Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

organized and edited by
The Erich Lindemann Memorial Lecture Committee

hosted by William James College

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 FORTY SECOND ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Supports and Challenges in Childhood Development: Individual and Community Resources in a Changing World

There are always times in human experience that feel especially troubled and threatening. Ours certainly presents problems from the personal level (substance use disorder, discrimination and injustice, socioeconomic inequality) to the world stage (war, oppression, refugee migration, economic aggression). How do children survive and mature in this threatening, depriving, and changing environment? What are their internal and family resources, and those from their natural communities and professionally planned programs? How can planners and clinicians make a positive difference? We present people who have lived and worked through this world to offer perspectives on what is happening and how we can help.

Speakers

Arnold Kerzner, MD: Emeritus Chief of Clinical Services, Human Relations Service, Wellesley; Distinguished Fellow, American Academy of Child and Adolescent Psychiatry

Lisa McElaney, MS in Mental Health Counseling, LMHC: Infant-Parent Mental Health Clinician, Center for Early Relationship Support, Jewish Family and Children's Service, Boston; Early Childhood Mental Health Consultant, Horizons for Homeless Children, Boston

Gemima St. Louis, PhD: Associate Professor and member of the Concentration on Children and Families of Adversity and Resilience, William James College

Moderator

David G. Satin, MD, FAPA: Assistant Clinical Professor of Psychiatry, Harvard Medical School; Assistant in Psychiatry, McLean Hospital

Friday, May 31, 2019 2:30-5:00 pm

William James College
1 Wells Avenue, Newton, Massachusetts

Introduction to the Lindemann Lectures by David Satin

History of the Erich Lindemann Memorial Lecture

The Erich Lindemann Memorial Lecture honors Erich Lindemann, a founder of social and community psychiatry. It does so by providing a forum in which to address community mental health, public health, and social policy issues, to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective even in times which do not emphasize the social and humane perspective. It is important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its history 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.

We are happy to announce that past Lindemann Lectures are progressively being made available on the web site of the William James College. They can be accessed at www.williamjames.edu/lindemann

In addition, a history of Community mental health and biography of Erich Lindemann—"Social Psychiatry and Social Conscience in American Psychiatry: The Community Mental Health Movement and Erich Lindemann"

Format:

Presentations by three speakers:

- Gemima St. Louis, William James College
- Arnold Kerzner, Emeritus Chief of Clinical Services, Wellesley Human Relations Service
- Lisa McElaney, Jewish Family and Children's Service of Greater Boston

Discussion among the presenters and with the audience

Speakers summary

Introduction by David G. Satin, MD

Life is complicated, difficult, and changing, now as much or more than ever. Living requires comprehension, adaptability, and coping. Some of the community mental health concepts Erich Lindemann developed are relevant: coping with life crises and preventive intervention to encourage constructive adaptation. Strengthening the mental health of children seems like the ultimate in preventive intervention, as children are coping with predicaments in ways that will shape the rest of their lives, their contributions to their communities, and the lives of following generations. How do they do it and what kind of interventions will encourage constructive adaptation? We will hear from an extraordinarily talented panel of people who have given much thought and experience to this on both broad and specific scales.

Gemima St. Louis, PhD

Associate Professor and member of the Concentration on Children and Families of Adversity and Resilience, William James College

Introduction by David G. Satin, MD

Our first speaker is Gemima St. Louis, PhD, associate professor at the William James College, co-director for its center of multicultural and global mental health, past president of Boston Haitian Mental Health Network, and alumna of the American Psychological Association Leadership Institute for Women in Psychology. Her focus of interest is on ethnically diverse children, adolescents and families with histories of trauma. Dr. St. Louis.

Gemima St. Louis, PhD

Good afternoon everyone. It's such a beautiful day. Thank you so much for being here this afternoon. My name is Gemima St. Louis. I am an associate professor here at the Clinical Psychology program at William James College. Before I begin, I would like to take the opportunity to thank the organizer of today's event. Thank you so much for the opportunity to be here to speak with you on a topic that is very dear to my heart. I am deeply honored at the invitation that was extended to me, and I feel blessed to be among such an esteemed group of colleagues. So, thank you, again.

I am a child and adolescent psychologist by training, but a community mental health provider by practice. Over the years I have really had to do some soul searching in terms of how I define the concept of community and to some extent the notion of community mental health. When it comes to addressing the mental health of children and adolescents, I felt an ethical, a moral, and a social obligation to really expand my definition of community and to

look at how we can be much more proactive in terms of the preventative and intervention programs that we put into place to help address the burden of mental illness among children. As a result, I have been actively involved in doing work both here in the state, nationally, as well as globally.

So what I hope to do today is to speak with you about the global burden of mental disorders among children and adolescents, and to do so I will be focusing on the following three topics: I will start with a broad overview to provide a context of who are we talking about when we're focusing on children and adolescents. To really provide a brief overview of the prevalence of mental disorders, to look at some population demographics, and also to address some risk factors. Then, for the second topic, to look at what are some of the social, economic, and psychological impacts of untreated mental disorders among children and adolescents. I will finish by presenting some specific work that has been done both here at William James College and across the state, as well as intervention and prevention programs that have a more global focus.

So, let's start with the basic background and overview. Children make up about a quarter of our total population. I will be utilizing the term "children", "adolescents", and "youth" interchangeably, to refer to the population that is under the age of 18. There are about 72.4 million of these beautiful individuals who are part of our country. I always say adults are kind of okay, but kids are the coolest people in the world. I think you would all agree with me. When we look at the trajectory, by 2050 the projection is that the total population will actually be on the decline, while the rate of older adults will be increasing. Specifically, when we look at demographic changes, we see that ethnic minority and racial minority children actually account for about 50% of the population of children. The ethnic group that really saw the highest increase was the group that identifies as Latino and Hispanic, so about 4.8 million between 2000 and 2010.

Across the globe…I'm going to test your knowledge. I'm going to ask you to guess, how many of these cool people live across the globe? What would you say?

Participant: 1.5 billion people

Dr. St. Louis: 1.5 billion of these beautiful people. Somebody else.

Participant: 3.5

Dr. St. Louis: 3.5.

Participant: 7.

Dr. St. Louis: 7? Seven what? Seven billion? Just to give you a frame of reference there are 7 billion people who live in the world, adults and children. So, unless you consider adults children at heart, then that would be too high. What's that over here? 1 billion. Okay. Here it is, 2.2 billion.

You may be surprised to know that the majority of these children actually live in what we call low- and middle-income countries. Just so we provide a reference, the World Bank

identifies low- and middle-income countries as countries where the annual per capital income is about $14,000 per year. So, the majority of kids that we are talking about live outside countries such as the U.S., France, Sweden, Spain, etc. Is there a hand?

Participant: yeah, what age do we mean by "children"? Under 18?

Dr. St. Louis: 18, yes. Good question. What you may be surprised to learn, perhaps if you don't know already, is that the pattern, the prevalence of mental disorders among kids, those factors are the same regardless of what country they live in. So, its 1 in 5. What is different, however, is around mental health disparities, how likely children are to access mental health services depending on where they live. So, disparity varies vastly across countries, but the prevalence is the same.

Here in the United States we know that it is one in five, so about twenty percent. What we also know is that about one in eight children has a co-occurring substance abuse disorder, and one in ten carries a significant mental health diagnosis such as schizophrenia, bipolar disorder, etc. In Massachusetts, as you can see the prevalence is about 20%. Not surprisingly, some of the most commonly diagnosed conditions among children and adolescents are mood disorders, anxiety disorders, and disruptive disorders.

The risk factors are numerous. We are all familiar with the research that showed that children who are exposed to sexual abuse, domestic violence, community violence, are at higher risk for developing mental disorders. When we take a broader, global perspective, there are other risk factors that can also put children in danger of developing a mental illness. Those factors may include wars, disasters, in terms of having a negative impact on the psycho-social well-being of children. In fact, what the World Health Organization has demonstrated is that rates of mental disorders tend to double in the aftermath of a major disaster or emergencies.

We also have to look at the impact of increased migration due to political instability, as the result of political pressures. Disasters and wars in many of these lower income countries that often have a significant impact on how children and their families are coping with those adversities. We know for example that exposure to violence, exposure to displacement, can lead to symptoms such as post-traumatic stress disorder, depression, substance abuse, and the statistics are pretty dire. For example, there are about 21.5 million refugees across the globe that have been displaced by war, 30 million that have been displaced internally. Sadly, the vast majority of these individuals, about 80%, are people under the age of 18.

So, we know the sad statistics. We know the risk factors. So how do untreated mental health disorders impact children? What is the cost to us as a society in terms of how much money we are investing to treat mental health disorders among children? What are some of the social and psychological impacts? That is the second topic.

There is definitely world-wide recognition, no one is in denial that untreated mental disorders is bad. If the mental health needs of children are left unmet, they are not going to

progress academically, they are not going to progress in terms of their emotional and psychological development. So, there is no disagreement there. In fact, about 30 years ago a seminal report was published by the then U.S. Surgeon General, Dr. David Satcher, who quoted that the burden of suffering by children with mental health needs and their families, has created a health crisis in this country. Sadly, we are still claiming the same statement that he made then.

We know children with mental health disorders, especially if they are untreated, are at high risk for a host of poor psychosocial outcomes including suicide. About 90%, according to the Center for Disease Control and Prevention, in 90% of completed suicides among children and young adults they had a preexisting mental illness. There are also significant burdens on us, in terms of the social impacts of untreated mental disorders. About half of students with a mental health disorder at about age 14 drop out of high school. About 65% of boys and 75% of girls who are in juvenile detention programs have at least one mental health disorder, and this is from the Institute of Medicine.

How are we responding to children's untreated mental health disorders? The Children's Defense Fund has certainly been an advocate for raising awareness of the fact that we are penalizing children when they act out in school by basically sending them to the juvenile justice system. We all know how well equipped the juvenile justice system is to handle mental disorders. The school to prison pipeline, where kids are demonstrating disruptive behaviors in the school system, they are referred to the juvenile system, and basically creating what the research has shown is a school to prison pipeline. Specifically, for boys of color we see that this pattern has been consistently demonstrated for decades.

So untreated mental illnesses can not only lead to school failures and involvement in the juvenile justice system. Other research has shown a direct link to chronic health conditions, low productivity, poverty, homelessness in adulthood. How many of you are familiar with the ACES study? For those of you who are not, I would strongly recommend it. This is seminal research that was conducted, I believe between 1991 and 1992 by Kaiser Permanente in collaboration with the Center for Disease Control and Prevention. What they showed was, the number of ACES, these are adverse childhood experiences that children are exposed to. Those could be sexual abuse, physical abuse, domestic violence, etc. Based on the number of adverse childhood experiences that an adult had, what is the likelihood in terms of their overall health, educational, vocational, behavioral outcomes?

The picture was pretty sad. The more ACES you are exposed to as children, not only were you at a higher risk for developing behavioral health disorders, but you also were more likely to have diabetes and heart disease. Those ACES were also significantly correlated with poor life potential. So, you were less likely to graduate from high school and college, etc. So, the findings of this study that was done with over 17,000 adults certainly points to the

importance of prevention and early intervention in addressing the burden of mental disorders among kids.

Question time. Second quiz, and the last one. If I were to ask you how much you think it costs us here in the United States, as a society, to care for adults due to untreated mental disorders? My colleagues here at WJC and my students, you cannot give the answer away. So guess. How much do you think it costs us annually, due to loss of productivity, disability, etc.?

Participant: $10 trillion

Dr. St. Louis: $10 trillion. Wow, you are very optimistic. Not quite. How about over here? A guess? $2 billion? Thank you. One more. $1 trillion? Okay. $247 billion dollars annually due to untreated childhood disorders. The way I like to remember that number is it is 24-7. That's how much it's costing us. Making untreated mental illnesses the most costly of all childhood disorders, even when you take into consideration cancer, childhood diabetes… the number doesn't even come close.

Why? Why does this issue continue to occur? Is it because we really do not care about the seventy-four million individuals who are living in this country? I really love this quote my Nelson Mandela, "there can be no keener revelation of a societies soul than the way it treats it children". We know that the statistic is that one in five has a mental health disorder, sadly only one of those children gets any kind of treatment.

For those of you who are parents, grandparents, or parents to be, imagine if five of you had children who had cancer and you were sitting in the doctor's office and the doctor came to you and said, "I'm so sorry that five of your children have cancer but the good news is we are only going to take care of one. The four of you go home. Figure out what to do with that. You can treat it on your own." But that is exactly what we are doing with childhood mental disorders. We are only treating one out of every five children who actually need the treatment. About 80% of children 6-17 have no access to care. Again, based on the research that was published by Dr. Satchers group, the needs are as high today as they were 30 years ago. For minority children the picture is even more dire. They are not only less likely to receive mental health services, they are less likely to stay in care even when it is engaged due to the fact that the services that are provided to them are culturally incompetent, they are fragmented, and they are inadequate.

Access to services in low- and middle-income countries are even more limited. There are about 270 million children, one in seven to not have any access to any kind of care, let alone mental health care. This data came out of a study from the World Health Organization. Regions of the world that have the highest percentage of children and adolescents, what we see is that they have the poorest level of mental health resources. For those of you who work with kids, you know that it may take anywhere from 6 months to 9 months perhaps to see a psychologist, to get a psychological evaluation or a cognitive assessment for your kid. Look

at this number. In low- and middle-income countries, 1 child for every 1 to 4 million children.

So, what are the contributing factors to these existing mental health disparities? Attitudes and stigma, right? There are those who believe that kids really don't have anything to worry about. Institutional barriers. There is also a shortage of trained professionals who have the cultural competency or even the clinical skills to effectively address the mental health needs of children. I always love to cite this statistic. In our field of clinical psychology, it's about 66% of graduate students that go right into work with adults. So, it's only about a third. We've been trying to change that number, and we're making progress. Ideally, we would love to see it 50-50. We also know there is a decline in community mental health centers, and the fact that there doesn't seem to be a unified system of care that can work within the multiple systems in which children are imbedded to provide better quality, better coordinated care. These factors have significantly contributed to the existing disparities.

I would like to talk next about the third topic. What are we doing? What can be done? Again, we know the numbers have been unchanged over the last 30 years. Do we want to be back here thirty years from now having the same conversation? What is happening locally, nationally, and internationally to really help reduce the burden of mental disorders among children? As some of you may know, May is mental health awareness month. In fact, the first week of May every year, SAMHSA sets aside the first week of May to promote the mental health needs of children. The tend to organize a host of activities, work with community-based organizations to address issues around stigma, make sure that families are aware of the signs and symptoms, and also provide to families a list of resources they can turn to when their children have mental health needs.

I think Frederick Douglas really summed it up when he said, "it is easier to build stronger children than it is to repair broken men". This really captures the essence of prevention. The earlier we intervene, the more lasting of an impact we can have in avoiding the outcomes that we saw earlier from the ACES study. If it is costing us $247 billion dollars annually to care for children, one way or another we are paying for it. Whether we invest in prevention, whether we invest in post intervention, one way or another as members of the society we are paying for the cost. So, prevention, early identification, intervention, and effective treatment management programs and protocols are certainly needed to ensure that we can change the trajectory, change the prevalence of mental disorders among children and adolescents.

What is also needed are community level and school-based services. I cannot understand, and this is my own personal bias, why we don't have mental health services in every school. We know where they are. Kids are there 9 to 5, or however long, Monday through Friday. We do not need to rely on parents who may or may not have easy access to transportation, to go after work, or on the weekend. They are a captive audience in the

school environment. There seems to be this discrepancy between the role of the school being to educate our children, as if addressing their mental health needs is separate from their educational needs.

Culturally sensitive and evidenced based prevention and intervention programs are clearly needed. And the diversification of the behavioral health field. Over 80% of clinical psychologists in the field today are members of the majority group. We don't do such a great job at recruiting, at training, at mentoring, at retaining individuals from culturally diverse backgrounds to really be able to diversify the face of the behavioral health field. What we do in low- and middle-income countries, because the disparities are so vast, we do not necessarily have as many psychologists, psychiatrists, social workers, counselors, etc. So, there has been a huge focus on training what we call stakeholders, these are teachers, faith-based leaders, etc. More types of internationally focused programs and trainings are needed, certainly to address issues in low- and middle-income countries.

I am going to share with you now three programs that we at WJC, in our small corner of the world, have been engaged in over the past few years in an attempt at turning the tides to address the mental health needs of kids. One of our programs is called the PATHWAYS program. This is a partnership we have with the Boston Public Schools where we bring mental health services, free of charge, to children who are referred because of a host of academic problems, behavioral challenges, etc. Its aim is really very simple: bring access to where children are. Over the last five years we have served about 500 children. All the services have been supported through grants, not billed for services, because we know sometimes kids may not necessarily have health insurance. So, if you are in the school setting and want to learn more about how to bring PATHWAYS to your school, you can talk to me afterwards.

The second initiative that we are really excited about is this grant that we just received from Boston Children's Collaboration for Community Health. Its aim is at specifically targeting individuals from culturally diverse backgrounds who may have an interest in pursuing a career in the behavioral health field but who do not have the financial means. So, through this grant we are looking at, over the next three plus years, to expand the behavioral health work force with a specific focus on training these students to work with children and adolescents. Of course, if you want to hear more, we do have a website: williamjames.edu/camhi, or I'm happy to answer questions at the end.

Lastly, from an internationally based perspective, we have been partnering with five countries, Ecuador, Haiti, Guyana, Kenya, and Trinidad, and establishing what we call international service-learning opportunities. And training students to think beyond Newton, beyond Massachusetts, beyond this country, to view themselves as global citizens. Many of you may be familiar with Doctors Without Borders, so trying to create community-mental-

health-providers-without-borders. The school hasn't endorsed it yet, but I'm working on it. So that's the idea.

How do we collaborate with communities that are really struggling with some of the issues that have already addressed, like capacity? Our focus with these international services learning program has been to increase mental health literacy, to promote awareness, decrease stigma. We do workshops for caregivers, for teachers, for faith-based leaders. In Guyana, which has the highest suicide rate in the world, we have been working in close collaboration with the Guyanese government to bring suicide prevention training to their gatekeepers. We also do a school-based prevention program, and the whole premise of these partnerships is to build sustainable programs so that we can enhance the capacity of these local organizations to care for their communities.

Locally, all of you are familiar with the Children's Behavioral Health Initiative, so I won't go through those details. But there are also state level interventions and prevention programs through the Department of Mental Health, Children's Hospital in Boston certainly has been at the forefront of providing resources to community-based organizations and other institutions. The national childhood traumatic stress network, SAMHSA among others, have really been the pioneers of helping to address these issues.

Lastly, in terms of what is happening at a global level, we have to give credit to the World Health Organization, such as UNICEF and UN, that have taken the lead in developing a global mental health agenda with components that focus specifically on children. For example, they adopted in 2013 the Mental Health Action Plan, which recognizes the essential role of mental health in achieving overall health for all people, with specific focus on how to promote equity in access to and utilization of mental health services by children and families. The other program that the World Health Organization has sponsored in 2017, the acronym was AAHA, that's a great way to remember it. It is the Accelerated Action for the Health of Adolescents, and its aim is to help government to take a greater stake in addressing the mental health needs of children because we recognize local community based organizations have limited capacity, to government needs to play a much more active role in providing the resources that are needed in order to effect long lasting changes. What I really love about AAHA is the fact that it also emphasized the benefits of including adolescents in the planning process, to get their perspectives in terms of what would work, what would be beneficial in addressing their mental health needs. And lastly, they have the mental health gap program, and what this does is to provide a set of resources and tools to organizations that are very much invested in doing this work across the globe, especially in low resource countries. There is a specific element of how to do mental health prevention, mental health intervention, that target children and adolescents.

In closing, I would like to share this wonderful poem with you that was published by Gabriela Mistral, a Chilean poet. She says, "many things can wait, but the child cannot. Now

is the time. His blood is being formed, his bones are being made, his mind is being developed. To him we cannot say tomorrow, his name is today". So, children represent the future of our society. Ensuring their mental health and well-being should be a priority for all of us who are concerned global citizens. Thank you.

Dr. Satin:

I want to thank Dr. St. Louis. One thing struck me in Dr. St. Louis's presentation. She talked a lot about mental health services and mental health professionals, but every once in a while, she would talk about non mental health professionals and mental health services. Teachers, and maybe others, physicians, the families themselves, as needing enhancement to deal with the needs of children and adolescents. This was Dr. Lindemann's definition of community mental health, communities providing mental health care and professionals being consultants or teachers, or researchers, about how communities care for themselves and can care better for themselves. One of the reasons is, he believed that community was a source of mental health and mental illness. Another was that he was aware that there are insufficient mental health professionals to provide all of the care and understanding that is needed. There is also some resistance to mental health professionals. It was interesting to see that element of understanding.

Arnold Kerzner, MD

Emeritus Chief of Clinical Services, Human Relations Service, Wellesley; Distinguished Fellow, American Academy of Child and Adolescent Psychiatry

Introduction by David G. Satin, MD

Our next presenter is Dr. Kerzner, M.D. He prepared at the University of Vermont College of Medicine, Pediatric Residency at Tufts Medical Center, Adult Psychiatry Residency at the University of Rochester, Fellowship in Child Psychiatry at Boston Children's Hospital. He has been on the faculty at Boston University and Harvard Medical Schools. He has been designated a distinguished fellow of the American Academy of Child and Adolescent Psychiatry. He is the founder and president of the Boston Institute for the Development of Infants and Parents. He was the chief of clinical services at the Human Relation Service of Wellesley for forty-one years. We know that the Human Relation Service at Wellesley was the first community mental health center in the United States, that was developed by Erich Lindemann at the invitation of the town of Wellesley for help in recognizing and dealing with mental health needs and services. Dr. Kerzner has been consultant to many other programs in the United States and other countries.

Arnold Kerzner, MD

Thank you so much. I thank Dr. Satin so much for his introduction. I am going to talk about, first of all, I think that Dr. Lindemann was a genius. He came into a community. The statistics that he faced were not exactly what you just heard from Gemima, but the statistics back in the 1940s were still not great in terms of the prevalence and incidents of mental illness. And he said, look, we have to do something other than just treating. Because there is so much going on with children and adolescents, and they keep coming into offices for treatment, and some of the statistics keep going up and up and up. What else can we do?

He had this concept that had never been tried before: prevention. You heard some of the wonderful things that Gemima said about prevention, but that's now. That's from a distinguished professor, Gemima. But this psychiatrist took a look at said, okay Wellesley might be a middle class, upper-middle class community, but as you saw from the statistics, wealthy people still have their issues. Believe me. I worked in Wellesley, as you heard, for forty-one years, and I had sort of a prejudice, "oh wealthy people don't have as many problems as poor people". But the truth of the matter is they have plenty of problems. First of all, they are always worried about losing their wealth.

So, what he did was, he came in and he said, "I have to establish a program for prevention". How do we go about preventing from this village, this community? He took a look at this community and the baby and the child are in the middle. Then he looked at all

the systems, all the circles that were surrounding the child. The first one is certainly home, the family, and the school is right there in that first circle, and he called it the microsystem. Then when you take a look at the next system, school, neighborhood, work, he called that the mesosystem. Then the exosystem, the parent's workplace, the child's school again, the community services, mass media. And then the macrosystem which is going to be the development of the ethical mores, the moral imperatives, the philosophy that the child is being bathed in. In terms of the morals that are surrounding this present culture, that's all I'm gonna say, and the morals that surrounded the village of Wellesley, he took a look at every single circle.

Then he did some collection of data in every circle. He said, where should I get my multidisciplined staff to insert their professional strategies, interventions? What circles are vulnerable? What circles are fragile? When he gathered data on all these circles he said, it's going to be very hard to work in every single circle, so I have to be selective. I'm certainly going to do as much support as I can with the baby and the child, the parents, the school system. I'm going to send consultants, who trained, to go into the vulnerable aspects of this village. I thought that was brilliant.

He sent in this group of multidisciplined professionals, that he trained, to do prevention because he said, what are the fragile circles and where do the people go for help in this community? He was surprised where they go. They go to school counselors, they go to some therapists, they go to clergy, sometimes to even police officers. He said, you know what, I'm going to give support to the caretakers, because they're going to get worn out. So, he developed school consultation programs, and almost every single school was covered.

Now, that's not all he did. Because in 1948, as Dr. Satin said, he founded the first community mental health center in the United States of America. This guy was unbelievable, a genius. And guess who we have with us today, in terms of two very distinguished professionals, who were a part of the Human Relations Service, the community mental health center he founded? We have a past executive director here in this room. And we have a past training director here in this room. The past executive director, who was the executive director for many years, is Fran Mervin. Can you believe she's representing something that Erich Lindemann developed back in 1948? She doesn't look that old. Sorry, Fran. The past training director is here, Hal Cohen. Unbelievable.

And then I'm up here. As Dr. Satin said, I worked at The Human Relations Service for forty-one years. And the truth of the matter is, I look it. So, I have the utmost respect and I'm honoring, I'm so pleased that you had me come here to honor this person who I think was absolutely a genius.

The Human Relations Service is still doing very, very well. The executive director, who many of you know, Rob Evans, has been there thirty-five years. Everybody stays there. It's a wonderful, wonderful organization. So, where do we go from here?

I'm going to need a lot of help from you, Gemima, your slides are so beautiful. But I'm going to talk about the last one. With treatment, what is so sad, there is a very high likelihood of full remission. If people get treated for depression, I'm just giving you the statistics for the time being on depression, but I could do anxiety, I could do bipolar, any emotional illness, everything has gone up, up, and up. But if people, I think Gemima said one out of five get treatment, if people actually can receive treatment, a lot of these conditions are remedial. They may not be cured, but the person feels much better if they are able to receive some kind of treatment, which I'll talk about treatments later on. With these frightening statistics, we are not preventing, nor are we providing sufficient treatment to our people with mental problems. Gemima just covered that beautifully. It was a brilliant presentation, I think.

Now the Lindemann Village, did it work? Well, believe it or not he decreased, the program of prevention, did decrease the prevalence and incidence of mental disorders. Did not cure it, in fact he had to open up the Human Relations Service because he realized that since he did not cure a lot of these problems he had to have a place where people could come for therapy, which is what Human Relations Service does now. It does both therapy, clinical work, and it also continues with Erich Lindemann's model of working in the community.

Now, in the middle is the child and a baby. Any time I can talk about a baby, sorry folks, I am going to talk about a baby. Ok, that is not me as a baby. Look at those little toes. Don't you just want to tweak the toes? Play coochie-coo?

By the way, thank you to the Lindemann family, I forgot to say, for being here as part of this talk. I really appreciate that.

So, there is a happy mommy and daddy. What does a happy mommy and daddy say about the baby, the most beautiful, precious baby in the entire world? Look at the toes, look at the eyes, look at the nose. That is an extremely tuned in baby. The research shows, by the way, that the baby can activate the mother's brain. They are in sync. The mother does a lot for the baby, but we don't give enough credit for what the baby does for the mother. The reciprocal dynamic is totally in sync. The baby can get the mother to become activated. This is now substantiated by MRIs, and all kinds of brain research.

Okay, let's give mom and dad plenty of time to be with the baby. For bonding, and to form an attachment. Let's see how much time the United States, the Family and Medical Leave Act of 1993 gave to the mothers and the fathers and the baby. Twelve weeks, of unpaid leave. Oh, that is wonderful. I mean, I could cuddle with this baby that I showed you for a lot more than twelve weeks. But Massachusetts is trying to develop a wonderful new, for some of you shaking your heads I put maybe because I thought it was going to happen and then my wife who is very much tuned into this, she's worked for the Department of Mental Health for thirty-five years and she looks at these statistics, she said "honey, it may not happen". I was heartbroken, but if it does happen, twelve weeks of paid family for a new baby, twelve

weeks for caring for a loved one, twenty weeks for caring for yourself if you have post-partum blues, if you have medical issues, if you get a pneumonia or something, wow. But Sweden, woah. New parents in Sweden are entitled to four hundred and eighty—sixteen months! There is a lot more about Sweden that I could say, but 80% of their pay and that is on top of eighteen weeks reserved just for mothers. Afterwards, parents can split up the time however they choose. Sweden is unique in that dads also get 90 paid paternity leaves, reserved just for the daddies.

You know oxytocin is the most wonderful hormone all of us have? We know that. Oxytocin. I'm going to give you an examination on that, because it's the love hormone. We have found a gene along the genome that produces oxytocin.

What does every village provide? A sense of belonging and connection. What I'm going to do is, I'm going to take you on a Viking cruise. The Viking cruise is going to make sure, for all your allergies, we're going to take care of it. For all of your food preferences, your gluten-free, your vegetarian, the five different vegans, the shellfish problem, you name it. This Viking cruise, by the way, you paid for it. You paid for a ticket for being here, you're on the cruise. The cruise is going to stop at four different villages. We're going to take a look at how those villages impact on the life and development of the child. Each village has the same circles as the Wellesley village. Because we know alone, we can do so little. But what we are trying to find in the village is the belonging and the connections that Helen Keller talks about. Every person requires a sense of connection. I think Dean Horner said it well when he said, "the need for connection and community is primal". As fundamental as the need for air that you're breathing, water that we're drinking, and food that I wish that we were eating. Now look at that connection.

You know, I do love to go to the ballet. There are a lot of people who don't. I happen to love it, in terms of connection and community, and the hard work that these people put in. Years, and years. Anybody in the ballet field? Oh, good. How are your toes? Never mind.

So, every village has the same circles. Now, the first village is called the Lindemann Village. We call it the overlapping, reciprocal, wrap-around, holistic, bio-ecological circles. I love that. So that's the professional way, for any of you who want to know about what we call that circle.

The second village is re-conceptualizing the child, which I am very worried about. What is the new concept of the child in this village? This village is called Boston. I have to say, "I parked the car in Harvard yard", because that's the way I really say it, I'm from Boston. I'm very concerned about this village. There is so much brain research in this village, they think that the brain of the child is the main engine that is helping the child to develop and evolve. If you think the brain is the main engine, you are forgetting all the rest of the circles that are impinging on the child, helping them develop. You can't remove the child from the family. You can't remove the child and wonder what's going on in the schools. When you're

concentrating on the brain, a dangerous thing begins to happen. I'm going to tell you what that danger is.

First of all, you can't see the bottom, but ask your doctor if taking a pill to solve all of your problems is right for you. Because that's what I'm going to talk about. If you think the brain is the engine, then you want to change what is in the brain, called the neurotransmitters. You want to increase the serotonin. You want to work on the epinephrine, the norepinephrine, and the acetylcholine in the brain. What do you think you want to do with that? You want to give medications. I think the idea of giving medications is being overdone. I don't know how many psychiatrists and providers are in this room. But I'll just use the ADHD child. The teacher first says the kid's not focusing, not paying attention. The teacher speaks to the parent. The parent is concerned. There is a form that is filled out. Distractibility, restlessness, impulse control. He's not doing his lessons; I think he is bright but he's daydreaming.

That was me, a personal story, up until the sixth grade. I was so distracted, I loved to daydream. I had a preponderance of a right-brain imagination type brain, and I just could not focus on what the teacher was saying, or I picked it up so quickly I got bored. And then a miracle happened. My sixth-grade teacher spoke to me alone, not in front of the class, and said, "look, I know that you have been struggling from grades one to five". I said "okay". She said, "we're going to have a new situation for you. This is a brand-new year. I respect you. I'm going to put you in front to help you pay more attention. And then, because you always like to speak to the girl in front of you, to the right of you, you like to pull her pigtails, I am going to do a co-ed chorus. We are going to develop a sixth-grade co-ed chorus, and you are singing in that chorus". And I said, "with girls?". And we developed a chorus. She showed me a lot of respect. I felt for that teacher, I wanted to work for that teacher. It was the first teacher in all my life that somehow connected with me and it changed my life. I would never have been here; I never would have made it through medical school. No way in a million years. I was an untreated ADHD student.

I'm not all against medications. I do think children are being overmedicated. Sorry, folks. I'm a psychiatrist, I can say it. Because after that form is filled out, there's now a teacher's form and a parent's form, they usually take it to the pediatrician. I was a pediatrician. I was trained as a pediatrician and I knew that I had to see kids for fifteen, twenty minutes. I rarely saw the fathers. I just yearned to learn more about the child, more about the family. But the clinician sees the child, and within fifteen, twenty minutes, if the form fits the DSM-V, the kid gets Ritalin or Adderall. And boy, that stays with a kid for years and years. Now, do I think there is a real condition of ADHD? Yes. But if I'm going to give medications, which I do, I am going to take a look at the family, the marital, because so many kids are sent to my office as scapegoats for marital and family pathology. Should that kid have that burden of the marital and family problem on their shoulders when they come

into my office? Should I not get a history of the marital or of the family dynamics? Should I put the kid on medication and ignore the marital problem? To me that is like malpractice.

A lot of kids have sleep disorders, because they're worried about one thing or another. They have a video game addiction. You can't get them away from that addiction. But a sleep disorder syndrome, a lot of times with a little bit of melatonin, which comes from their brain, so I'm not giving them a prescription. A small amount of melatonin, 5 or 10 milligrams, if I am going to give something, then the kid can take a low dose of melatonin and sometimes fall asleep. But if I'm going to give medications, I'm not going to ignore school issues. Bullying, learning disorders. There is a new condition called Asymmetrical Brain Syndrome, I'm not going to get into it because there is a whole lecture I give to medical students on it. That's where there are certain brilliant people who have a paradoxical brain, where one side, let's say the left side that is more the planning side, the organizational side. They have a marked discrepancy between that side and their right side, the more imaginative, creative side. And it is difficult for them to put both of those sides together as they grow up. Those kids are misdiagnosed over and over again. They are brilliant but they just cannot coordinate.

So, when you're using a med, sometimes a trick I have is that I believe in the placebo effect. In fact, there is a whole new program at Beth Israel Deaconess Hospital, his name is Dr. Cusack, if I'm pronouncing it correctly, I don't think I am. But the placebo effect is a big secret in terms of psychopharmacology. They don't want you to know that Prozac, if I give you a sugar pill versus Prozac for mild to moderate depression, what percent of people will feel better on the sugar pill versus the Prozac? Forty-six percent! Believe me, the psychopharm folks do not want you to know that. I was amazed that it was that high. Forty-six percent. So he decided to do a lot of research on the placebo effect. He found that the placebo effect changes some of the same brain neurotransmitters as the Prozac, and the many other medications.

Okay, now the third village. I have about four or five more minutes, just where I want to be. The third village is the integrated approach. If we're really going to get a brand-new President Kennedy, when he said in 1963, "I give tons of money to a brand-new mental health act". We now need a president in this day and age that is going to do another mental health act, because that was 1963. We are now in 2019. We need that brand new major program which should have both elements, which is the preventive mental health model, which is what Lindemann did, and the clinical mental health model whereby the child and the family, all of those things that I talked about, all of those circles, have to be addressed and looked at. You have to put together, not just the kid as a brain, or genetics, you have to look at the kid's social, family, school and village.

The interesting thing about talking therapy is we have a way of saying, what the basic meta-psychological elements you get when you are in almost any talking therapy. You get

listening in a non-judgmental way, you get a reflection of your feelings, you get compassion, and you get empathy. What other psychiatrist, that I admire, had a wonderful divergent theory from Freud. Alfred Adler. What did he say? You know what, Freud said in our unconscious is aggression and there are sexual instincts. Adler said you have to add one. The human needs a social connection. We need to feel belonged. He said there is a third one. Not just sex and aggression. He said there is one that we need, social bonding. What he said about empathy, "to see with the eyes of another, to hear with the ears of another, to feel the heart of another, is the social feeling of empathy".

For those of you who do therapy, I am not the type of person who says keep your feelings as a therapist away from your client, do not show them all the feelings that you're feeling. As a matter of fact, I think that if you have compassion and empathy, first of all the client is going to sense it. Second of all, if they ask you something about your feelings, it is perfectly okay as a form of attachment and bonding, which I think is a part of every therapeutic situation, except for maybe psychoanalysis where the analyst sits on a couch in back of you. That's fine for some people. But what I think what we really need to consider is the idea that, if you're feeling that degree of empathy, I think some of it is going to be very important in terms of the psychotherapy you're doing.

The fourth one is the last one. It is the dream village. This dream village, you have to read this on your own, you will not believe this, is called the Umbunto child, the Umbunto village. It's more of a philosophy. Remember when I said that the last ring around the circle, it's a philosophical, ethical, humanistic, philosophy, ideology. It surrounds the whole village, the essence of being human. Umbunto speaks particularly about the fact that you can't exist as a human being in isolation. You know what I'm doing with all of you? I'm trying to connect. I'm trying to belong. If it were up to me, I'd go down every single aisle and shake your hand. I'd give some of you a hug. I would receive that hug and say, "thank you". I would feel like I'm more connected with you than standing up here and showing you a lot of slides.

Now, there is one village, and there is one person in this room from this school, I still work at an Umbuntu facility, the Lighthouse School in North Chelmsford. I am telling you it has every quality of Umbuntu. I am so appreciative that I am working, still working, in that village. I could not, I don't have to work, I've been there five and a half years because I love it and I love the staff and I love the kids. There are two hundred and twenty kids there, and most of them are on the spectrum, and the others have very significant emotional problems. This saying is on the wall of my supervisor, this is Anna Fitzgerald, you can read it, it's beautiful, "it is not the breaths we take; it is the moments that take your breath away". Like this moment. I am; therefore, you are. You are, therefore, I am. Try to develop this philosophy of Ubuntu. Thank you so much.

Dr. Satin:

Dr. Kerzner introduced us to the multiplicity and the complexity of the interaction of the individual, and the family, and the community. It's hard to follow, not just his talk, but the reality. He was right. It is complex. As somebody once said, if it is all clear to you, you don't understand the situation. You remind me that Dr. Lindemann suggested a complete change in diagnostic nomenclature in psychiatry. Not to stop talking about what was wrong with the individual, and what caused it, and what you could do to change the individual. But to put it in terms of the social environment. What is the situational complexity, the situational problem that these people are dealing with? And how are they dealing with these problems? And what can be done to help the problems that are causing the upset and the reaction that people have to those problems? So, don't blame the people, look at the social environment that they are coping with, that they are struggling with.

Lisa McElaney, MS, LMHC

Infant-Parent Mental Health Clinician, Center for Early Relationship Support, Jewish Family and Children's Service, Boston; Early Childhood Mental Health Consultant, Horizons for Homeless Children, Boston

Introduction David G. Satin, MD

Our next speaker is Lisa McElaney, infant/parent mental health clinician and early childhood mental health consultant in the Center for Early Relationship Support at the Jewish Family and Childrens Service of Greater Boston. She has been trained in both circle of security parenting and child-parent psychotherapy. She serves on the board of The Children's Trust. In a previous life she was a documentary film maker and president of Vida Health Communications. In that capacity she helped to produce nine National Institute of Health funded projects, designing and evaluation paternal and child health interventions. I look forward to hearing from Lisa McElaney.

Lisa McElaney, M.S., LMHC

I am a radical generalist. It was a real opportunity for me to think about what we would have already heard before I spoke today. I knew, given the topic of what we are talking about, that it would raise a lot of worries, concerns about our future. A lot of us are thinking about, especially in the work I do, with women, children, and systems caring for them, what are we doing? So, I wanted to come with my humanities background, and see if I could muster up some hope, find some ways in which we really are able to reach to our better selves, our better angels, and enlightenment. I think this is consistent with Dr. Lindemann's approach, as I am hearing about him today. But I like to read Alfred North Whitehead who said, "the common sense of the 18th century, it's grasps of the obvious facts of human suffering, and the obvious demands of human nature, acted on the world like a bath of moral cleansing".

So, what we're talking about here is a moment in civilization, in which there was finally enough knowledge and evidence about the science of things, that we called upon to believe in the humanity of things. That humanity as much as, maybe even more than, divinity had answers for us to cure all our ills. That's an enlightenment hope.

Still, when I saw the topic for today, I felt itchy inside. It's difficult to think about this topic. It's especially difficult when you read the red words in the subtitle. Because here is where we are living a lot of the time. Those of us doing the work, we're living in the red words right now. So, part of what I want to talk about today comes from my own determination to land in the second part of the subtitle, and to think about the resources, what it is we do bring from our humanity, from our communities of caregivers, from

knowledge and experience, and legacies like the Lindemann's'. Because it is there that we carry what we need into a future that is brighter.

My age may befuddle, I am the youngest clinician on the panel today. I had another life. As you heard, it was in making documentary films, but they were always about maternal and child health. So, I entered this world as that radical generalist, making videos and other media-based interventions that were looking to address behavior change usually in at risk populations, but always in parents and in the people and clinicians who care for them.

So, I was a public health researcher, and I was funded mostly by the NIH, and I developed interventions and then measured them. But now I find myself on the other side of the aisle, in the clinical world. So, I took myself back to graduate school and became a counseling psychologist, and landed in a wonderful place, Jewish Family and Children's Service, and The Center for Early Relationship Support. Wouldn't you know I am still in the same sandbox. I'm working with children and families, but now in a different capacity entirely. In The Center for Early Relationship Support, as you can see, we work with a population who are facing many of these issues. We support the population facing these issues. We try to ourselves be a community of support to bring them care they need.

Today I want to get down into a little bit more granular place than maybe we have so far and speak to my reasons for hope coming from my current practice, which is in relationship centered care of dyads, mostly, in my home visiting work. In systems consultation, to Horizons for Homeless Children, where I am embedded by JF&CS, as an early childhood mental health consultant. I want to talk about those two interventions into some of the problems we see in the first three years of life, and in developing relational health that we think is so fundamental to future psychological well-being in children, and in adults.

Many of you may be familiar with some of the research around home visiting. It is one of the great success stories. We actually have longitudinal data. David Old, with the Family Nurse Partnership, really was able to take another radical idea, like community psychiatry, and suggest that home visits by a nurse in the period surrounding birth would make a difference in outcomes for children. The evidence is really pretty significant. It is an evidenced based practice, home visiting. At least by the nurse, and now other programs too. Parents as Partners, Healthy Families America, are providing home visitors to intervene in that perinatal year as parents, usually mothers, take on their new role and try to form a relationship and attachment with their newborn. So, it has a history of success.

The latest report, this one, continues to affirm that we have real reason to invest in home visiting programs. Not least of which, they are inexpensive. They have a pretty good return on investment. But, because we see less investment even in this inexpensive intervention, we aren't seeing as robust a return on investment as we might. What I do at The Center for Early Relationship Support is visit with women often who are referred to us by hospital social workers, but they can self-refer, they are referred by obstetricians, by DCF,

by therapists, all of whom are feeling as if their vulnerability as they become parents may be putting their child at risk, and certainly may be causing them to feel depression. What it offers us as clinicians, the home visiting opportunity, is a way to look at the beginnings of cue responsiveness. How is mom learning to read her infant? We're looking for the reciprocity, the back and forth, the mimicking of exchanges as infant and mother learn each other's languages, reveal themselves to each other. The home visit, unlike the clinical visit, gives us opportunities that we could never have otherwise. And it is wasted, given that we don't make this universally available to every parent.

We get to see the "ghosts in the nursery", as Selma Fraiberg called them. They may be actually hovering in the room next door. It could be a tortuous relationship with a mother, or a grandmother, or a partner. As clinicians entering into that sphere now, we are able to sense, see, or be told by other members of the community caring for this infant, what may be putting this relationship at risk. We have so many opportunities to assess the strengths of the family. It is amazing what we can see in short home visits that could take months in a clinic setting to really understand. We are able to manage, and see how families manage, the realities of exhaustion, for instance.

How many no-shows are we used to with this population? Imagine a person who doesn't have transportation getting to a clinic with a newborn in tow. We ask so much from an exhausted, depleted, parent. And then we are dismayed when they don't respond, when they don't take advantage of what we offer them. In home visiting we never have to have that element in the dynamic. We have the opportunity to do just in time intervention. We may be seeing things in the home setting that we'd never know about from the clinic. These could have to do with rodents, as simple as that. The difficulty of getting up the stairs with a twin stroller. Some of the things that make our families' lives more difficult than they could ever tell us become visual and experienced by us in the work as we visit.

I see myself as entering this interstitial space, between a developing mother and a baby. I am tending really to the relationship between them more than I am to either one of them alone. So that's an idea that is a little different. That the treatment focus is the relationship. I'm using a whole lot of things in my toolkit. Lots of them psychodynamic and talk therapy, a Rogerian sort of client-centered, unconditional positive regard for a parent coming into this new role. I wear a very thick attachment lens. Partially that is because after graduate school I did a fellowship in infant-parent training, and there learned the basics of a theory and approach of looking at relationships that is really informed by something different than I got from other education. I'm look at the reflective capacity of mom. How is she able to integrate what she is seeing? What is she noticing about her baby? What is it speaking to her about her own experiences of childhood now re-evoked? How does that experience shape what she is doing with her infant, feeling about her infant? Is she parenting in reaction to that

experience of her own? Is she wanting to re-write her own history? Can she reflect and think about what's happening in her experience?

I swim in the alphabet soup of interventions. Obviously, I can't be certified and trained in all of these, but I have been exposed to most of them and am certified in some of them, and I borrow and steal liberally. Most good therapists do, because that's where we are being reflective too, where we are reading our patient, our client, and seeing what it is that will turn them. What it is that will open their curiosity.

If we imagine that this is a cross-section of a healthy, grown human being, if you think of this as the sapling in the very first minutes or months of life, this cross-section indicates a tree that is in pretty good shape. It really hasn't had, until very late in life, this assault. We don't know what it is. But generally speaking, this organism has done pretty well. We like to think that this is what we wish everyone would look like. But most of the women I meet have a more complicated picture. I like to look at this particular cross section as I think about one person I have in mind who I would like to share with you in a little vignette.

As you can see, she is a 29-year-old mom, who had this insult here mostly throughout her early life. Phoebe, I'll call her, who is the mother of Achilles, I met two summers ago when she got a referral from her obstetrician to our service. Intake person went out and did a history, but as it was summer it took two weeks for a clinician to be available to do the first home visit with Phoebe. She was 29. Her mother had been an opiate user. She was placed into kinship foster care when she was 14, left Vermont where she grew up and then was in Kentucky. Now she is back here working as a residential care worker and she is married to a Guinean man. She's wanted all her life to be the parent of four children but found herself in pregnancy "not feeling the way you should", in her words. Then at birth, that sense of not feeling the way you should got worse, and deeper. We encountered a mom who wasn't able to even look at her baby. When I showed up on the day of our first appointment, with all of the assessment screens in hand, knowing that there was an elevated risk, but it wasn't off the charts. I had seen much worse. I wasn't expecting what happened.

So, I climbed to the third floor of this three-story house, and there was mom, grand-mom who was that opiate user, quite agitated saying, "we don't know what to do". She won't come out of her room; she won't look at the baby, who is now three weeks old. I had no relationship yet, no alliance with this young woman. There was no connection to build from. And yet I could see immediately that she was in crisis.

So, my job that day was to do everything in fast-forward. To sort of establish trust as best I could, given that she was dissociated and somewhat comatose even. The baby who was in a little car seat was fortunately sleeping, but never even acknowledged by mom. Partly I knew my job was also, as much as I wanted, to hold this baby, feel this baby's reality. I needed to focus on mom. Mom needed to hear that I was there for her. I knew that grandma

was outside and that this baby, if he were to wake up could make his way to his grandmother.

Fortunately, we had enough time to evaluate, what we could determine was a pretty severe depression. That day, it was not 4:00 on a Friday afternoon, it was, say, 1:00 on a Thursday afternoon. I could call her health clinic; I could get her nurse midwife. They patched me over to mental health. That person called Beth Israel Hospital, made them aware that they were sending someone there in an ambulance. The best of all possible occurrences took place. It never does happen that way. Usually, those of you who are in the business know that this isn't how hospitalizations look most of the time. But for this young woman and this baby, it worked. The community of caregivers were there for each other. The nurse midwife heard me, the psychiatrist heard her, the emergency room heard her, and mom arrived with everything known that could be known and had a good two week stay in the hospital, which obviously interrupts this early birth and post-partum experience. So, then my attention becomes much more on how we repair this rupture for this mom. What is this relationship going to be like for Achilles, who didn't have his mother now, really emotionally for the first three weeks, and physically for two weeks after that? Holding him in mind, holding what he's experiencing is my job too.

That is where I am saying I am in the relationship space. I am thinking about the connection between them. What is it that I'm going to do to nurture that, to help it grow from out of this crisis? We spent about a year and a half together, which is about three times longer than what I spend with most of my folks. We are a relatively short term, but flexible intervention. Lots of our moms have depression and anxiety prior to childbearing. So, we are looking at a pre-existing mental illness and they have individual clinician's they've been working with usually, so I then begin to collaborate with that person in helping to address the relationship and attachment. Because, as we know, this child is at risk. Not having what we know is necessary in these first five weeks, and what we know is compromised still for mom, is putting this child at risk for being one of the children Gemima was talking about. We know that if we can infuse this moment of early life with as much exploration and cue reading and responsive, just inch-by-inch experience between mom and baby, we can get to a really amazing place. Usually within a six-month timespan.

The second intervention I want to talk about, besides home visiting, is early childhood mental health consulting. Just to give you a little description of how we do it, because it is a field that is emerging and growing and defined everywhere differently. If you ask Head Start what is an early childhood mental health consultant you'll get a different answer than if you ask Horizons for Homeless Children, where I'm embedded. That may be true for preschools too. Our model at JF&CS, which we are evolving and iterating day by day and month by month, consists of a team of three embedded mental health clinicians, our clinical supervisor, and then an outside consultant to the four of us, whom we see monthly and

review cases with. It's a pretty intensive caring-for-caregiver model. Because what we're doing now, as opposed to the in-home option, is systems work. It would be great if it ever looked as lovely as this diagram makes it look. In general, as the early childhood mental health consultants, we're down there at the roots. I'm not actually intervening with families in the way that I do in that home visiting scenario. I'm working with childcare providers, primarily. In zero-to-three spaces.

We have, at the Dorchester Horizons for Homeless Children, 55 children in our zero-to-three classrooms, five classrooms. I'm working with 17 teachers. Our ratio of students to teacher is better than most places, and beats EEC requirements. I'm consulting to directors, who are often caring for caregivers too. Occasionally we are called upon to work with parents, and we may lead groups. We use Circle of Security, which we find to be a really an attachment based, effective group for new parents. And we do training for this group of care providers. Now, as I said, it would be great if it looked as crisp as it does on the previous slide. But, in fact, most of the time I feel the work that we're doing is in a much darker, muddier place with not so clear pathways. Just to give you an example, I'm going to talk about the last month at Horizons.

We had a flood. All five classrooms were destroyed. Fifty-five homeless children were homeless again. Now, separated from their regulating care givers, the people that they have the most time with per day, meaning their teachers but also their peers, spread all around the city of Boston. Because Boston rallies, ABCD comes in with one classroom, we get another basement somewhere, we split the kids up and put them in Roxbury and Jamaica Plain. Horizons for Homeless Children, imagine, we are talking about children who have experienced the most intensive traumas you can imagine. Homelessness is just one. Fifty-five children. We are looking at mostly refugee and immigrant communities. We are looking at folks who have experienced duress from birth forward, their parents, so certainly the children too. Now they're without this place that has become their regulating force.

Our director resigned. Not because of that, that was just in the process. We had a shooting, you may remember, this is on Cushing Hill outside St. Mary's Women and Infant's, which is where our facility is. Four men in a car, shot. So, the parents who are now coming to the makeshift basement that we have for some of the children are walking through police tape to come to the makeshift place. One parent calls the director and says that she'd like that directors help in relinquishing her two-year-old. She is just exhausted, depleted, can't do it anymore. Wants the best for her child, feels it isn't her. The director calls me and says this mother is undocumented, isn't able to get access to care immediately unless she goes to an emergency room, but she is not going to present as someone in an emergency room, like the first mom I described. She's very sure she wants to relinquish her child.

So, our job is suddenly now defined by that reality. It doesn't fit my job description exactly, but it's part of this systems work. It is part of the responsivity of this role of early

childhood mental health consulting. What does today present? I was able, with our family advocate, to get that mom in to have the father of the baby come in to build a plan. I could call colleagues. I could find out which of the psychiatrists I've worked with could get her in somewhere fast. She ended up at the refugee and immigrant counseling service in Boston the next day. All of this was part of a system of care that was back to that tree.

You've heard enough about this today; I won't dwell much on this. It reinforces what you heard, which is that bizarrely, we invest more in late life than we do in early life, even though the return of investment for society and for individuals, is much higher if we do so early on. Here is really the best illustration. The blue line is telling us where we get the most bang for your buck in terms of years, in zero-to-three. We pay teachers least in the time of life when brains are most malleable, and growing, and forming. Their capacity to regulate themselves, to learn, to handle distress, to know how to ask for help, all of those things that lead to those preschool suspensions you've heard about are predetermined in zero-to-three, and this is where we are paying people the least to have the most impact. Our college professors, that orange line up there, are getting the most. Childcare workers are likely to live in poverty. Almost a quarter of them. It doesn't help that most of them are also of childbearing age, and so, use what income they do have to pay what we know are the exorbitant costs of childcare. If they have an infant, as much as 2/3 of their income in most states, including Massachusetts, goes to childcare.

Now I'm thinking about the stress being experienced by the adult caregiver of children. If that person is feeling stressed, how must their children in their care be feeling, and who is tending to them? If you take anything away from my portion of the afternoon, it's to note this particular resource. Go to the Brazelton Touchpoint's site when you go home, I promise you'll see ten minutes of video if you didn't already happen to be on this webinar last week, that will give you the sense of hope that I think we really need to keep alive. This wonderful set of videos comes from colleagues of June Lee who is at Harvard Graduate School of Education. Kelly Raudenbush from The Sparrow Fund captures an interaction between two Chinese orphanage workers and two babies at meal time. Dana Winters, who captures at an Atlanta, Georgia childcare setting, one childcare worker with three children. These two actions capture what June Lee calls a sort of turn in expectation we all need to think about.

We do carry the understanding that high resource communities are going to have higher quality offerings for children and childcare settings. For sure that's true. It is true that lower ratios and safer environments don't flood five classrooms. What Lee is looking at is where though is it happening in those places where we wouldn't expect it, like that Chinese orphanage, or at Horizons for Homeless Children, with childcare providers who are making less than $20 per hour, who are paying for their own childcare too, who don't have the vacation that we do. Why are we seeing it these situations and what does it look like there? He's asking, where is it possible that we may be seeing that the developmental needs of

children and the capacity of the caregiving adult are combining to create a developmental relationship that supports the child? And what makes that possible?

I would tell you that I see that at Horizons for Homeless Children. Someone mentioned training earlier on today, and part of it is that. We have 30 days of training by the time someone has been on our staff for three years. We have an investment in early childhood mental health consulting, which is not true for all childcare centers. We have three teachers in classrooms, rather than two. This is absolutely essential if you think about what is required now by EEC for documentation. You cannot be present with children with the kind of ratios that we think are acceptable for just safety. But for this, a developmental relationship, if we invest in the personhood of the caregiver, we are seeing connecting relationships between the caregiver and the child.

I think that it is really easy when we are stressed or dispirited, to see things in black and white. So, entertaining the idea that there are places and there are ways with the resources that we currently have or, sadly, with the commitment that we currently have, from society in general to children and families, there are ways we as clinicians on the ground, in the microsphere, and certainly in the big picture, can maintain that hope. One of the things that I do to keep that hope alive is I keep Steven Pinker's book, Enlightenment Now, on my bedside table, because it's filled with really great graphs and the research for this is so amazing that over a hundred pages tells you what the research data and footnotes are. For a geek like me, this is just gravy. I can go to sleep sometimes by looking at a graph like this. Because it tells us that, as scared as we are, and as in-our-face as the neglect is, the trends, if you look at the big picture, are good. They could also be better but look at this one. True, we're looking now at staying alive as opposed to quality of life, but one does require the other.

So, this is amazing. This is less exciting, but I like this slide because it tells us something either to be really embarrassed about, which can also be something that is motivating. So, if you're looking at where we are, it's sort of missing almost off the top there. So, it's as bad as you thought. Here is another good sign. Childhood violence and victimization. We're seeing this uptick, obviously, due to gun violence in schools, but in general, there's a trend that's good. So, I do have to constantly find things like this mantra to keep myself knowing what those graphs tell us. Because, in the microsphere, it can get really scary sometimes. We work really hard to try to give children this sense of safety in exploring the world. We want them to go out in the world, climb that tree, and know that there is support underneath them. And we want the community to recognize when one of its children may be at risk and take its responsibility.

So, I dream big. I take Arney Sweden statistics, I swallow them whole. It is what humanity looks like when it takes care of itself, right? Those 480 days of parental leave, the child allowances. I think too we want to demythologize parenthood, this is a bigger picture,

but this is my kind of rebellion against the baby shower experience. The reducing parenthood to something that should be celebrated, captured, commodified, rather than to understand it, as we do adolescence, as a complicated period in life.

I might say, boldly, I put more investment in parent education than sex education. I say that because every fifth-grade boy I know is on the web and learning what he wants to learn about sex that way. But nobody is really investing in parent education. All of our families are entering it blind, with that expectation set up by the baby shower. I'd use social engineering boldly. Just like the city of Oakland is deciding which potholes to repair based on what the socioeconomic status is of the streets surrounding it. They know that if some car that is owned by one of my childcare workers goes into one of those potholes, that's two days of work missing. Different from another community where it's not quite the high stakes.

I'd say that the NIH shouldn't be investing in those ends of life intervention to the same degree that they are now, rather investing in zero-to-three. Those are decisions that we can be making as voters. I would do more and measure less. I mean, lots of us now are running our programs, even at JF&CS, on federal dollars from SMASH, for which we're required to pay big time, and possibly this is true for you too Gemima and the grants you get. So, we're paying for evaluation services, the work of doing the work is considered experimental. We're constantly experimenting. When the fact is we already know all of what we need to do to support children in the first three years of life. There is nothing yet to be discovered. It is one-to-one intensive, reciprocal care. And how do we make that happen? I read the attachment for mothers. There to me more inspirational. We hear lots about Bowlby and Winnicott and all those folks who got the credit. But here are those who did a lot of the work that informs what we do today.

Lastly, I'd like you to just close your eyes. I know you're tempted to read along. But if you could, just close your eyes. We've talked about a lot that's really evocative and stimulating. For me sometimes it's on the edge of depressing, but I hope I've given you at least a couple of examples to think about that we could be investing and spreading more, and then I'd like to leave you with this, a poem I got from my friend Rema Olivette, a midwife who works for WHO in Paris now, and she posts a poem every day for caregivers, because she knows what we are facing if we care for women and children. This is a poem by Rebecca Badger that she wrote her daughters.

I want to tell you that the world is still beautiful
I want you to look again and again
To recognize the tender grasses curled like a baby's fine hairs around your fingers as a recurring miracle
To see that the river rocks shine like God
That the crisp voices of the orange and gold October leaves are laughing at death

I want you to look beneath the grass,
To note the fragile hieroglyphs of ant, snail, and beetle
I want you to understand that you are no more and no less necessary than the brown recluse, the ruby throated humming bird, the humpback whale, the profligate mimosa
I want to say, like Neruda, that I am waiting for a great and common tenderness
That I still believe we are capable of attention
That anyone who notices the world must want to save it

Thanks.

Dr. Satin:

This is really a perfect ending for this sequence of presentations we've had today. With Dr. St. Louis talking about the world wide perspective on childhood and its needs and its services. Dr. Kerzner, talking about the complexities of the relationships between individual, family, and community. And McElaney, giving a perfect example of the definition of community mental health that Dr. Lindemann would subscribe to. Dealing with life crises, engaging in preventive intervention, to see to it that the outcome is constructive and not destructive. Involving and respecting the roles of community care givers, obstetricians, grandmothers, physicians, and so on. And helping those community care givers to be more sensitive and more effective through what he would call consultee centered mental health consultation. Talking to caregivers about their roles, not necessarily about their patients. It's a cycle that has been completed. Now we are privileged to hear an interaction among the presenters and with the audience.

Discussion

Dr. Kerzner:

So, are we first going to explore your questions, your comments, and I guess the second part would be for all of us to say what we have experienced ourselves?

Dr. Satin:

Whatever moves you.

Dr. Kerzner:

Whatever moves me. I'm going to get up. So what about your comments from what you've heard from all of us? What about your questions? I know once someone is brave enough to ask a question there is a ripple effect. Let's see if anybody has a comment.

Participant:

This may be very obnoxious. I am obsessed with the children in the orphanages and the refugee camps, and you know the war victims. Are we headed for a world of children who are so disconnected, and so bitter, and so angry, and potentially violent, what happens with all of that energy? Are we ever going to be able to make anything good out of all that? I mean, I just feel like there is so much potential for disaster.

Dr. St. Louis:

I think that's a wonderful question, as concerned global citizens, it should be a concern to all of us. I think part of what we also need to hold onto is the knowledge that, even in the context of war-torn regions, it doesn't always mean that all hope is lost. I think certainly for somebody who works, as I have most of my life working with children and adolescents, I am always of the mindset that it's never too late, right, to intervene. It's never too late to bring mental health services, and other types of social support services, to make a difference in the life of a child. So, even in these dire circumstances, and knowing what we know, certainly about long term negative impacts, there are still opportunities. If we can certainly stop wars from occurring, you know, what are the resources. I know from the presentation that you just gave, Lisa, that we have to find ways to maintain that hopefulness, that level of optimism, and also finding ways to bring resources early enough so we can counter the long-term negative impacts.

Lisa McElaney:

I guess I would say too, that as much as the xero-to-three time period is so critical, it is also indicative of what resilience we have as human beings. The sad truth is, that children through millennia have never been treated the way kids should. Childhood is really an

invention of post-Victorian worlds. They used to be small adults, they were people and future laborers. So, the awareness we have of the developmental experience is really relatively new for us as human beings. But I think it offers a really amazing window into what potential there is. Now, there are down sides to living in this world of too much information. Some of what I think you're experiencing, and I experience, is subjecting ourselves to a lot of information, flooding us all the time, that we didn't always have to the same degree. It is important to keep that perspective too, that these things were happening and we didn't know. We just need to think back to Winnicott and what work he was doing working with children who were deprived of any kind of human contact, to know that too, exactly what Gemima says, later interventions made differences. So, not a panacea, but support.

Dr. Kerzner:

I'm just where you're at now. Very, very concerned, and very worried. I guess what both of you have been saying, in my clinical work when you have someone that improves and regains a pathway in their live and feels better, than that really helps me, because there are some people who really do improve and come through their stuff. The new research on neuroplasticity is that the brain can change at any age. I can't believe my brain can change at my age, but the brain can change at any age. One of the best books on that is How the Brain Changes Itself by Norman Doidge. If you want to have a little optimism and you want to feel a little bit better about the situation, How the Brain Changes Itself by Norman Doidge. It is a phenomenal book of optimism and hope.

Participant:

Yeah, I think I have a really loud voice. So, it's related to what you said, and it is also related to Dr. St. Louis, and hope with reason, I hope. Task shifting, Vikram Patel's task shifting in global mental health. Do we know it? Well I'd like to offer that as hope with reason. He's a psychiatrist, he's from India. I'll give an example of task shifting, if it would help. The grandmother's bench in Zimbabwe. Yes, are people familiar with this? Grandmothers have life experience, and some of the way that you talked about stakeholders, is what Vikram Patel talks about with task shifting. So, these grandmothers are trained in some basic interventions for mild to moderate depression and anxiety. They literally sit on a bench, in the village, they're trained, they're also trained to refer, and they sit and they talk with people one-on-one and people feel better. That is just one example of the kind of task shifting that you might want to explore because it gives some hope, and it addresses the brain drain and it addresses the workforce problem, the staffing problem globally in mental health. Thank you.

Dr. Kerzner:

Just one thing in terms of grandmothers sitting on a bench. The basic meta-psychological components of connecting with another human being, listening without judgment, compassion, reflecting their affect, this is so powerful Why wouldn't we try to get grandmas and grandpas to do that? Now, I bet they don't need formal training in the way we think of it. So, I'm so glad you brought that up. It is so powerful to take a walk along the beach with a friend. Why do you feel better at the end of the walk?

Participant:

Especially for Ms. McElaney, I have enormous respect and adoration for the work that you've been doing, but I am really rather saddened and confused that you talk about parent education and counseling, but all of the examples you gave were mother-counselor and mother-educator, and father's didn't exist. You then talk about how can we waste all of the talent in the world by not training all of the professionals in different fields that interact face-to-face with children, and you ignore the roles of fathers and men, and grandpas. What do we do with that?

Lisa McElaney:

I think it's a great question. It's a real conundrum. Today's paper had some really terrific news, it's in the business section, it's not my normal place to find, but it's looking at the changes in policy and performance, if you will, of fathers in early childcare. So, I often find myself in this weird place between my ideals and my reality. Every single case, every single family referred to us is a mom. I would say probably 70% of them don't have a partner, a male partner, who is involved in this early childhood experience. So, in terms of my particular examples, I am dealing with a population of women caregivers both as professionals, and there is one male caregiver in the childcare center where I work. Terrible, but true. I am working mostly with mothers rather than dyads. Occasionally, and in one practice I'm in, I'm working probably 30% of the time with couples, but those who are doing the heavy lifting in terms of at risk of attachment, who are referring into our practice, are mostly women caregivers. Most of the work I did in my prior life was addressing both sides of the equation, in my clinical life it's not who is coming.

Participant:

Well I think maybe who is coming as opposed to who is out there. There have been generations of fathers and grandfathers, and their wives, who both worked in factories, on different shifts, and the both raised a child. Not seeing each other very frequently but being with their children. There are all kinds of situations where men are clearly there, but no one bothers to ask the questions. My wife and I were looking for a pediatrician years ago, we had to female pediatricians who would not establish eye contact with me during an interview. Needless to say, we did not use those pediatricians. But, they're out there, and the

assumption that men just don't know the questions automatically—and also, you talk about working hard to get people in minority groups into the helping professions, where are people encouraging men to go into early childhood care? When I was looking for draft information, I got a job with the city public schools, in elementary schools with small children, I wanted to work in first grade, kindergarten. I didn't take the job because I couldn't justify it in terms of teaching children whose fathers were in Vietnam getting killed. But, in any case, every single person comments to me, "well that's great, you go to grad school and become a principal and a superintendent".

Dr. Kerzner:

I think what you're saying is very powerful and very important. But I do see a few more hands. There are some male childcare workers in this room, by the way.

Participant:

In hearing what you just said, with the lack of examples that involved fathers in families. Also look at the trend of what single motherhood looks like. You have to look at what the reality we're living in is. The reality is we don't see much of those single fathers, but they exist, and they are out there. So, with you speaking on that I do appreciate it, however, she did speak from her experience and where she's working. So, I mean, you can't really be mad about the lack of examples. Although my comment is more so, when we talk about this community, we speak about, you made a point about the lack of diversity when it comes to these professions. And to me that is a concern as someone who is looking to be a LMHC, a licensed mental health counselor. How do we work towards building, breaking down that stigma that does exist, because that's a part of the issue that is created when you have a lack of professionals and a lack of diversity, and a lack of motivation to move into a space where you might not feel the most comfortable because you look the most different.

Dr. St. Louis:

To the comment that was a made a few minutes ago, in terms of the involvement of fathers, there are a couple of organizations that we have partnered with. I just want to let you know their names. The focus, the mission of these organizations is specifically on engaging and working with fathers, specifically early on in the child's development. One of those organizations is called Fathers Uplift. Their primary goal is to target specifically urban fathers who may have been disconnected from their families. The other organization that also focuses not only on fathers, but young adults, urban males, is called The Base. They are doing a phenomenal job in the community. So, in case you were interested in learning more, I would encourage you to Google those two organizations, because they are doing really an exceptional job.

Participant:

Can you hear me? My name is Howard King, I am 88 years old. Something happened to me when I was 11 that I was unaware of. I came today because I wanted to share with the group, at their request, what I've learned, and when I learned it, so that it might be useful to others. When I was 11 years old, there was a major disaster in our community. It was called The Coconut Grove. Four hundred and ninety-two people were killed, and many others were injured, and their families were seriously impacted by their grief. In November of this year an article was written in the Harvard Crimson entitled, "How a Fire Impacted How We as a Community Deal with Grief". All of you can find this article if you want to. But, it was a person who was being honored today, Erick Lindemann, who was born in Germany, came to this country in the 30s and in the 40s, in the midst of this disaster, was requested to reach out to the many people who ended up in Mass General, and their families that were in major grief. One person said, "I lost my wife in the disaster and I didn't lead her to rescue". A few days later, looking seemingly happy, he opened the window and jumped out and killed himself. That experience, it reflects the importance of grief and what Erick Lindemann taught me without my realizing. Until a week or two ago, before I began to do some research into who is Erick Lindemann? What role did he play in my life, professionally? Erick Lindemann went to Mass General, worked with the many families that he dealt with, and I without realizing it have an immense gratitude to help me become the kind of person I've become. I wanted to share this experience with you, and I hope it will be useful.

Dr. Satin:

Let me thank you for coming and for helping to make this such a rich experience. The panel is just extraordinary. To cover the world all the way down to the specifics of individuals is wonderful. I promise you that this Lindemann lecture will be available on the internet within a few months, as soon as we get it processed. We will ask to have the slides included so that people can have a full re-experience of the Lindemann lecture. Remember, there are forty-one other Lindemann lectures that will be online, so you can look back into the rich experience from the past series of lectures. And, being optimists, we expect to be here again next year with another topic of importance in social psychiatry, social medicine, and social issues. Please let us know if you have some suggestions about what would be good topics and what would be good speakers. We appreciate some help in making this as rich as it is.