, and state employee health and life insurance. The solution is cutting unnecessary and inefficient services—misuse of Medicaid benefits and programs. In fact, the Chief of Staff to the governor applauds the "political opponent" of decreasing public human service programs "...who says 'Hey, here's a program that's worthwhile, and here are the 15 reasons why it's worthwhile. We understand you can't fund it, but here are the 10 ways we've figured out to make it work, through leveraging the private sector, or downsizing this or that aspect of it.' Or 'Here's a way we think you can substitute this cut for that cut.' That sort of psychology is starting to take root, and I think it's a very useful approach...."iv.

Hardly anyone looks at the income side of the balance. If the larder is emptying is it because too much is being eaten or too little is being provided? For example, the Social Security Trust Fund was growing when it supported only old age and survivors benefits, despite the fact that the population is aging and an ever-larger proportion is drawing benefits. When disability benefits, Medicare health insurance benefits, and borrowing to reduce the federal deficit were added without adequate increase in contributions it began to empty. Some note in passing that the American public wants first-rate health care but does not want to increase taxing to pay for it.

4. Professional Attitudes

Mental health professionals and organizations play multiple roles in the mental health picture. One role is to fight for accustomed roles and standards, as befits guilds responsible for the continuity of their traditions and constituencies. In this role they decry the deterioration of the quality of services offered to those in need and the decreased participation of their professionals in programs and institutions. They resisted redefinition of roles and practices when the community mental health approach was being explored, and in the era of degredation of services and standards.

In another role some professions see opportunities for advancement, and others see the danger of displacement in the new social order. First psychologists, then social workers, and finally nurses found that new tasks and staff structure, and then the search for economies in cost and professional preparation offered them opportunities for jobs

and leadership positions that had previously been preempted by physicians. Conversely, physicians (including psychiatrists) found that the higher status postions, higher pay, and greater job opportunity and security they previously enjoyed were threatened. The result is heightened competition and conflict over job specifications, legally mandated privileges, and representation on planning bodies. However, the loss of programs and services translated into displacement of one after another of the traditional mental health professions as ever-less care is offered, ever-more elementary needs are addressed, and ever-less competence is sought.

Finally there has been a double response to the relentless dismantling of mental health programs and services: One response is compromise of past principles and ambitions as professional associations, too, accept the assumption that they must join and find virtue in this diminishment of the mental health enterprise. As a substitute role they seek to help plan and administer the process both as a way of mitigating its effects and as a new source of employment. It is interesting to see health planning, administration, and documentation (epidemiology, nosology) rise in popularity as professional subspecialties in place of the diagnosis, treatment, and etiology of mental illness and health that were esteemed in previous eras. Those who persist in their interest in and advocacy for mental health care and committment to social responsibility may be seen at best as impractical, and at worst as jeopardizing the profession's acceptance by authorities. Ethics and humane concern can be adapted to the political and economic interests of the professions, and we join the enemy we cannot defeat. Community mental health is translated into "public sector psychiatry", the goal of prevention of illness is exchanged for the efficient care (and scientific understanding) of the severely mentally ill, and success is guaged not by decreased morbidity but by cost containment.

The other response is for professional competition to give way to some circumspect cooperation in decrying and trying to limit this loss of concern for society's mental health and the restricted professional opportunity that ensues. Paradoxically we may see a pale reincarnation of community mental health as the various professions ally with consumer advocacy groups in their concern for the community's mental health needs.

5. Academic Perspective

Academia no longer finds social and community psychiatry respectable. In the first Erich Lindemann Memorial Lecture "Community Mental Health in Historical Perspective" and in other writings[v] Gerald Caplan's opinion was that it is not supported, respected, or practiced in urban and academic centers, but is effective and valued where resources are scarce, such as rural areas and small cities. It is no longer to be found in

the structures or curricula of most professional schools, or included in training programs. It does not appear in the titles of published articles except rarely among those dealing with the history of psychiatry. "Public Sector Psychiatry", its nearest relative, deals with policy-making, funding, and administration in government programs, in which the practice is the housing and maintenance of the severely and permanently disabled, utilizing minimal and undependable resources. Similarly, in the Federal Republic of Germany the equivalent Sozialpsychiatrie and its idealistic supporters, the Deutsches Gesellschaft für Sozial Psychiatrie, focus mainly on the funding and administrative structure of state mental hospitals and halfway houses for the severely mentally ill. Japan is said to take a biological approach to mental illness. Only Italy has legislated a social and community care system after the government abruptly terminated state mental hospitals.[vi]

The Chief of Psychiatry at the Massachusetts General Hospital (MGH) wrote to a community psychiatrist on the staff: "...Our guidelines state that in general whenever contributed services are no longer given or required, the basis for a hospital (and therefore Harvard) appointment stop. A letter of resignation is required and I would appreciate your sending me one...."[vii]. Later he reported that there are questions as to this physician's clinical competence because "...His orientation is mainly psychosocial...."[viii]. In a demonstration of his prejudice about the ineffectualness of community psychiatry he wrote "...In my view, any physician...must be, in order to be deemed competent, fully able to assess the medical condition of the patient and do so habitually through appropriate history, physical and laboratory examination. To evaluate the person's thought, feeling and behavior without this is to fail one's responsibility as a psychiatrist. No physician will be hired by me ...who does not meet these conditions: it is one of the credentialing criteria of the Psychiatry Service at the MGH. I understand that this is not the case in other respected institutions, where a purely psychosocial approach...would be considered both adequate and appropriate. I did not mean to suggest that you were incompetent to practice at these other institutions...."[ix]. This in the department Erich Lindemann brought to leadership in social and community psychiatry!

It is an interesting parallel that the Erich Lindemann Mental Health Center's first superintendent was a veteran of the early days of social activism in community mental health, and supported community-based services; consultation and education; preventive intervention efforts; and clinical, teaching, and research involvement in these endeavors by professionals and academic institutions. He has since changed his attitude and work, is known for psychopharmacological and epidemiological approaches to psychiatry, and criticizes community mental health. He has publicly opposed as malpractice solely psychological and social approaches to some mental illness.

These are fair examples of the current medical-academic perspective. Even the memory of community mental health and the passions it evoked are little known to students and younger teachers and administrators. This is an era of biological and descriptive psychiatry. It emphasizes the individual as the focus of study; pathology as the form of need; and submicroanatomy, chemistry, and genetics as etiology and therapy. Psychology is a supportive modality, and social issues are not within the province of medicine. As in previous eras of biological psychiatry, a degree of nihilism and limited responsibility for immediate help is combined with expectations of future omnipotence in understanding, curing, and even preventing mental illness—surely a biological public health perspective!

It is in the non-medical professions that one may see more psychological and social ideology: Psychology vies with psychiatry for investment in neurobiological testing and intervention, with ambitions to take fuller, independent authority for treatment. Nursing takes more of the administrative role in both treatment (unit direction, administrative policy-making) and program monitoring (quality assurance, insurance claims). Social work most retains the role of social concern and advocacy, though clinically it is often pressed into service in the rationing rather than disbursing of care. The rehabilitative therapies—occupational, physical, and vocational—in some cases newly espouse a psychosocial and humanistic view of people functioning in their family, social, and cultural environments.

III. A Historical Perspective on Cycles of Mental Health Practice and Ideology

There was a time when a social and community perspective on mental health was dominant: the era of the Community Mental Health Movement (CMH) in the twentieth century United States. This spanned the somewhat arbitrarily chosen period1946 (the year of the formation of the National Institute of Mental Health) to 1972 (Richard Nixon's second term as president of the United States and the effective implementation of political and fiscal conservatism).

The theoretical and technological roots were the development of both the social sciences and psychology toward an interest in group and social influences on human behavior and mental illness. Gestalt psychology, medical anthropology, the study of small group dynamics, and predicament studies in cultural anthropology and sociology began to suggest diagnostic and therapeutic interventions. Public health researchers became interested in applying to psychiatry the epidemiological methods used in infectious diseases. During World War II experience with small unit morale, psychiatric illness provoked by environmental stress, and the

treatment of acute mental illness in the front-line setting in which it was produced[x] prepared an interest in applying this theory and experience to the civilian society.

The ideological and moral roots were in the experience of mass hostility, conflict, and destruction in the periods surrounding the two world wars. Both the arts and the mental health professions became concerned with the human condition and the direction civilization was taking. The conquest of political evil by good in war raised hope and confidence in the prospect of conquering other evils, such as sickness, poverty, prejudice, and mental illness. The mobilization of great resources in the World Wars lent confidence to the new crusade.

These triple motors—technology, mission, and means—found a crescendo of outlet in the community mental health movement. It began with post-war research in the social, psychological, and medical sciences; and academic and clinical experiments in epidemiology, group therapy, and preventive intervention. Erich Lindemann's research in social psychiatry, teaching of public health mental health, direction of the Wellesley Human Relations Service (HRS—the first community mental health center of the era), and leadership of the Psychiatry Service at the Massachusetts General Hospital and Harvard Medical School introduced the social sciences as enrichment of public health, family care, and the concept of a "therapeutic human environment" in the hospital and the community.[xi] The study of the mental health consequences of forced urban relocation ("The West End Study") was a landmark in academic contribution to both mental health epidemiology and public policy.

After strenuous debate and struggle, the federal government's Community Mental Health Centers acts and massive funding overwhelmed voluntary efforts and developed CMH plans, programs, and centers. CMH was the key to training, research, clinical, and planning grants and programs. The interaction of CMH with programs of social betterment (the War on Poverty, the Great Society), civil rights, popular control, and anti-war led to disappointment of idealistic expectations, political radicalization, and reactive fear and resentment.[xii]

This, in turn, fueled a counterrevolution of political and economic conservatism. It contributed to the retreat to the "safe" biological study of individual pathology; conservative/nihilistic expectations; and anatomical, biochemical, and genetic studies devoid of social responsibility and involvement. A conscious political decision was made by psychiatry to ally itself with non-psychiatric medicine rather than non-medical mental health professions in order to distance itself from social conflict and preserve its competitive advantage.

These changes of course are epitomized in a petition by members of the MGH staff after Dr. Lindemann's retirement, stating their opinions that "We...are greatly concerned over the choice of a new Chief of Psychiatry at the M.G.H. We have the following

opinions: ...That acutely ill psychiatric patients should be cared for in a general hospital...psychiatric leadership must be provided to...establish an environment in which intensive treatment and responsibility for the welfare of patients, rather than inquiries into the hypothetical cause or causes of psychiatric illness is made the paramount function of the Psychiatric Service...encourage the use of physical and chemical methods in the treatment of psychiatric illness...To accomplish these desiderata we believe that Dr. Lindemann's successor should...not be a member of, nor lend his support to, any school or cult of psychiatry which substitutes 'faith' for the scientific method of diagnosing, treating and evaluating the results of treatment of mental illness...."[xiii]. This at the MGH, dedicated since its founding to basic research in all other medical specialties, and written by adherents of the school of biological psychiatry!

And so entered the era of biological psychiatry distanced from social responsibility, very much like the one that held sway during the latter part of the nineteenth century. Then, too, the state provided custodial care by largely untrained attendants for the severely and chronically mentally ill. Psychiatric ideology held that insanity was of biological origin (constitutional degenerate psychopathy), amenable only to paliative care until laboratory science had unraveled the neuroanatomical and neurophysiological causes. This achievement was expected to result in the prevention, cure, and eradication of insanity.

The end of the nineteenth and the first half of the twentieth century saw clinical observations of the influence of interpersonal and child-rearing experience on later emotion and behavior. Rebellion against the increasingly sterile and hopeless biological scholasticism grew. The result was the era of psychological psychiatry and the flowering of psychoanalysis and other psychodynamic psychologies, gestalt and other social psychologies, and psychologically-based social institutions and movements such as child guidance, court clinics, and Mental Hygeine.

When psychological psychiatry, in turn, became restrictive and unhelpful, and observations were made of the effects of social environment, crises, and relationships on psychological symptoms and adjustment, the previously-outlined era of social psychiatry supervened.

A cycle of psychiatric ideologies suggests itself. Its historical roots are in the constant interplay between biological, psychological, and social explanations of pathogenesis and treatment[xivxvxvi], including the recurrent emergence of social and moral approaches to mental illness[xvii]. Laboratory-based organicism, hospital and consulting room-based psychicism, and religious and philanthropic social reform have battled and succeeded one another as official dogma without general understanding of the multiple factors that determine psychiatric practice and teaching, and the ideologies behind them.

What, then, are the factors that determine these ideologies, changes in them, and their sequence?

IV. Factors Influencing Cycles of Psychiatric Ideology[xviii]

In reviewing the history of psychiatry three perspectives emerge as underlying the ever-changing approaches to mental health and illness, as mentioned above: biological, psychological, and socialxixxxxxixxiixxiii. All three attract some recognition, interest, and advocates at all times, and from time to time there are attempts to integrate them in a non-partisan way. However, they tend to compete for popular acceptance and for authority in professional education, clinical practice, and prestige. One tends to dominate at any given time, and they seem to succeed one another in the above order at approximately 30 year intervalsxxiv. Oliver Wendell Holmes, sr. noted that medical ideas are subject to the same cultural and social influences as are other aspects of society, and that "...Much, therefore, which is now very commonly considered to be the result of experience, will be recognized in the next, or in some succeeding generation, as no such result at all, but as a foregone conclusion, based on some prevalent belief or fashion of the time...."xxv. Thus, culturocentric ideas of ultimate truth, evangelism, and xenophobia clothe the contemporary perspective, and it is elaborated into an ideology which influences group loyalties, technology, and institutional policy.

Changes in phases of the cycle seem prompted by a combination of strains and opportunities both within psychiatry and outside it.

Rigidity in Established Perspective

Within psychiatry the ruling perspective at any given time seems to generate excessive claims and expectations of accomplishment[xxvixxvii]. Simultaneously it suppresses alternative ideas and practices more vigorously, and becomes more sterile in elaborating its own ideas. This has been observed about the organic psychiatry of the late nineteenth century[xxviii], psychoanalysis in the first half of the twentieth century[xxixxxx], and medicine as a whole[xxxi]. When this unrealistic and rigid ideological system is challenged by new observations and technologies it loses favor to a rebellious rival that is more practically effective and creative.

Avoiding Implementation

A more pragmatic observation is that new fields of medical interest are popular in the academic community during the phase of "froth", when abstract theory and rhetoric are easily generated and funding and reputation are to be won by ready entrepreneurs. When the phase of "work" comes—the laborious creation and implementation of

concrete action with less generous and more uncertain rewards—the adept shift into more promising allied or general fields[xxxii]. This leads to loss of popularity of the old field and ostentatious theory and rhetoric for the new one.

Societal Change

The process of ideological shift within psychiatry may be reinforced by a parallel revolution in the parent society[xxxiii]. In fact, it may be argued that psychiatric views of mental illness and complementary standards of normality are but a special case of the social philosophy and normative standards of the parent society. Examples are: the political authoritarianism and philosophical positivism of the mid-nineteenth century encouraging the growth of organic psychiatry[xxxivxxxv]; the new humanitarianism of the later nineteenth century producing the sanitation movement[xxxvi]; the political individualism and philosophical naturalism of the beginning of the twentieth century encouraging the rise of psychoanalysis[xxxviixxxviii]; and the increased economic productivity and political activism of the mid-twentieth century resulting in social medicine and community psychiatry[xxxix]. After all, Parsons has argued that illness and treatment are one of an array of social roles established by society to deal with socially disruptive behavior[xl], supporting the view that medical standards follow from social standards.

Conservatism of Medicine and Academia

Society is not homogeneous, however, and some institutions support certain trends more than others do. There is evidence that academia and medicine are socially conservative institutions and favor biological factors over social factors as the causes and cures of health and societal problems. Ackerknecht describes the "university psychiatry" of the late nineteenth century in France and Germany as organic and neurological in perspective, in contrast to the speculative (milieu and philosophical) psychology of the early part of that century. It is illustrative that Pinel, who worked with the thinking and environment of patients, came to psychiatry from theology and mathematics, while Griesinger, a leader of the organic school, was professor of internal medicine before he became interested in neurology as the basis of mental illness[xli]. Psychoanalysis, as a new idea, was resisted at first by academic psychiatry and medicine. Later it became the dominant academic othrodoxy and resisted the challenge of social psychiatry, which reached beyond the individual and family with which physicians are comfortable[xlii].

It is noteworthy that, even within academia, many departments (agriculture, business, engineering, forestry, industrial relations, public health, social work, urban planning, etc.) have long traditions of research, education, and service focussed on social problems. Academic medicine and psychiatry, in contrast, look down on applied studies

and feel that social issues are a diversion from their primary functions of training and basic research focused on sick individuals[xliii].

It may be that social influences external to academia and medicine—such as political pressure and major funding—are necessary to provoke significant innovation both in academic medicine and society.

Constancy of Succession of Psychiatric Perspectives

When psychiatric perspective does change it seems always to be in the order Biological—> Psychological—> Social—> Biological etc. The reason for this order may be inherent in the relationship among these perspectives: Insights into biological mechanisms spawn an enthusiasm for the expansion of these principles to cover all human experience. When biological psychiatry becomes too impersonal, resistant to clinical observation, and insensitive to humane concerns psychological psychiatry uses the accumulated experience of human feeling and thought to support a more personalized and empathetic approach to mental health and illness. It then becomes ascendant and, in its turn, entrenched in intra-individual phenomena and resistant to concerns on the levels of environmental conditions that influence mental health and illness, the welfare of population groups, and societal function and change in general. When these spurned concerns are fueled by a period of social activism in society as a whole, social psychiatry becomes the dominant perspective. Its core is a concern for regaining and preserving mental health in its social context, but it is also linked to social criticism and social change. Thus, groups within social psychiatry may be drawn into political advocacy and action, and become the targets for political reaction from within psychiatry and from the host society. The perception that social psychiatry is over involved in political action and neglects "scientific" truth and the treatment of the sick ushers in a counterrevolution of biological psychiatry with its exclusive focus on the individual patient and emphasis on organic rather than social factors[xliv]. Psychiatry as a whole becomes conservative and shuns burdensome, dangerous, and discredited social responsibilities.

V. The Social and Moral Implications of Mental Health Ideology and Practice

Oliver Wendell Holmes remarked that, although medicine is thought of as an objective science, it is as responsive to the philosophical and religious pressures of the day as the barometer is to changes in atmospheric pressure[xlv]. The argument might be made that medicine (and psychiatry) are social institutions that are influenced by—nay, aspects of—society's values, goals, and practices. Thus, the cycles of psychiatric ideology reflect cycles in social ideology and the values, goals, and practices they embody.

Can social and moral implications adhere to psychiatric ideologies? Certainly it is not fair to say that some ideologies or their proponents are more moral and caring about people than are others: most support their arguments in part as concern for their fellow man. And, in the ideal, all ideologies and practices can be helpful in some ways. Finally, in reality no era is pure in its ideology: experience suggests that there is an abiding preservation and intermixing of some of the products of all the psychiatric ideologies at all times despite changes in dominance. Surely virtue and vice are distributed independent of ideology, though one's intents attract one to an ideology that gives them more articulate voice, fuller support, and freer rein.

But different social philosophies give rise to different psychiatric ideologies, and, as an extension of the relationship, these ideologies facilitate different social outcomes. Historian Arthur Schlesinger obseved that societies go through periods of ferment and creativity, and periods of inaction and retrenchment: "...One has to remember there's a kind of cyclical rhythm in American public affairs, cycles of intense activism succeeded by a time of exhaustion and acquiescence...."[xlvi]. Another historian, Barbara Tuchman, suggests that when people have a sense of comprehension and mastery of social forces they are moved to vigorous action and great accomplishments; when social forces seem too large and beyond their control they produce no noteworthy social accomplishments[xlvii].

I would argue that comprehension is an artifact of man's motivation and imagination, and is manufactured, as are his intellectual and manual tools, to serve his purposes. In the absence of overwhelming determining external forces—such as the the ice ages, the invasion of the Roman Empire by the asiatic tribes, or the bubonic plague—man develops comprehension and tools to implement his ideology. Insights and technology only facilitate an ideology.

It is unfair to equate social psychiatry with activism and accomplishment in general. The era of reflex physiology and brain anatomy, and the era of psychoanalysis were also times of challenge and creativity through their respective biological and psychological ideologies. The current era of biological psychiatry may well leave worthy accomplishments in genetic and biochemical insight and engineering. However, it can be argued that eras of social ideology in psychiatry correlate with ferment and innovation primarily originating in and focussed on the social sphere. The corollary is that eras of biological and psychological ideology in psychiatry are correlated with more hesitation, consolidation, and conservatism in the social sphere. In this way psychiatric ideology has significance in terms of social philosophy: it reflects and contributes to the sociopolitical climate of its parent society.

From this perspective, I would argue, we can relate social psychiatry and social ethos to social conscience: When society's and psychiatry's values focus on concern for the

wellbeing of groups of people and of mankind as a whole their ideology is likely to be a social one. And a social ideology leads psychiatry (and mental health as a whole) to efforts to understand the lives and needs of groups of people; to concern over the effects that social conditions—including economic and political policies—have on them; and to efforts to ameliorate their lives. It is thus not coincidental that a social ideology leads psychiatry toward an understanding of people's social networks, satisfactions, and the adverse consequences of disruptions in this sphere. It stimulates social therapies—group psychotherapy, the psychiatric education and sensitization of non-psychiatric health professionals and institutions, mental health consultation to key community caregivers and agencies, and informing community policy-makers of the mental health implications of their programs. It spurs efforts to retain people in their communities and move them there from restrictive environments—whether mental hospitals, wars, or oppressed social status. It propels the mental health professions into social and then political policy, since these mightily affect community conditions, community mental heatlh, and mental health resources. And it may well make them into advocates of social programs and political policies.

This sequence may also be what disaffects other psychiatric, mental health, health, and political factions from social psychiatry and the social ideology, precipitating a shift in the ideological cycle. But it is a consequence of the moral implications of social ideology, and may be inescapable. As implied previously, the cycles of psychiatric ideology reflect cycles in societal social philosophy, and may imply cycles in moral values.

Thus it was inevitable that the Community Mental Health Era included the study of life crises (such as bereavement[xlviii]) that produce physical and mental illness, and community conditions (such as forced urban relocation[xlix]) that produce social disorganization and depression. It is significant that community mental health centers close to patients' homes, a community voice in mental health programming, and the advocacy of social policies that support local institutions and cultures appeared at this time. And it is no accident that CMH appeared in the same era as the civil rights movement, broad government social programs, and radical political reform, even though they contributed to CMH's downfall. The social psychiatry perspective implements a social conscience of humane concern with lives and social conditions.

From this point of view it is also understandable that the succeeding era of biological psychiatry is coincident with a high priority for business and self-reliance, reduced funding for human services, only maintenance mental health services offered by the least expensive and least capable staff, and the inexorable withdrawal of government from caregiving. It contributes directly to the numbers of mentally ill in shelters, in nursing homes, and on the streets. It contributes to that lack of professional care for those at risk

of life crisis and crippling maladjustment, as well as those in acute crisis; only those who have failed and are lost come within public support programs. Public policy has returned to the almshouse and the workhouse! It is also consistent that psychiatry mainly avoids social issues except for concern over the funding of psychiatric research, training, and services and the work status of mental health professionals. Its professional focus is on the pathology that inheres in individual patients, and the genetics and biochemistry of these problems and their solutions. Concern for the human condition and the condition of groups and communities is reserved for philanthropic moments and non-professional roles. The biological ideology in psychiatry is concerned with the impersonal mechanics of illness and treatment, and does not professionally address the lives of persons individually and people as a whole.

Is one ideology more moral than another? I think that would be hard to prove. But surely the ideologies embody different moral values that lead them to different actions with moral effects. And both financial decisions and ideological thrusts reflect social philosophy.

To quote Pogo: "...We have met the enemy and he is us...."

Danna Mauch, PhD

Consultant on Public Policy, Massachusetts Association for Mental Health; Principal, PDM Health Strategies

Introduction by Robert Evans, EdD

I'm glad to introduce Dr. Danna Mausch. She is currently a partner with PDM Health Strategies, and is a policy consultant on health care and mental health areas. She specializes in the organization and financing of mental health care, with a particular focus on managed care, something of increasing relevance and interest these days. She received her doctorate at Brandeis, and her career, like David Satin's, spans a full range of things in community mental health, and probably is the most varied I have ever encountered. She has been everything from a mental health attendant, at the lowest end, if you will, of the line, to a director of a big mental health system, having served for six years as a director in Rhode Island. Before that she was with the Department of Mental Health here in Massachusetts, as what we now call the Deputy Commissioner. She has been an area administrator, an agency director, and her background even includes, even to this day, working on issues relating to the homeless. She directed a national policy project on homelessness, and published a report which is still widely used as a template in that area, and is still part of the national task force on the homeless, and she will be our first respondent and will respond to Dr. Satin's remarks with a focus on consumer issues. Dr. Mausch.

Danna Mauch, PhD

Thank you. I'd like to thank you on behalf of the Massachusetts Association for Mental Health and their interests, the interests they represent of mental health consumers, for the opportunity to participate in the Erich Lindemann Memorial Lecture today. I bring regards from Eleanor White, the president of the association, and Bernard Carey the executive director of the association, and I'm accompanied today by Joseph Finnegan who is the director of government relations for the Massachusetts Association for Mental Health. We convey our regards and our appreciation for the Lindemann family, and to Dr. Satin for having us here today.

Dr. Satin's paper offers a provocative analysis of a number of the critical issues confronting those of us who are policy makers and practitioners of community mental health, at least as community mental health was conceptualized and promoted by the work of Dr. Lindemann. Dr. Satin cites a number of events in Massachusetts and at the federal level that threaten the spirit and interests of community mental health. Certainly

reductions in funding are grave, the impact on clinical programs is now substantial, there are decreases in critical community support and consultation services that compound, as Dr. Satin says, the inadequate implementation of the community care movement, a phrase I prefer to use to deinstitutionalization.

The prevalence of poverty and the high incidence of homelessness among vulnerable persons who are suffering from mental illness will be reinforced and aggravated by today's decision in Massachusetts to eliminate general relief benefits, something that's going to adversely affect about 40,000 citizens of this state. Those are benefits to individuals who are poor and unemployed in Massachusetts. For many with mental health and social functioning problems, general relief has provided a measure of economic benefit, and really the first material resource for moving beyond a homeless shelter, for example, or an inpatient unit. It's been a key tool in a mental health professional's armament to wage their individual war on poverty, something that Dr. Satin talks about early mental health practitioners being involved in. We are certainly challenged by his warning about the weakening of advocacy and commitment to social responsibility among professionals and government leaders.

There does not appear to be a sensible path for our state and its most vulnerable citizens that does not involve the need for new revenues, or a better use of those resources remaining. We all know, I think, as wallets grow thin, hearts and minds narrow, and we need more than ever the advocacy, commitment and leadership of knowledgeable professionals, and I think more than ever need that to be in concert with the voice of consumers and their families in this business. Dr. Satin laments the loss of focus in many quarters on community psychiatry in the attempt by many to limit its application to public sector psychiatry. Certainly the rise of biological psychiatry and the limitations of the role of community psychiatrists in recent years has contributed to this problem in Massachusetts and elsewhere. It seems a bit of a paradox, as other medical specialties have moved to integrate psychosocial treatment into their programs. Dr. Satin cautions us to question the managed care initiative in the Commonwealth, and the privatization of services envisioned as their companion.

Certainly whatever system emerges will change the current organization and utilization of care, and if implemented solely to save money, the principles of community mental health will certainly be perverted. If implemented in the narrow fashion to simply manage the benefit or cost of care, it will be a perversion and will succeed only in limiting expense, limiting care and limiting consumer choice. However, if managed care for individuals who are poor and mentally ill, and dependent, as in this state, primarily on the Medicaid program, can be implemented to manage the care, rather than the benefit, the potential exists to solve a number of problems that Dr. Satin discusses, and discussed here today regarding community mental health here in Massachusetts, and I'd

like to talk for a moment about the consumer perspective on the care thatís now available.

I think from a consumer perspective, care under the current system is very much in violation of the principles of community mental health, and also of principles of sound, managed care. Care is now fragmented, people with serious mental illness particularly have to go to multiple agencies in order to get the range of their needs met. It is often unaccountable, there is single point of authority. The care is infrequently under the direction of a physician, and consumers frequently complain that they have rare time with their doctors, and don't, in that brief time, have the opportunity to talk over what's really happening with them, and what their concerns and interests are and what the effects of their treatments are, etc.

The system of care has certainly been driving the overuse of crisis and inpatient care, and also, interestingly enough, the overuse of outpatient services to do things for people that might be done in different ways, because there is really there is little availability of more appropriate community interventions, many of which were envisioned by the community mental health movement. This, in turn, limits access to those who are in need of service at critical points in time. Because inpatient units are backed up, those who need acute psychiatric care cannot get in. I think managed care has the potential, if done properly, to assign a primary care physician or psychiatrist to individuals, who would be responsible for assessing individual needs and formulating and managing the delivery of care. It would be the opportunity to form a consistent and stable and continuous therapeutic relationship, and one that would be accountable to the consumer or the patient and to the larger system in terms of management of resources.

Managed care also has the potential to deliver services within a single network, as community mental health centers were originally envisioned to be, where it would be a comprehensive agency providing multiple elements of service and care. It would have the opportunity, create the opportunity, to utilize more creative community interventions, which are now either not seen in a favorable light or not covered by the funding agencies, or whatever. It would have the opportunity to improve access for those people who are not now getting services by managing the resources better. This, of course, will not happen if the resources are dramatically reduced.

It also has the opportunity to increase revenue through federal reimbursement, which, despite all of the sophistication in Massachusetts, are really not at this time being adequately accessed. There are opportunities under managed care to cover a much broader array of services than are presently covered, to cover many of the community mental health interventions which the state does not currently cover.

To insure these positive outcomes of managed care, however, it's important that community mental health centers and community support agencies that have

longstanding commitments and connections to their communities and to people in those communities with mental illness become the providers. I agree with Dr. Satin it's not going to be much of an achievement if large health maintenance organizations that have continually rejected people who have high needs for care from their systems become their providers of their care. It's equally important that consumers have a voice in the shape of service delivery, and in the opportunity to gain access to alternative forms of care in the community. That consumers and their family members form an alliance with psychiatrists and other professional leaders to demand that primary care be provided by those who are knowledgeable and committed to the field of community mental health, and not by people who are primarily committed to, as I said before, managing benefits or costs of care across a broad class of individuals, many of whom are not as dependent as many of the individuals served in community mental health centers today. They are on a broad and intensive, in some cases, range of care.

It is particularly important that community leaders have a role in managed care entities, and that these entities, whatever they are, see themselves as managing in a social, economic and community context. There are progressive public care systems on which Massachusetts might model this effort. While each of these systems strive at present to improve care and expand services, they are certainly not ideal, they have a common feature of a few things I'd like to go over.

First, that services are provided through a comprehensive community mental health entity. Secondly, that services are provided locally, with local control and authority over resources and clinical decision making. Third, that a primary care provider, or psychiatrist, in the case of the example I will speak of in a minute, at the center is at the center assigned to the individual, and individual who is skillful, who leads the clinical team, and oversees care that is active, with the patient and the patientís social network, and this includes not only care delivered within the community mental health center but increasingly the care thatís delivered to people during their inpatient stays. A fourth point is that the emphasis is on community-based care, including community-based inpatient care that is often coordinated between the community mental health centers and local general hospitals.

These progressive systems are, in several cases, close by: Vermont, New Hampshire, Rhode Island, western Massachusetts, to some degree. I noted your mention of rural areas and small cities and their romance with the principles of community mental health, and as I cite these places, I am reminded that they are more characteristically rural areas within small cities. They are places, they are systems that have depended on community mental health centers, on the originally conceptualized comprehensive community-based agencies. The authority resides within the community mental health center to screen, admit and treat individuals in the center, to develop rehabilitation

alternatives that are most suitable to local conditions. They are agencies that have a reasonable resource base with which to carry out their responsibilities, and they are places where consumers, families and practitioners work increasingly in alliance with one another for improvements in care, as well as for the general operations of the facility.

Consumers are hopeful that change will involve opportunity, not only crisis, although they see the short-term financial difficulty. They also see their strength and voice and contribution rising, and the opening for the alliance with professionals. Other examples I might cite that are more positive: I'm a faculty member in the Department of Community Medicine at Brown University, and within that department there's really a clear understanding that health care and mental health care cannot be adequately provided without a sufficient appreciation of the community context in which that occurs, without a sufficient appreciation of the social and economic factors that influence the lives of patients in their system.

Health care for the homeless programs that were funded by the Robert Wood Johnson Foundation, which have been very indigenous health care efforts, often based in shelters and outreach centers for homeless persons, have also recognized as fundamental those principles of community mental health in serving their people. There's a new service in New York City called The Visiting Psychiatric Service, which does outreach to indigenous sites in the community, including shelters, where they literally practice and learn in the community with a full awareness of the effect of the context and the social networks on individuals health and mental health status.

These approaches are now being examined in light of the current economic crisis and social crisis, particularly that of homelessness. The work of the National Task Force on Homelessness, which includes for probably the first time since the 1960s, since the war on poverty, an interagency effort in the federal government, including Housing and Urban Development, the Health Care Finance Administration, the Veteran's Administration, the National Institutes of Health and the National Institutes of Mental Health. They are focusing on some of these integrated and indigenous community health and mental health efforts. What is emerging from their discussions are recommendations not for the alms house, not for the work house, but for something that's more like the settlement house, which is a local , community-based service offering housing and support to people, often in one site.

In closing, there has, despite setbacks, been tremendous progress in psychiatry and community care in the last 30 years, and I think our challenge and on behalf of consumers as well as on behalf of this movement is to work in the next 30 is to consolidate those gains, to resolve what have been some very serious setbacks and to move forward to fully embrace and implement community mental health. I remain, as

they now label those who we serve, seriously and persistently optimistic and inspired by the legacy of Erich Lindemann. Thank you.

Robert L. Porter, EdD, MPH

Northeast Director of Corporate Psychological Centers; Director, Deliphi Economics International

Introduction by Robert Evans, MD

Our second panelist is Dr. Robert Porter who is director of Delphi Economics International, based in Brewster, Massachusetts, and that's an international corporate consulting firm, and he's also the northeast director of Corporate Psychology Centers, which is a subsidiary. He's previously been the chief operating officer of the Department of Mental Health here in Massachusetts, Executive Director of the National Association of Mental Health Administrators in Washington, D.C., director of mental health for Cape Cod and the Islands, and on the faculty of Boston University. He has a background and works in international development, including corporate and public program development throughout Europe, South America, Saudi Arabia, China and the Soviet Union, and has extensive publications, and his education includes international as well as degrees here from Boston University and Harvard, and he's been asked to respond to Dr. Satin's paper by embodying also a focus on the service providing side of the equation.

Robert L. Porter, EdD, MPH

With the multitude of issues that Dr. Satin has raised, it is reasonable to question whether community mental health has ever been promulgated as a pervasive public policy at the federal and state level. At the risk of being labeled an extremist, again an attribution to which my wife considers chronic, I would pose that community mental health has never been tried in the true sense. Of course it's been articulated as public policy, and there is significant evidence of its effective as well as its ineffective implementation in a variety of cachement areas in Massachusetts as well as across the country. But the firm resources to implement a comprehensive continuity of care program that is representative of community mental health has seldom been allocated.

The many successes that we can delineate have many times occurred in spite of the obstacles placed in front of them. We are truly a nation of unparalleled commitment, resource, technology. The effort in the Persian Gulf has demonstrated such. The same commitment of resources and technology has seldom if ever been demonstrated in the delivery of community mental health as promulgated by the federal and state government.

One might ask why. I would conjecture that because of the role that political, ideological consequences play in the formulation of policy and the implementation of programming. Ideology is not pie in the sky. We can all have our operational definitions,

as a former academic you're always safe when you have an operational definition. My operational definition of ideology is that it is in fact a science of ideas, it is the body of doctrines, the myth and the symbols of a social movement or an institution. It's relative to cultural plans and it entails theorizing of a visionary nature, and that's why historically has brought us here today.

In evaluating systems all across the world, be they industrialized or developing countries, Europe, South America, Saudi Arabia, the Soviet Union, China, it can be evidenced that a political ideological formulation is the basis for policy and implementation of mental health systems. Now, that ideology may be very subtle in its implication, or it might be explicit, but we can factor that out as being the basis.

I'd like to emphasize what both David and Danna have made reference, and that is the most significant distortion and bastardization of community mental health in the political ideology implementation has come under the rubric of deinstitutionalization. Deinstitutionalization is just that—it's out of the hospital and out of the institution. It does not represent continuity of care, has not represented continuity of care, it represents a game of numbers in the context of something else.

Consistent with a number of the issues that David raised, the following are some pragmatic variables that need to be addressed in the practice of community mental health. As David has mentioned, the conflicting ideological conflicts in psychiatry itself, the rigidity of established practice, inherent in the definition of change is resistance, and how is that addressed in a comprehensive systematic way? It is the competition for scarce resources, there's the competition inter- and intraprofessionally, competition with paraprofessionalism, competition with indigenous workers, that the ongoing turf wars.

There was reference made to Baltics--well, if we just take Boston--Mass General Hospital, Mass Mental Health Center, Cambridge, Beth Israel, New England Deaconness--if that isn't a Balkanization…etc. Empowerment, ownership, the NIMBY syndrome--not in my backyard, decentralization versus centralization, uncertain rewards as it relates to the practice of community mental health, leadership versus management, the unproven quality, the unacceptable quality of prevention, proactive versus reactive. I would pose that community mental health is in fact a science, and it's a technology that stems from theory and it stems from values. But ultimately the implementation is predicated upon a belief system--a way of life, a quality of life, a value structure.

From these beliefs emanate respect for the individual, a tolerance for deviance, the least restrictive environment, normalization, all of those buzzwords/concepts that were the cornerstone, the foundation, of the delivery of community mental health. Community mental health needs the confluence of historical determinism and the great person theory. The fact is that American society does not tolerate deviance. The American

society is predicated on being an individual as exemplified by two great former leaders of our country, Ronald Reagan and John Wayne--be an individual, and they believe it.

But what's the implication? Like me. And the fact of the matter is the mentally ill oftentimes are, they represent deviants, they represent unsightliness, sometimes they smell, sometimes they sound in ways that we find intrusive, and what's the way to handle that in terms of the current political ideological orientation? Be oversimplistic, give them the best possible care we can, out of sight and out of mind, and that's the movement, and has been the movement for a long time.

One of the greatest myths that have been promulgated in these great task forces that have been set up in the recent and past years is that we need more beds. We don't need more beds. We need more quality in the beds that exist, and we need a different type of bed in a different type of environment, for when one does an evaluation of those folks who are now hospitalized, conservatively speaking, 50% of those folks could be moved if a different type of bed were available. It doesn't take away from the fact that greater quality is necessary in the existing beds.

The 60s and 70s represented an era of social change, increased productivity, political activism and humanism. An attitude existed that translated to the concept of community mental health. In some cases it was very chic, that attitude. Instead of that cliche, a chicken in every pot, in the late 60s and early 70s, we were going to have a mentally ill person in every neighborhood, and if you were really chic, two in every garage. But in fact the resources were not allocated accordingly, the dollars did not fall from the hospital, and the myths were perpetrated.

Direction, in terms of community mental health, and this is not ultimately represented by Dr. Lindemann, direction could not be maintained after the passing of the original leaders. We suffer from the but syndrome, not the and syndrome. So I would pose that yes, in fact community mental health can be ultimately successful, but not so without the addressing of a number of objectives in terms of its implementation and its practice, starting with defining the roles that political ideological consequences play in the formulation of policy and the implementation of mental health systems, as well as for specific treatment. Understanding how the members of the therapeutic community are affected by political ideology in order to obtain therapeutic goals. Three, delineate how ideology determines constraints and subsequent strategies for therapeutic approaches.

We need a definition of the concept of development. We need to delineate the values and conditions that affect development of a country in general, and mental health programs specifically. We need to define the issues that each profession would have to confront in the organization in the planning of social programs. We need to delineate the difficulties of obtaining reliable data and the basic hindrances for building the concepts

of health and illness. We need to delineate the difficulties for determining indicators that affect the real health and welfare level. We need to develop general evaluation criteria for mental health planning, utilizing such indicators as, A: cost-efficiency ratio, including in the cost of using economical human and physical resources; B: preventive capacities of the community; C: capacity for the community to generate new types of organizations, social dynamics to cope with increasing mental health demands; D: personnel performance; E: training; F: assessment of disparity between theoretical planning and actual implementation; and G: the time requirements for the implementation of programs.

We need to analyze the classic models of mental health programs and their basic infrastructure. We need to examine the needs, the possibilities and consequences of training methods, ranging from psychiatry, psychiatrists to indigenous personnel. We need to define intervention alternatives, and particularly emphasize those that are culturally specific. We need to delineate trends in community mental health, assess their measurable parameters, and determine their degree of feasibility. We need to outline a plan for social psychiatry, appropriate for the needs of a country or a locale. We need to assess and evaluate adequacy of programming. Lastly I will pose is to take something simple and make it complex is rather common. To take something complex and make it simple is creativity. Thanks.

Discussion

Robert Evans:

Thank you. This is the point where we have a chance to share some views, both among the panelists and among those of you who are here, all of whom have been very patient while a lot of very complex thoughts have been shared here. I think we would like to at this point be able to open our discussion both to hear back and forth among the panelists and from those of you who are here as well, in terms of what kinds of thoughts and questions and reactions you've had as you've been listening to this whole variety of viewpoints here this afternoon. Let me see first if there's anybody who's just been bursting, waiting to say something or share a thought with us. Yes, someone is.

Participant:

I've just take a lot of training…what am I doing, why am I teaching…?

Robert L. Porter:

May I respond to that?

Robert Evans:

Yes, please.

Robert L. Porter:

That's inconsistent with community mental health and the variety of services that should be …a support, so there's an inconsistency there in terms of what we're trying to promulgate.

David G. Satin:

I know that Lisa is not shy about speaking up about her principles, nor does she have wishy-washy principles, and I wonder, I spoke from the point of view of someone who is frustrated at having all of these terrible things go on around me and nobody's talking about them, and nobody's putting words to it, and everybodyís giving excuses for it, and making, being polite about it. How do you do it, when you deal with public health, or when you deal in direct services, and you see a lack of funds, the lack of recognition of what is needed and the horror thatís going on around you? How do you do something about it, both vocally and in action?

Robert Evans:

We all, I think, wish to find or to hear somebody to be able to say the times will be changing soon, and find some kind of substantive evidence, some hope that something

really will be responding to the concerns, and so I was interested, Danna, when you said some of what you did about models that you think actually work, and when you talk about the difference between managing the care versus the benefit that's not serving the people, a lot of talk about management and I wonder if it would be fair in maybe encouraging to people…if you would elaborate even a little bit more on what that actually means, because one of the ways that those of us who are in the field, I think, would like to find some way to be able to do what we are doing and do it better, and to be able to speak the right language and to respond to people whose concern is about managing the benefit, the money and so on, in a way that would be constructive and would also somehow be in line with the kinds of philosophy that David was talking about.

Danna Mauch:

Managed care in the sense of managing the care has several elements of it that are particularly familiar to people who've done community mental health. In fact it's largely why in the private sector private insurers have begun to get into managed care for psychiatric and substance abuse. They're almost exclusively recruiting people who have been trained in community mental health. It involves having an assigned provider of care, a single provider of care, who is responsible to either provide care directly or coordinate and access other elements of care that the patient requires.

It involves the principle that Bob spoke about of continuity of care, and not only continuity of care, but in the caregiving relationship, so that the notion that comes from community mental health about therapeutic relationships and from other areas of medicine about primary caregivers, but which has been grossly violated by the development of very fragmented care systems in most communities around this country. It is addressed. There is the sense that resources will be managed by providing the most appropriate care to people in its least restrictive form at a particular point in time, so that there is no possibility to do that effectively if the only resources at one's disposal are inpatient care and outpatient counseling.

There needs to be a broader array of care that permits other kinds of interventions, either prior to the need for more intensive forms of care, perhaps in the hospital, or after that as a kind of step-down from care and assistance with, as was mandated by community mental health originally, integration into the community and into the functions of living to rehabilitation and support programs. And the other idea is that the care is provided locally in ways that are both responsive to individual needs but also reflective of the local environment and the needs of the local community, and the boundaries of the local organizations are permeable to that community. That doesn't mean that everybody in the community qualifies for care, because one feature of most managed care systems is that there are qualification criteria for who participates, which

is one of the confusions, frankly, for the mental health field. It is one of the reasons it is so difficult for public mental health systems to use their resources effectively is that they are often expected to meet every social need that no other public agency wants to serve.

And so adjudicated juveniles where DSS people and others have just kind of given up on them get sent over, and elders who may have organic problems but haven't the resources to get into private care may have flooded those systems at one point in time. There are different groups of people. Now many people with problems with substance abuse that are manifesting in ways that affect mental status or behavioral are being rejected by the substance abuse system, and coming more to the mental health system, and that's not to say there aren't those people who have major mental health problems who also have problems with substance abuse. But different points in times the pressures are different, and that among persons who are homeless, while there are substantial proportions who have serious mental illness, there are other parts of that group, particularly people who have histories of chronic inebriation, where more and more of that pressure is on the mental health people to do something, so that it really becomes difficult for mental health to use what resources it has to target the population truly in need of mental health care. That's aside from the issue of resources that are reserved for the general community mental health, which would certainly say that you would target resources to people with all kinds of problems, needs and disabilities, but anyway, I'll stop.

Many of the states that don't provide general relief also have abysmal social welfare systems. I don't know, maybe somebody else here knows of a state that's doing progressive things and doesn't provide some economic relief to people…

Robert L. Porter:

There are none.

Danna Mauch:

There are none that I can think of.

Robert L. Porter:

I think that where political ideology comes into play is that there is a political ideology that you need to impact on that ideology. If we can take, to depersonalize it for a moment from the current administration, and use the successive Dukakis administration differences. It's not a negative towards, for that administration. There was a political ideology in his first term of this humanistic approach, and thus there was the promulgation and the advocacy of community mental health, and then a lot of the issues and problems that have been delineated came to the fore, and a lot of other things happened. The second term there was an equal political ideology. Different. It was called

competence, and competence was an ideology, and service delivery was predicated on that as the driving force. You addressed the problem of the moment as the methodology that you deliver services, for which you deliver services. That there was a construct was secondary, if it existed at all, I propose. So, yes, Danna does, very eloquently and pervasively and effectively, and I think that until there's a mobilization...see, where's leadership? Where's leadership here? Leadership is representative of who gets elected.

Participant:

David?

Participant:

I could speak... what's happening in the health system. I'm director of psychiatric case services at the Erich Lindemann Mental Health Center, and I was also influenced by working with Human Relations Service, also founded by Erich Lindemann. Today...because a secretary of Human Services was coming to pay a visit, perhaps contemplating the closing of the mental health center, at least in terms of dealing with patients. My two programs alone see 25,000 clients a year. The Pine Street Inn is 50% mentally ill. In the prisons systems approximately 10-12% are mentally ill. Speaking to the political question, I think the statistics are obvious, that what's going on is perhaps politically motivated, and based on an ideology.

You had a deinstitutionalization 20 years ago. Now they're saying we need to take money out of human services. One of the programs I run is a day treatment program which treats the most severely mentally ill in the Commonwealth of Massachusetts--people that you see in the streets or in supportive housing and homes. We get $56 a day from Medicaid for a six-hour day, including a meal for these people. We put out 500 meals a week on a $350 food budget. The $56 a day that Medicaid pays, the Commonwealth is responsible for $28 a day for keeping the most severely mentally ill in the Commonwealth in the least restrictive setting.

I'd like...because people who have severe mental illness have human rights, and that is oftentimes ignored under the fiscal restraints that are going on now. There was an emergency meeting today up at the State House in regard to stopping funding for day treatment, which costs $28 a day, which is either going to get people on the streets, in jails or who knows what the alternative is. You know, you don't want to trump it up and make it more hysterical, but really this is the true reality that is happening right out here, right down the street is one of the major hangouts right on the corner, for people who have no services.

This is where the political ideology comes in: nobody wants to hear this, but they will either abandon people on the streets, for instance by doing away with what's left,

and there is very little left of what was a movement, the community mental heath movement, the counseling centers in Chelsea, East Boston, Revere, the poorest communities in the Commonwealth are holding on by a string.

As Rob was telling me, the Human Relations Service can probably make because they exist in Wellesley and Weston. Well, there is not that room in Chelsea, and what is happening is people who have mental illness are coming into the streets in greater and greater numbers. They're talking about closing the Lindemann Mental Health Center, which was named after the man who founded a movement to help people like this, and also to save the taxpayers probably the most amount of money, and that is what is happening right today.

Participant:

Grateful to Dr. Satin who describes, and you know it costs about $400-$500 a day to keep somebody in an inpatient unit, and the Commonwealth is not willing to pay $28 to keep people in treatment with professionals to better their life. I wish people had the opportunity, the general public, to come down and see and talk to the people I deal with on a daily basis--the people who go from the streets to even being back in a community college, with proper treatment and care, and I think that, and all the numbers that we've been hearing for the past year, this is what's being missed.

I think there are lots of reasons for it. One: people want to protect people with mental illness, so TV. cameras don't come in. I think also people are afraid, as was mentioned by one of the speakers, of people who are different, but I hate to think that it is a cycle, that 30 years from now when I'm long gone from this field that we're going to have to reinvent it again, but we're this close from losing community health, and the idea was right.

Participant:

I don't hear any argument here in this room.

Participant:

The problem is I tell you, I would come down, I was preparing the talk for Secretary Fosforo today, you know, I've seen him before, he seems to be a nice man, but, I mean, you could talk to him, I think I've given this plea before, I'll give it again, but they'll say, "Well, geez, we've got $2 billion worth of cuts, and we're not going to raise any taxes, you know, the Commonwealth won't stand for it". I wish the public would confront the realities of the suffering of human beings that are happening every day in the streets of Boston.

Participant:

Thank you

Participant:

There's a couple of things I'd like to say. One is… I also would acknowledge the reality of that. I work part time in crisis servic. Exactly what you said about…the frustration with funding. But I'd also like to speak at one point to maybe a larger trend and some skepticism that I have about the sufficiency of a cycle model. I'm talking about discontinuity as another way of looking at what's happening. If maybe we tended to shift that we're not going to have the same cycling out of in terms of… politically…how to do services…But, I'm here to say that I have some real questions about what uses the managed care model… I'm familiar with different care models, and I think that insofar as they're oriented towards a case management, comprehensive ethos we're describing, they're very useful for people who have such severe disorders that they're unable to find economic resources on their own. We need it in that regard. We need comprehensive medical services.

The problem I see with managed care is rather than it could be used, as people said, to limit, and that's the way I think it will be used, especially if they're adopting a closed panel HMO model, and that further, that the managed care, you kind of said it in a sympathetic way, that it's used to limit the target population, and I think that what I'm most afraid of happening as far as community mental health ethos goes is the further fragmentation of, that the community as a whole and who's getting served, that who is being served.

Look at how Massachusetts has enacted regulations—they're probably more restricted than most states. That's clearly a general trend that emphasize the federal definition of mental illness. As a result in large segments of the population will be eliminated from any kind of long-term therapy of any sort. Now where I see that problem in two ways: one way is that given…largest scale and to allude to cultural changes, I think that there are good arguments to be made that character disorders, which are more prevalent in terms of what we see lately. I'm here to say that they appear to cause a certain socio-economic and social standing, and that restrictions these on eligibility will exacerbate that kind of a trend for people with character disorders.

The other conflicting trend I see is that people who are now recognized as either childhood victims of physical or sexual abuse, or adult survivors, are also going to be eliminated from services. Okay, what model is going to address that kind of need? A kind of discontinuous model that draws on theory, along that kind of selection and prediction/tradition. It might articulate some of the points of conflict. I think that if you follow some of the political-economic themes we're pointing out--the lack of allocation of resources for mental health--one of the reasons why people I believe are fed up with

taxes is that if you follow that…people talk about that change in terms of a shift towards post-modern culture, also post-industrial organizations, the profit structure that…The reason why… are being maintained in that kind of economic change is again taken out of labor, taken out of human service. Now if you… the discontinuous

chain to that point then you use other intellectual models along the lines of those being suggested…struggle for these resources.

I think that one thing to highlight, like I said before, what kind of an alliance can be made among advocacy groups? Populations that will push for services for one reason or another. I think that's the only way that one might return to some sense of community as a whole in terms of need of services, and one area that I see that that is developing is people who have resources, let's see recently there was the, at the local level here, the League of Women Voters advocating for increased statute of limitations for victims of physical and sexual abuse. That's one way to sort of look at what are the kind of structures that would support the rights that people.

David G. Satin:

One of the things I think you are arguing is the social side, the social political side of the professional ideology, socio-political relationship. They mutually reinforce one another. What you're saying is, do something about the socio-political environment that will then make a different kind of professional ideology acceptable, and I think that's an argument. You're more optimistic than I am in feeling that you can influence it. I'm getting kind of deterministic but you're probably younger than I am, so you have more time to get discouraged than I. Your concerns about why can't we go up to the legislature and explain to them what they are doing—"Don't you see what youíre doing?" I also think that that's futile, because they don't care. I don't mean that in an inflammatory sense, I mean it in a literal sense--they are not focused on those issues. They will come up with a rationale for it -- the poor are always with us, we cannot eradicate illness, you want a religious explanation for it or a scientific explanation for it. They're not focused on that. As individuals they are nice people, but nice people have found themselves bound to do not nice things because it is their duty or because it is their fate or because it is inescapable. They're nice people to their families but in their professional lives they are bound, they are following other goals, and their goals are now saving money because we don't have it, because we must get business started, because the Commonwealth will go bankrupt, and what happens is too bad, really too bad, but it's got to happen, because they see this as the driving force, and I think that I have to argue from a different premise--that that is not the most important thing to happen, that taking care of people is most important.

It even makes me uncomfortable with the very businesslike idea of setting limits on eligibility, because there are limits to the resources of the care providing system. How can one make, and why should one make, limits on eligibility? There are only so many people who can be sick, or there are only so many people who can be helpless, or there are only so many people who can be poor. It is not acceptable to have more than that number, and therefore you have to set some kind of arbitrary cutoff point. There are as many people as are who need help, and what you need to do is find the resources to do it. To say that all the resources have to come in money, or all the resources have to come from one caregiving system I don't think is tenable.

To me thatís the genius of community mental health, where you say there is a unity to the community, and everybody has to find ways of helping the mentally retarded or the psychotic or the poor, and if you don't have it in money or you don't have it from this agency then you get it from other agencies. Community mental health started out by working with inadequate resources. They never had enough money, they never expected to have enough money. They expected to get an alliance among people who had ideas and who had enthusiasm for helping, and thereby crafting a way of responding to these needs, so it feels to me that one is buying into the economic limitations model to say we have to set limits to the eligibility...

Danna Mauch:

I wasn't referring to a limit on eligibility in terms of absolute numbers of people but to the increasingly common practice of defining certain criteria around need, and the assumption being that anyone in that criteria was eligible for service but that people who had other needs might ideally be going to some other care system or support system and getting their needs met, and trying to focus resources and competency capability around a specific set of needs. I do think that there is the hope on the side of the people who want to manage the benefit, as opposed to manage and provide reasonable care, that you can get some absolute number and you can plan kind of constantly, further limiting that number, and increasingly limiting the utilization by that defined number of people.

I agree with you, I think thatís problematic. That's what an HMO does, that's how it plans--it enrolls a set number of people and it may at some point in time agree to enroll another set number of people, and it plans to manage its resources and make its money successively limiting the care given to that defined number of people. And that's a model that's not going to be effective for people in mental health care, especially people who have more serious disabilities, and the public care systems that use the care principles of managed care do not limit it to "you're only going to have 4000 people in our system this year". The people who meet this eligibility criteria are going to be the priority clients, and they do often have to make do. You get rising demand at certain points in time and there

aren't always the resources that come along with that, which is why I opened my remarks saying these systems don't feel that they are set yet, that they have sufficient resources, that they have everything in place, but they certainly have these elements of the structure and this approach in place, and as you say they fashion solutions that don't always require money, because they do enlist the aid of the larger community. Those are the systems that are most successful.

Robert L. Porter:

I agree with all the things that you said, and I just draw one different conclusion, that goes back to the leadership issue and some of the things that you said. In total agreement, I still think that if there were a leader, that these folks who are well-meaning, educable, and where the leadership will come, that's the optimism, I don't know, but I think that if the leadership can forthcome they're educable that there are ways, as the cliche of the day is, be wise and privatize, that we can be public and privatize, and can in fact engender an educable and educating kind of mentality, and that things can be done differently, and I think that the essence of community mental health is in fact more with less, and I think where itís done as true community mental health it is done more with less, so I don't negate any of your points, I just have my naive optimism.

Participant:

I'd like to draw it to a close on this note, that maybe we're just coming to the end of a very miserable cycle, and I like to support the theory that maybe weíre emerging with a humanistic John Wayne, Kevin Costner in *Dances With Wolves*, and maybe we can become the symbol for a new cycle of concerned people.

Robert Evans:

You know, I think we'd all like to comfort ourselves, and the question is are we better off doing what we see as a realistic look at the real situation, or in fact do we just batten down the hatches for a while. I'm just convinced more than ever that some of this stuff is matters of substance, and I think a lot of what David was speaking about were really matters of substance, and some of it as he was also describing were matters of perception, which obviously you know goes into anybodyís notion of what substance is, but should we be, for example, bemoaning how rotten things are? Should we be grateful for what we have, because we've never had that much, and it's always been a precarious thing to be doing?

Some days I feel one way, some days I feel another, and I think a lot of us wonder are we on the edge of some fundamental shift that's going to make things like they never were before, and much worse, and we're never going to get back to stuff that matters to us, or are we in fact in a cycle that's going to somehow, like a pendulum, swing and things will renew? I think we only know those things looking backwards, and it always

looks inevitable in retrospect, and when you're living through it never does really. I was reading a management book the other day suggesting that in fact that the real text that anybody running a sophisticated organization needs is not a book like that very one but *Through the Looking Glass*, and that kind of thing would be a much better manual. And I think it's always very hard for us to tell, and therefore us all wondering, do we really have something that we can hope about, or are we really just getting together to soothe one another? But it's an old question about who soothes the soother, and who heals the healer, and while it seems a modest goal, nonetheless it's one that ought not be overlooked, it seems to me, and we may know more a year from now, two years from now, three years from now. We may find leadership emerging, it's possible, who knows.

In any case, I hope that the same time next year most of you will find your way back here, that the community will have found for us another interesting topic, and another chance at least for those of us who are believers to gather and to reflect on our situation and the larger one around us, and what are role needs to be about all that. I thank you all for coming.

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