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

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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 TWENTY-FIRST ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Surviving and Thriving: Community Mental Health Programs in These Times

The term "Community Mental Health" is little heard these days, but community mental health programs are found at all levels of government, as well as in non-profit and private endeavors. How have they adapted to the current environment of lower priority, limited resources, managed care, and competition from venture capitalism? What strategies allow them to survive and even thrive? What resources make for resilience in this climate? How do mental health professionals, governmental bodies, advocates for those in need of services, and communities relate and develop "pathways toward trust"? This Lindemann Lecture offers a spectrum of practical models of struggles, missteps, and successes.

Lecturer

Robert L. Evans, EdD, Executive Director, The Human Relations Service, Inc.

Discussants

Peter D. Kirwin, MSW, LICSW, Director, Town of Falmouth Human Services

Brenda Lindemann, MPH, CHES, Vermont Agency of Human Services; Vermont Health Department; School EPSDT Health Access Program Liason; President's Summit for America's Future: Vermont's Promise, Coordinator

Moderator

David G. Satin, MD, LFAPA, Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

Friday, May 8, 1998, 2:00 – 4:30 pm

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

Introduction by David G. Satin, MD

This is an era of lowered priority for human services, and increased prioroty for personal and business reward. This is often accomplished under cover of claims of eliminating waste and fraud without diminishing services.

Thus, by definition, community mental health has lower priority and higher criticism, and diminished support. Community mental health programs are faced with the need to integrate the values which originally inspired them, maintaining high quality services, and finding the means of survival and success. Part of this is finding moral and financial support locally rather than from government sources. Some find this inevitable and beneficial. In his book *The History and Politics of Community Mental Health* (Oxford University Press, 1981) Murray Levine says:

> ...Now it may well be that large-scale, planned solutions are invariable chimerical and self-defeating. Perhaps, in accordance with the anarchist insight (Sarason), we outhgt to eschew centralized governmental solutions in the future. Sarason seems to agree with Kropotkin (in 1899) that any large-scale governmental effort will inevitably fail in the sense that it will reduce the psychological sense of community, and reduce the sense of responsibility primary groups feel for solving the problems of their own members..." (p. 103).

Erich Lindemann and Frederic Ilfeld wrote a paper in 1971 entitled "Professional and Community: Pathways Toward Trust". In it they outline several models of working relationship between health professionals and communities. They are "Paternalistic", in which professionals are the authorities in a setting of values and methods shared between professionals and community; "Cooptation", in which community residents are incorporated in professional practice as liaisons with communities; "Collaboration", in which professionals and communities negotiate cooperative working relationships; professionals serving community needs under community direction; and, the ideal, mental health professionals developed from within the communities themselves.

In this Lindemann Lecture we will hear the experiences of community health and mental health programs and their relationships with communities, and their pathways toward survival and success.

Robert L. Evans, EdD

Executive Director, The Human Relations Service, Inc.

Introduction by David G. Satin, MD

Let me introduce this year's Lindemann Memorial lecturer, Robert Evans. Dr. Evans is the executive director of the Human Relations Service, Incorporated. He is a clinical and organizational psychologist, and was at one time a teacher of French and English in various high schools, so he knows education from the trenches. He received his doctorate from Harvard University in 1974 and joined the Human Relations Service staff at that time. In 1981 he became its director. As a clinician and administrator and a consultant in schools, he gradually specialized in the administration and consultation fields, and consults to schools throughout the United States and Canada. His special interests are in organizational change and resistance to it, in leadership, and in the changing relationships between families and schools. He recently published a book called, 'The Human Side of School Change.' Human Relations Service is a private corporation which faced crucial changes in public policy and funding. Its experience of survival may not be as idiosyncratic or as of narrow interest as Rob Evans modestly suggests. This year, for example, it is celebrating it's fiftieth anniversary. Its survival is triumph, and we may learn valuable lessons from its experiences.

Robert L. Evans, EdD

Thank you. It remains to be seen about as David knows, and I had some apprehension. I am Erich Lindemann's administrative heir, actually one of two in the room, since Dr. Fran Mervin, who is also here and was my predecessor, and also qualifies for that title, and I don't know what Erich Lindemann would have imagined about a fiftieth anniversary at the agency he started in Wllesley. I don't imagine any of us could have forecast what we'd be like fifty years later. I certainly couldn't for myself, anyway, and I've been happy to anticipate being here and also a little apprehensive.

I'm happy to be here, first, I get a chance to see Betty again, and that would make it worthwhile alone, and to see other old friends as well, and because it is the fiftieth anniversary of our little agency, it seems somehow fitting to be here, but I've also worried a little that somehow we would just be a gathering of the truly faithful, huddling together to share out similar views of things and sort of talking about the world as it used to be and is no longer, becuase I, at least, as I get older, feel a stronger wish to do that.

Second, although in a way I make a living sharing my views, around a number of the topics for today, my views I don't think are much different from those of vast numbers of

other practioners and indeed no more informed than theirs. And third, although I'm going to share some with you abut out experience at HRS in its post-Lindemann era, there is, has always been to me sort of a problem about trying to extrapolate from one place to another and to draw generalized implications and theoretical points of application, when so many of the things that go into the life of any institution are so idiosyncratic.

For example, we have for years tried to study organizational leadership, and look at successful organizations, whether they're companies or schools or whatever, and find out what the leaders there do, and then figure out how we could teach that to other people. This has actually provided lots of academics with a good, steady living for a long time. But it hasn't led to a vast improvement in the leadership of organizations, because it turns out often that although you can make a list of the tasks and the functions and the skills that are required, and this might be relevant, no person filling a job is a list of tasks and functions and skills, but is in fact a person interacting with other people.

And so you can learn financial management and you can learn principles of supervision and evaluation and this and that and the other, but applying them to people is a different story. And in our case at the The Human Relations Service, not only was the beginning unique but to this day we're odd and eccentirc in some ways, and different in some ways that I'm going to mention, and so although I want to share some ideas about things that I think have made a difference and can make a difference in the surviving and thriving of institutions in mental health these days, I am a little modest about how much our experience applies elsewhere, and that's one of the things I hope we'll have a chance maybe to talk about a little together.

I am not going to try to give you a comprehensive history of The Human Relations Sevice, which some of you who are here know better than I. I do want to try to talk about some of the passages we've been through that are relevant, I think, to the larger world of these times that we're in. I was thinking a couple of days ago that from one point of view, if you backed up fifty years, probably people would have been delighted to think about how broadly some basic notions of, say, prevention and early intervention have become filtered throughout our scoiety.

If you pick up the Boston Globe, yesterday's, the back, there's a huge list of events and activities and organizations devoted to everything from self-help to various kinds of prevention and intervention and so on in an effort try to improve the quality of people's life and functioning, things that never would have been there a couple of decades ago, and certainly not further back than that.

There is at this point a fairly widely accepted notion that early experience makes a big difference in life. We've held on to Head Start despite sort of strong attacks against. It got a lot of validation just a couple of years ago. We had a huge spread of things like

employee assistance plans in the workplace, in which the corporation pays money to somebody to provide short-term counseling and other kinds of educational and early intervention services to employees, because business people got persuaded that this would save them some money, and would be a good investment in their people, and that you could prevent and reduce different kinds of problems that would be diffcult in the workplace.

In theory, what we refer as health maintenance organizations, if they actually did any health maintenance, would also qualify as an example of this. Even if you just watch TV on a random night, you will see a lot more acceptance of psychological explanations of behavior, and even a routine understanding of psychosomatics and other sorts, than would have had a couple of decades ago. So if we wanted to make the case, we could make the case that an awful lot of the ideas that Erich Lindemann and his early colleagues pioneered and helped nuture have actually flowered in a variety of ways, and actually come to be taken for granted at vertain levels of our society.

On the other hand, prevention has never been well funded. To my knowledge I don't think it has ever gotten more than one cent out of every mental health dollar spent in this country, and it's certainly getting less today. If you were listening to NPR yesterday you would have heard a report, an audit was just done on medical benefits with a special emphasis on mental health benefits, showing they have declined fifty percent in the last ten years of managed care. The typical employees medical packages now covers less than it used to, but it covers signficantly less in the way of mental health benefits than it used to. Government funding has been slashed and whittled at the state and federal level, we're examples of that.

There has been an upsurge of medical and biological approaches to all sorts of mental illness and a consequent downturn in funding for and support for social and interpersonal and other kinds of interventions that would try to address those problems, and, as I'm going to try to suggest later on, I think there are some ways in which the general notion of interpersonal and psychological explanations for life, living and problems in living has lost an ascendancy that it used to have, that there are some ways in which the tide seems to have passed us by in some respects, which presents a set of challenges of its own as well.

So I thought, since it fits my nature a little better, that I would indulge in some of this depression with you here this afternoon, and count on the panelists maybe to help us out a little on the upside, but actually, not exclusively.

For those who don't know us let me just tell you a little about HRs history and then try to draw some implications from it. We are a tiny little agency located in Wellesly, Massachusetts, not too far from here. We have a $1 million budget and about thirty

employees, although if everybody was full time we'd have about sixteen. So we are tiny, even though that's twenty five percent bigger than we were eighteen months ago.

We serve primarily three white, wealthy, suburban towns: Wellesly and Weston, which we have for decades, and more recently the town of Wayland, though we see people from all over and we run a variety of other programs too. Most of them we have developed in the last ten years, but not all. We have always provided consultation services to our local schools, which they still pay us for. We provide five employee assistance plans to local institutions, we provide college counseling to local college students under contract at Babson College, and we run a small summer day camp program for special needs preschool youngsters. I'll tell you a little more about some of the specifics under these.

So we are in a modest way, similar to many other outpatient clinics that have served the state for a long time, with the exception that most of them are a lot bigger, and many of them have gotten even bigger as they have merged in a desperate effort to stay alive in these last five plus years. We don't serve the same communities, not nearly as diverse communities, as many other agencies do, and we don't provide a whole network of servics that range all the way up to day treatment, for example, and other kinds of things beyond outpatient counseling. We have been a little different also in that the agency was founded, as many of you will know, not to provide treatment primarily, and in fact the early going was much more oriented towards research and towards prevention services, and for a good while the agency was a training arm for The Massachusetts General Hospital. Residents would come out to work in the schools and in the community in Wellesley and so on, and so that our history has always had, from the very beginning, a strong push and press and impressed in community and prevention, and in early intervention.

History, howeever, as has often been the case, has gotten the better of us in that you can't do prevention work well without people wanting to see you for treatment. The notion, actually, which I remember I once had, that if you did enough prevention you wouldn't have to do treatment, turns out not to be ture. If you do good prevention you do good case finding without trying it, and people say, "gee, that was helpful. I'm having a problem with my daugher, can I come and see you?" So in fact for decades now we have been primarily a treatment place, and not primarily a prevention, and certainly not a research, place.

Those traditions, as I will try to say later on, have nonetheless been very important to us and made a difference in our coping at least up to the present. A couple of other things that are worth mentioning: unlike a lot of agencies, we have had an extraordinary degree of continuity in terms of the people who serve it. Most of us who work there have come there and stayed there, and in fact, Zelda Rider, who is sitting right over here, is I

believe the longest serving employee we have ever had, and is retiring this year after thirty five years of serving us as a social worker at the agency. We have others who have been with us for twenty five, comparative newcomers, and so on, but we also have board members who will frequently make, as it turns out over time, a commitment of ten, twelve years or more, not all at once, but in terms of staying with us over time. So it has been a place that has not had, as many agencies have, a revolving door of staff and trustees, which has then meant that there is much less institutional continuity when it comes time to cope in a crisis. This is actually, I'll say in a few minutes, has been very, very helpful to us. If you look further back in the agency history, you can find a couple of crisis points, and these could be viewed differently by those who are internally and externally affiliated.

Back in the sixties, when the Commonwealth of Massachusetts was creating, in the wake of the federal mental health legislation and so on, a network of community outpatient clinics, they essentially used an HRS model in creating what were called partnership clinics. This would mean that each community, clusters of towns, would be served by a small outpatient agency, or not so small in some cases, which would provide a range of services, and ideally some prevention and early intervention services and community outreach and so on, and in exchange would get some state dollars and some municipal dollars, and then would earn money with the rest of its time and try to put this package together in a way that would enable it to serve a broad spectrum of a community according to what folks could afford. The people who were instrumental in linking HRS up with the state in the late sixties, I remember several of these folks and folks on the state side will tell you that they saved the agency from going under when it no longer had the labor provided by Mass General psychiatric residents and that sort of thing. My own view when I got to the agency was that the agency had sort of done the state a favor by agreeing somehow to linkup with it in some way, so I guess there are different views of this.

In any event, from then until about the nineties, the early nineties, about a third of the support came from the state itself, and we derived then additional support from the local municipalities and earned the rest of what we needed, like many clinics did. The 1970s, I don't know how many of you remember this vividly, were sort of the heyday in a way for community mental health. Budgets were fat and rising, there was a lot of interest in child-based work, in prevention, in early intervention services. Municipal budgets were going up, inflation along with it, but nonetheless there was a lot happening. Third party payments came along, and thanks to Fran Mervin we were the first agency in the state that got eligible for those, and that made a huge difference to our ability to grow, and at that point $500 of outpatient treatment a year looked like a gold mine. A gold mine.

We had no idea, of course, that it would just stay at that level forever and then get whittled down as time passed, but it bought you a lot of service at that time. And so the agency experienced some rapid growth then, and was able to build on the basis it already had, and entered the eighties and lived through most of those in very good shape as well. One of the things that happened when I became the director was that the task facing me was essentially to maintain traditions and practices that were already in good shape, not to change things that were not in good shape, and that continuity was very helpful to us as well.

However, life got tougher, and in ways that we couldn't have expected, and that seem to me to have been duplicated in places all over the state, if not further abroad in the country. For the really sort of twin traumas that happened to us in the late eighties and early nineties. The first one was that in the wake of state budget cuts and the shift in priorities, the administration in Massachusetts decided that it was going to cut back and peel back on community services. Over an eighteen month period we had all of our state support eliminated, which meant we lost the money that had paid almost a third of our salaries. Gone. We still had the people to see, but we didn't have the revenue coming in for that amount.

Then in addition there was the acceleration of managed care. I've promised myself often not to use that word anymore. For a while I've been using managed cost. And then today, before I came here, we got two pieces of mail from two managed cost outfits. One of them was asking us to update the listing of our practitioners, almost all of whom were listed with wrong names and addresses in Missouri. The other one was a reminder from the people who managed the Medicaid stuff in Massachusetts that we had not submitted our quality improvement plan, and I was realizing they actually haven't paid us, in eight months, anything. And so I'm not sure management is actually a good term for them either, managed cost, whatever.

But in any case, what happened was, as all of you know, was that people began to lose access to coverage and access to treatment, and this began to make a huge difference as well. So if you can imagine the scenario in which you have the same services to deliver, but you lose thirty-three percent of the subsidy that supports it, and at the same time the folks who are able to pay are less and less able to pay. This is the scenario that's been repeated all over the state. It provoked for us a crisis on a couple of fronts: the obvious one is literally making ends meet, and the larger one was to recast for ourselves what was the future going to hold, and how would we adapt, and how would we first survive, and then would there be a way to thrive after that. What we did, and here I want to remind you of something I said in the beginning, I can start describing things that worked, and that would in theory work anywhere, and actually are not rocket science, as you'll hear in a minute. I do think it's important, nonetheless, still to be modest about whether just

anybody is situated in their current setup so that they could simply do this. Not because we're so great, but because of some of the uniqueness of our situation.

The first thing we did, of course, is tighten our belts, and we went four years without any salary increases. We decided that we were not going to lay folks off, we were not going to turn people out of treatment, we were going to keep providing the services we possibly could, and we were going to try to sacrifice if we could, to make ends meet. Second, we did what some of your introduction alluded to in a way about the government stuff, that is we got our board more active and started raising more money, which we had always done, but they redoubled their efforts and actually made a huge improvement in that area. That was not nearly enough, but it was helpful.

As this was happening we then actually spent a fair amount of time thinking long and hard, and what I guess you would call strategic planning about what were we going to do, and there really were a couple of options in front of us. One of them was to figure out what would it take to survive, and the second was would that be worth it? Because there were a number of us, yours truly included, who were willing to consider the prospect that we would not choose to survive at all costs.

That is, for example, what a number of agencies decided they had to do was go chase money, that if a grant came for this, you should apply for it. If a grant came for that, you'd apply for that, even if these were services you didn't know how to do and hadn't previously delivered, or that didn't fit well with your other stuff. There were agencies that fired every one of their salaried employees and offered to rehire them on an hourly basis without benefits, for example, thus helping morale to plummet overnight, and to diminish institutional loyalty immediately, and that kind of thing.

We decided not to do that also. We had a question then which we have had more recently in a very different way, that really came down to, well, so, who are we, and what are we here for, and what are we going to do? Nobody would have been happy going out of business, that's for sure, but we weren't prepared to survive at just any cost, that is, in the sense of just becoming just anything. We weren't prepared for example, to find a way to just serve people who could pay and make ends meet that way. What we did do was have a lot of endless, I think it's fair to say, Zelda, we had endless discussions among the staff about this, and we had protracted discussions with the board as well.

What we decided finally was a policy that had a couple of fairly simple, and in some ways I guess obvious, components that we would stick to. One, that we had always seen our mission as being to treat and to reduce and to prevent mental illness as we could in the places we were serving, that we would do that to the absolute best of our ability, even if we couldn't do it as much as we would wish. For example, we could no longer offer such reduced fees as we had before because we had less subsidy—we just couldn't do it. But we would still not abandon that commitment. Second, that we would look to develop

new services that would have a couple of characteristics. One, they would be close to our existing competence base. That is, we would try to build on strengths, rather than develop new things that we didn't know anything about, whole new service areas or skills. And we would try to develop these right close to home, even if they weren't immediately in the towns that we normally served, so that we would stay close both in terms of competence and in terms of geography. We weren't going to be opening satellite clinics fifty miles away, and stuff like that. We hoped in fact that what we would be able to do through this kind of a strategy would be to generate some new programs that might actually make money, and throw off a little money that we could then plow back into the subsidy of our basic community clients whom we didn't want to abandon. At the very least that these programs would help to sustain the viability of the agency so that we could keep serving those folks. It's been a very successful strategy, and it hasn't been just successful because we're wizards, but partially because of where we're located and whom we serve and so on. It has made a huge difference to us, and has paid off in a number of ways.

A couple of things made it possible to work our way through this, and most of them have to do with people. We have an unusually gifted and committed staff and board, and we have a strong history thanks to our origin of community connection. For example, we have a board of thirty, which is a lot for a little place. Actually this is the first year we've ever had as many employees as trustees I think in our entire history, at least since I've been there. You don't need thirty people to be the trustees of a tiny little agency, unless part of what you feel you need is normal people to vouch for you, which in mental health work turns out to be crucial. And we have a board which has, I'm proud to say, very few mental health practitioners on it, and we have always benefited hugely from this too. We have normal people, not those who work with deviants, not those who work with the fringes, who live on the fringe enough as it is in our work, and we have always benefited from having pillars of the community and ordinary folks with brains and commitment and who have been willing to invest themselves in the agency, and this has been helpful to us.

It was particularly around these hard times here, because we had a cadre of trustees who had been with us long enough to have some institutional memory, and who have had a real commitment to the place, and whose heads would nod if you mentioned the word 'Lindemann' for example, even if they had never met, well, actually some of them had met Betty, but many had not met any Lindemann, but would nonetheless know something about the tradition and the history. We had for some time had a policy, for example, of inviting ex-school committee members when they retired from the school committee, or former selectmen, or we almost always had the police chief, and we

usually had a clergy person or two, and other folks who played other kinds of community roles like that, and they were crucial to us.

There was a grim and bitter night during the darkest hours when, in addition to the state cuts and the HMO damage, the town of Wellesley had a belt tightening and was going to make a major cut in its municipal funding to different things. At a selectmen's hearing somebody floated the idea that maybe they should stop all mental health funding, which would have been sort of the final straw, it seemed to me. When I got home that evening, about as depressed as I'd been, the phone rang and it was the president of my board who'd been there with me, and he said, 'Don't worry about this. I'll fall on my sword before I'll let this happen.' And although a lot of people could have assured you, I knew that this guy knew what he was talking about, and actually could do that, and would do that, and that sort of stuff made a huge difference to us in having that kind of critical support at the right time, and having connection that would sustain for us local support when other larger ones were fading away.

So what we did was this: we developed five employee assistance plans over a period of a couple of years, serving local municipal employees and local colleges, for example. We expanded on our school consultation work and began relationships with some other schools in nearby towns that are not the primary ones we serve. Then over a period of a couple years we developed some other services, one of which was sort of a throwback in a way for us, in that we, way, way back at HRS' early beginnings, the agencies founders had, among other things, taken themselves off to meet regularly with local clergy and consult with them, help them in their work, and also with local physicians. We went back to the physicians and created new arrangements with local pediatric practices, in which we essentially took care of all of their mental health intake, whether we would see the child or family or not. But the doctors who were scratching desperately to find out who on the managed care list would be appropriate to refer their six year old to could have the family contact us and we would take care of it, and do all that stuff and get them squared away and provide them with treatment if it was needed and so on, a relationship which has exploded over a couple of years time into just a boatload of referral and work to do, and has given us as an agency a whole new access point to children and families in the early stages of all sorts of conditions that we had formerly been seeing later on when they were much more severe.

For the first time in years we were able to do a lot more work with parents of young children. For example, instead of, say, just adolescents who had come to be by far for a time the largest part of the child population. So the net effect of all that has been to cause an eruption, really, a rapid growth in intake of patients and so on, and we also took a page from our old history in a way, although with some misgivings, and we made some compromises with the devil, and formed some managed care alliances, not many, but

some, and that made a difference in terms of who had access to be seen and who could use their coverage to come and see us and that kind of stuff, and all that made a difference to us as well.

And so we passed from a time of great crisis to a time of euphoria, to a time of rapid growth, which we said, 'Isn't this a better problem to have?' Only now it just seems like a problem instead of a better problem in some ways, because the thriving part seems to be not so simple either. Even though it's better than worrying about just the surviving, and we have had rapid growth which has caused us over the last two years to have to increase staff about twenty five percent. It has required us to think about whether our campus, if I should call it that, is big enough or not, and what would we do about the fact that we were having an influx of work, not just from the towns we serve, the three primary towns in our catchment area, but from surrounding communities. It looked very good on the bottom line, but it was starting to create other kinds of pressures.

So last year at this time we were having, to my amazement, anxious discussions about how to manage growth. Some of the same themes recurred that had happened in the depths of 'How will we stay alive?' like, 'What are we here for?' Because in fact we could, and from a business point of view, one would have, say, opened up a satellite, kept on growing, and maximized the income, and we had a couple of drags on that made us pause and ultimately hesitate significantly. One of them had simply to do with quality, another had to do with quality of life, I guess they're related in some way. The third, and in some ways the most important, had to do with mission and purpose.

The quality issue was fairly simple. There has been a lot of received wisdom in the last ten years that the future belongs to the big. All these hospitals around here are just going to be one thing, it seems to me, in a short time. And in mental health the wisdom has been that the way you would survive would be to get bigger and provide the full range of care, from the most preventive, if there was any option to do that, to all the way up to day treatment, everything short of hospitalization, and that the places that would survive would be the places that would be big enough and that would be like that, and that the managed care and the other insurers would want to deal with these kinds of outfits, not with little, separate places. That's how you would survive.

And so in Massachusetts at least, I don't know about elsewhere, people have been merging frantically, and when they haven't been doing that they've been going out of business, and going belly up. We had several offers to merge, which we turned down, and then we then ourselves were not convinced that the future, at least for us, belongs to the big, and we began to think of ourselves more as what the business folks might think of as sort of in a niche market. We do, unlike many agencies, serve towns that have a lot of folks who can choose to pay out of pocket for service, by no means everybody, but a sizeable number which gives us an opportunity that, say, that many inner city agencies or

rural agencies would not necessarily have. That's part of what I meant about thinks being different about HRS—it's not us, it's the setting.

Second, that also meant, however, that those kind of folks will not pay money if they don't have a strong conviction that what they're buying is quality. That matched up internally in that most of us would not be willing to work there if it meant the kind of prostitution of services that was going to damage quality. My experience over the years has been that if you want people to make the sacrifice that it takes to work for the money we can pay, they have to be convinced that what they are doing is serving a mission which is larger than just making money. When I said they have to be convinced I don't mean by pulling the wool over their eyes, I mean because it's true.

And, finally, for a lot of us who had been there for a long while we didn't want to split in two and have satellites, and have tons of people we didn't know, and have the workplace be utterly different on us. I know this shouldn't, kind of, figure in our planning in a way, but it actually turned out to be very important. Last year, literally at this time, I took this dilemma to the board to say, 'Here's where we are. The work is coming out our ears, the intake is going like this. We could keep hiring, we can grow, we can subdivide, but we have these hesitations about it as a staff. We want to know what you think.' We had long discussions, and the board turned out to have very strong views about this, which is, we're here to take care of our communities. We are interested in preserving the service to the folks we are primarily here for, and we think that's actually crucial to our essential survival in the long run. And so we made some conscious decisions not to get bigger, to concentrate our work most locally and to, in essence, turn away and send elsewhere a significant proportion of the clinical work that was coming from well outside our precincts, which we have done all this year, and which itself, actually, has been more of a hardship than I had imagined.

You know, one dilemma when you get burdened is that you get attached to your burdens. You complain about them, and if people offer to lift them from you, you say, 'No, no, no, that's all right. Somebody has to do it.' For example, the folks who do the intake of new cases at our place who now had to send away some cases from towns far away and connect them elsewhere hated doing that. They were convinced that we could do better service for this youngster and his family than somebody we were sending him to, and it felt terrible to them to say no. We had never said no. We had run a policy that goes back decades, well beyond me, during Fran's tenure if not before that, in which we do not construct a waiting list. You call us up, we will see you within a week of your call with very rare exceptions, no matter what it takes, and we haven't been able to do that this spring. It's been very hard also on the intake folks not to be able to respond as promptly as we would wish. But nonetheless we made this decision at the moment so far, we're about to take this up again in a couple of weeks time, not to get bigger for the

sake of getting bigger, and to be able to preserve the quality and the mission and the connection. If we had not done that I don't know what this year would have been like, and I don't know what we'll decide for the future, but it has been an enormous challenge of a kind that was really unprecedented for us.

All this said, I think there are, it would be honest only to admit downsize. The quality of life of most clinicians, people who make their living clinically, at least in this state has plummeted, just plummeted. People are increasingly reduced to the status of hourly workers. The red tape has multiplied. The notion, anybody's notion, that somehow managed care is the answer to the red tape wastage in the insurance business is beyond me, actually. Because the red tape, as many of you all know, is just phenomenal, and the time it requires and so on. The person who, say, does twenty or thirty hours of clinical work a week will now be seeing many more people less frequently and with more crises occurring that would have been the case, say, five, six, seven, eight, ten years ago. They are working harder and in a less satisfying way often than what they would have done. So even though the numbers are vastly better, and we have stayed alive as an agency, and have had some remarkable success, nobody would claim that everything about this is rosy.

I want to comment on a couple of larger implications and then I'd be glad to stop and hear from panelists and so on. One question that the committee asked, and preparing for this had to do with policy level things, about who tells who what is needed and what will be done, and I have always felt ambivalently assertive about this. Ambivalent because I think I sometimes ought to think differently from what I think, but our experience at least has been not what I once thought it would be. I actually don't think we would have survived, certainly not as well, if we had taken a much more collaborative route outside of the agency, done, for example, lengthy needs assessments and surveys and interviewed all sorts of people and collected a lot of data. We've done that in the past, and we didn't do it this time. My experience has been increasingly that demand follows supply more often than the other way around. We don't have fax machines because somebody asked for them or said to some manufacturer, 'We need these.' We don't have computers because of that, in fact we don't have voicemail, or call waiting, or caller ID on your telephone, none of that stuff, because somebody thought of it and asked about it. We have it because somebody created it and made a market for it.

We didn't do quite that. What we did that was very collaborative was internal within the agency, board and staff together, in a combined, collaborative working arrangement. We did not actually turn to our communities for lots of advice and input and so on. We were very confident that the thirty trustees were giving a lot of what we needed about that, and have always depended on them for that, and we figured out what we thought would work for us, and how we could keep delivering what our sense is would be

valuable for our communities. I'm not opposed to asking and seeking and so on, but our way of surviving at least was not by trying to engage much larger constituencies in the planning for our future.

Now I don't know that three years from now that won't be a good thing to do. I think periodically it probably is a good thing to do in some ways. But for us at least we took a route which was more in-house, and let us design for ourselves what we think we can offer and how we can make this work. I don't know what we would have done if we were a different agency with a shorter history serving different communities. I'm not sure that something else wouldn't have been in order, but for us, in any case, this was what worked.

Looking ahead and implications—I want to see if I can sort of share a few general thoughts about that and then I'll stop. I think the community mental health world of the sixties and seventies, which is where I cut my teeth, and what I remember in some ways most fondly, was very heavily structured on and built around theories that I might think of as Lindemann-esque in their nature and their orientation, not that they were all Erich Lindemann's, but that a lot of what got created at our place, thanks to him and his early colleagues, really set a tone and were replicated widely. I think a lot of that has declined beyond what I, at least, could have possibly imagined, in terms of emphasis and influence. Even, as I said earlier, as some ideas about prevention and early intervention have become widespread in the populace at large, in the field it seems to me they're in sharp decline. Some of you may see this differently, I don't know.

Psychological causation, though popularly accepted, is no longer at the center, it seems to me, of a lot of stuff in mental health. For a while, it was very common, George Albee and others would talk about a kind of a pendulum that would swing back and forth from biological to interpersonal and social, and then back and so on. I'm not sure that we won't have such a return, but at the moment it feels to me like that's not the right metaphor, that something is slipping in one direction somehow. I don't know what will happen in the long run. I certainly have no gift of sight there. But the medicating conservatives certainly are carrying the day at the moment over the social liberals, it seems to me, and in the broader sense, I, at least, I don' t know about others here, have the sense that a couple of things are different in ways we couldn't have imagined.

One is that the notion of serving a community is to me very different because communities are very different, and I think that it's actually, even in fairly small suburbs such as we serve, harder to speak rightly of a community except in the sense that there's a geographic boundary. But for example, if by a community you meant some fairly widely shared values about how people ought to behave, we have less and less of that, it seems to me. If you just meant places where people live for a good long time, we have less and less of that. We have, in fact, much more mobility, much more turnover and much less

continuity within geographical communities than we used to have. And if you look at, for example, the governance, whether it's boards of aldermen or city councilmen or selectmen or whatever, the turnover is very rapid now compared to what it used to be. And so if you as an agency of any kind take as your mission to try to serve a community, what you're serving though is never static. It's much less fixed in many cases than what is was. And so it's harder to get a grasp on it and it's harder to have continuity.

For example, let me pick one thing that drives public schools nuts. Ten years ago, fifteen years ago, there used to be somebody who wrote about the local schools in the local newspaper, and that person lived in the town and was usually a true adult, not twenty four years old, and actually had some history and continuity, and sort of knew the place. Now place after place has the local newspaper staffed by kids barely out of college, who have a hard time spelling in some cases, who have no history there and are often covering eight or nine towns, and the reports of things that appear in the paper are just completely different in nature than what they used to be. While this doesn't define a community and it doesn't epitomize everything, it's one example of the kind of thing that I'm talking about here. This is another reason to me why it didn't make such good sense to go through protracted community surveys about how our agency ought to adapt to the future here, because I think it's harder to know who you're asking, and there's less continuity there.

The second thing is that it's amazing to me for as wealthy as we've become how worried our communities are, and the anxiety out there seems to me to be of epidemic proportions at this point, certainly among parents who are raising children. That is, even though people may be doing better than their parents ever dreamed of doing, their confidence about the future is not keeping pace with the success they're having.

I had a vivid example of this a couple of years ago. My older son graduated from college and got a job, and every single person I know congratulated me. I don't mean like perfunctorily, I mean like this was a big deal. And I'm thinking, four years at what was then twenty six thousand dollars, eighty four thousand dollars out of my pocket, and the kid finds a job. Now, why would you spend that money if he wasn't going to find a job? So then I stopped to think. When I got out of college it cost thirty-five hundred a year, 1966. I went to teach in Brookline High School, right nearby here. Full-time teacher earned five thousand a year. At that ratio, five thousand dollar first salary to thirty five hundred last college, my son would have had to start his professional career at over forty thousand dollars a year. Not at barely what it cost me to send him to college. It's a different world out there, and people's anxiety is intense, even if they're doing comparatively well, which both creates a press for services of a kind, but also changes the nature of community dialogue about all sorts of things, from schools to the budget to the health services to you name it in a way that is very different from what it used to be.

Just recently in the Wellesley paper there was a heartfelt plea from a member of the Natural Resources Commission for more civility in town government discussion. In Wellesley, even, they are now pleading for civility, can you imagine this, because there's less and less of it. So, in addition, I think, there has been in most of the agencies that I'm familiar with, a fairly widespread demoralization among practitioners that I've alluded to earlier, and that in many, many cases agencies that used to cooperate and collaborate are now if not active, at least potential competitors, which makes it much less likely that they're going to share information, resources and planning to produce more comprehensive results for a community. Many of us, at least in the greater Boston area, can remember times when there was much more networking, much more interagency meeting and collaboration and planning and so on than there has been in the last five to ten years, particularly in the last five years, and that's had an impact as well, and it's one that I think is beyond the capacity of a single agency to change.

So in this long story, which I'm now going to stop, there are both ups and downs, there has been tremendous anxiety and great exhilaration, and a sense that hard work and luck have made a real difference to us, and I think at least for some of us, and for me certainly, an enormous sense of relief that we would find, at least in our own way, fifty years later, a pathway of trust, but a way to continue at least some significant themes that were important at the very founding of our agency, and have brought to me many times the old notion fairly widely known in mental health that we in HRS have had for a couple of decades now in front of us which is the old Chinese character for crisis being composed of two characters, one for danger and one for opportunity. These grim times, and I think in many ways they are grim, invite us, it seems to me, not just to despair, but to think individually and collectively about which opportunities we wish to pursue and to work like hell to make them happen, and I had this experience that I want to leave you with.

A couple of years ago I went out to Utah to work with some school principals, and one of them came up to me afterwards and brought me a little article written by Vaclav Havel, the Czech playwright and president, and it's called something like, 'Never Hope Against Hope.' A short one-pager, and this is a guy after all who knows something about sustaining hope against very long odds. What he had to say there was that hope is not the same thing as optimism, that it's an orientation of the spirit and not a state of the world, and that real hope is not the same thing as a willingness to invest in enterprises that are headed for obvious success. It's the ability to work for something to succeed no matter what happens. I have spent a life often being used to thinking about judging success by results, and not just by effort, or by effort alone, and I guess it would be a shame, you can't leave results out, but one of the things that the question about surviving and thriving in these times has raised for me is of looking for opportunity amid the danger,

and looking for ways to do the right thing no matter what's going to happen. My experience, at least, so far has been that this has actually has been crucial to our survival as an institution. I don't know that it would be for everybody, but I can't imagine how one could stay in community based caring for other people without holding on to something like that, because the alternative, it seems to me, is not just that you aren't optimistic all the time, but that you don't have something to hope for. And I can imagine, I've done this work for a while without being optimistic, but I can't imagine doing it without being hopeful. That's the end of the sermon, and I'm happy to invite your comments.

David Satin:

It seems to me that's a very clear model if you look at it in terms that Erich Lindemann and the anthropologist Clyde Kluckhohn used to talk about. It is coping with predicaments, and it seems that HRS became efficient and found new lines…

Robert Evans:

Well, I should say we were always efficient, we became astonishingly lean.

David Satin:

Found new lines of business, maintained self-reliance, set its own directions, and made carefully chosen relationships. You talked about how different community is, and I think we can discuss whether it isn't community anymore or whether you have to take a different perspective, a larger perspective, a different, larger perspective of what constitutes community, and what community needs are. The quote from Abraham Lincoln almost escapes me about conditions are anew, therefore we must think anew and we must act anew, and that's how we will save our country. And you said something that really struck me, about thinking about whether you chose to survive, because there are other agencies for whom you would think about whether they deserve to survive.

Robert Evans:

Gee, I guess, I don't know. That never occurred to me. There's not doubt in my mind that we deserved to survive, but I wasn't sure that we could.

David Satin:

Well, the difference between the two I think is a matter of scruples. If you have scruples you'd think about whether you choose to survive. If you have no scruples, other people wonder whether even if you do survive you should have.

Robert Evans:

We were not willing to turn our backs on the folks we saw as most in need of service, even if we couldn't do everything we wished when we were poor, and we were not willing to do it when we were rich, or to get richer.

David Satin:

It's a lesson.

Brenda Lindemann, MPH, CHES

Vermont Agency of Human Services; Vermont Health Department; School EPSDT Health Access Program Liaison; President' s Summit for America's Future: Vermont's Promise, Coordinator

Introduction by David G. Satin, MD

Our first discussant is Brenda Lindemann who is a health educator and planner. Her degree in public health was from the University of Michigan. She is a member of the Vermont Resiliency Network Trainer, the Women-Centered Girls First Mentoring Program, Society of Public Health Education of New England, the Vermont Governor's Prevention Conference Planning Committee, and the Vermont Prevention Institute Consultation Team. Her jobs are as liaison to the Early Periodic Screening, Diagnosis and Treatment Program, a health access program of the Vermont's Agency of Human Services, coordinator of the President's Summit of the Vermont Promise, Health Outreach Specialist in the Breast and Cervical Cancer Screening Program, all part of the Vermont Agency of Human Services, and was the Prevention Planning Specialist and Director of the Vermont Prevention Institute of their Agency of Human Services. Prevention is not a popular word these days. It's one of those things we cannot afford. We have to do something else which presumably is more important. I wonder how a whole state maintains prevention in its lexicon and finds the spirit and the resources to keep that up.

Brenda Lindemann, MPH, CHES

David bumped me up because my children are here and they're getting restless. The natives are getting restless, and I do want to take this opportunity to introduce them. My son Jamin and my daughter Ami, and next to them, my very dear friend, Marion Reynolds, and the extended family, and my uncle is here and my mother, and many, many friends.

I'm going to just say, public speaking is not my forte or my favorite. I'm going to rely fairly heavily on overheads, so bear with me a minute while I get these organized. I want to just make sure I have them in the right direction and so forth.

First of all I want to thank David for letting me be here. And of course I want to thank my mother and my father in absentia and my children for being here. I wanted to just give my daughter a little credit for creating this fashion plate that you see in front of you. She was my consultant while I was getting ready to come down here in what I should wear. She gave great advice. I tried on some earrings and a pocketbook, and she

said, 'No, Mom, no, Mom, not that—that.' So this is the composite of my daughter's new career in fashion consulting. And my son, I just want to thank for being such a good cooperator, for being a good boy today.

Anyway, I'm going to basically talk about Vermont, and I'm coming from the state perspective. I work, as David mentioned, for the state of Vermont to create human services for the Department of Health for the last ten plus years. I know from public speaking, the little bit that I do know, that you're supposed to start off with a joke to loosen your group up, or loosen yourself up, so I'll make an attempt at telling a little joke that I heard actually on public radio the other day that I thought was kind of appropriate, because I have a lot to say and not very much time to say it in.

The joke went like this: there was a woman who was very happily married to her husband for some fifty plus years, and he died, and so she wrote his obituary, she wrote a long, two-page obituary, and she went to the newspaper and the editor that was receiving it looked at it and he said, 'This is way too long. We just can't possibly publish this. You need to really cut it down.' And so she went away for a few minutes and she came back and she gave him the piece of paper, and it said, 'David Sweet, died April 12, 1969' and the editor said, 'That's nice, but we have a minimum-you have to have ten words.' So she went away and she came back and she wrote up a little bit more, and she came back with the thing she wrote; 'David Sweet, died April 12, 1969. '62 red Toyota for sale.' In a nutshell. The essence is there.

What I'm going to start off with is just an overview of what we've been doing in Vermont, and this again is more general. I'm really not an expert in the mental health field, I'm more health and human services, but I'm going to be addressing which is competent mental health services in Vermont, but that's actually probably my least, I have a least expertise on mental health system in Vermont. I did bring some materials on some of the programs that are the ones that we're the most proud of, so if people are interested, I have some materials and leaflets on the table.

I think what I'm going to be doing is a lot of bragging about Vermont and I think how well we've done up there. I came back to Vermont about ten years ago, probably eleven or twelve now, and I certainly can't take credit, for some reason or other, people were already on board about prevention up there. I was hired to work with a group called The Prevention Institute, and basically just came in and rolled up my sleeves and worked along with the rest of the folks that were really committed to prevention work.

This first overhead will tell you some of the things that are so good about Vermont, and that is compared to the rest of the country, we spend a higher percentage of our tax dollars on prevention, and almost half the amount on remediation. So right away, I really have this feeling in Vermont, and I don't quite know what to attribute it to, except individuals and people getting on board with the whole concept of prevention, but people

up in Vermont really get it. They really know what prevention is, where to put their energy and their emphasis and their dollars, and it's working.

Over time, what we've seen is that Vermont is first in the country with children being fully immunized at the age of two. We have been first in the country to student-teacher ratio, second in teen birth rate and so on down. I don't know if you can see that well enough. These are our ratings in the country. We certainly do have our downfall and areas where we need to do work. Drunk driving is a very high crisis in Vermont, especially among teenagers. We've had several humongous tragedies in the last two years of groups of teenagers getting drunk and being killed in car accidents. Children in substitute care is still very high. Our annual wage is very low, and the number of adults who smoke is still pretty high, so there are many areas where we need to do a work in.

Now this last little group, where, and I'll show this in a bigger form later, but this summarizes where Vermont is placing its money, and its placing its investing in innovations, early primary prevention programs, the WIC clinics for the young mothers and their new babies, education, child care, child support, housing, health and Medicare. And at the far end of the continuum we're one in the country that's spending the least on hospital care, Medicaid, psychiatric hospitalization and police. So the emphasis really is on the early intervention and prevention in our community.

I'm just going to run through this quickly because I don't want you to necessarily really understand every piece of what I'm about to say, but this is a model to show you how things have progressed in Vermont. In the 1900s to1950s the emphasis was on public health services and social work. In the sixties, the next programmatic areas that came along were Head Start, that you mentioned, and special education, there was more emphasis on providing services for special ed children. In the seventies, added to what was already in place, the clustering of the ones down here on the bottom are the programs that were already in place, in addition we started the special ed for three and five year olds, more emphasis on a variety of rich, quality child care and mainstreaming children in the school system and other services. And in the eighties we have already in place things already mentioned and additional was first prevention plan, and that's actually about the time that I came along.

I did not write the first prevention plan, but I've written I think about three or four subsequent, they were biannual, required by a state law, they have a primary prevention plan in the legislation. Parent education, access to substance abuse, alcohol and other substance abuse drugs enhancement services, interagency groups and child centers which really emphasize offering services for children and their young parents, parents or their young children, mandated health education in the schools, special ed, zero to five, home visiting, and we had a Directors of Mental Health Agency at that time. Garry DeCarolis I don't know if you folks know that name or not, but he's now down in

Washington, he was what was director of the Children and Adolescent Special Services Program, and that Act 264 which describes a system of care for mental health and mental retardation services for children and their families, so that was in place at that time.

1990, where we are now, moving right along, and this is out of a presentation that was made by our commissioner of Health and Human Services, Cornelius Hogan,who made a presentation at last years' Governer's Prevention Conference, so this data is about a year old, but it's still pretty solid, it's probably just more than what's showing here. All of these outside things were added to the cluster of already-existing services. We now also have two, thanks to Garry in Washington maybe, I don't know, we competed for two federal grants, one is called an access grant, and another is called a CUS, Children Upstream Services, I don't know if that means anything to you.

Anyway we're doing welfare restructuring, got a healthy baby program which meets with all young mothers and their new babies with outreach home visiting, there's school-to-work, we have sentencing options for people who are convicted of crimes, rather than just sending them to jail. We sometimes find ways to have them serve their time in other ways a little more creatively, school-based health centers—that's a new addition in Vermont, where we're trying to use the school as a community base, so that it will be, for example, some schools have the senior citizens meals at the school, health centers at the school, and also we've gotten very results-oriented. Our commissioner is very results-oriented. He really wants us to start documenting in numbers where we can where we're showing our signs of improvement.

Of course everybody's thinking about the year 2000, so here's what we hope to have, and this is really basically, there's a term for it but I'm not coming up with it right now, but sort of circling a child or a family or a community with as many possible services and so forth for them in place. That's enough bragging, and I think I've done enough, well, I'll just quickly show you in another way. Two-year-olds fully immunized, Vermont is up here in the US and that was in 1989, 1994-95, Vermont is way up, 87% of our children are thoroughly immunized in their early years. Early prenatal care, Vermont, and here's the US average, rate of parentage established in out of wedlock court cases. We have a very good rate of return on getting income back to the mothers who are supporting their children through the paternity actions. Teenage birth rate, Vermont is low. People who have health insurance: Vermont we have almost free health insurance coverage. I can't say specifically about all the mental health services, but almost everybody is under some form of health insurance in Vermont. Child abuse victims is going down. Child support—there's another way of showing the amount of money that's being collected right now in 1997, we're collecting up to $90.9 million that goes back toward supporting the mothers and the children that might not otherwise have that income. And ANFC, our Need to

Families with Needy Children, average income is going up, we have a lot of training programs, we're trying to get people from welfare back to work. I want to show the number of households on welfare going down, and the number of households with working and earning income going up. I want to just show the pregnancy rate is lower than the national average here, long-term care, lower than the national average, going down dramatically, that's a savings of millions of dollars, $15.2 million, here. Corrections, we saved about $60 million on non-institutional, deinstitutionalization of criminals.

This is getting a little more into the mental health specifically. For people with developmental and mental health disabilities, we have community and rehabilitation and treatment of clients living independently very high, about 84%, services provided by children's service program are ever-increasing, and we have excellent emergency services, more consumer participation and funding for respite for families, so a lot of it is external. There's not a lot of institutionalization, either in the mental health or the… Let me just close, this is the institutionalization for developmental disabilities. We just closed our last facility in Vermont, and actually most of those clients are the first in the country in terms of the number of clients. And special ed, our very high rate of services again in Vermont, first in the country compared to the national average. Institutionalization for mental illness, Vermont, way down compared to the national average. We're actually at eleventh place at the moment. We have just one state hospital, and there's about, and I read, I don't know but I think there are about fifty residents in the state hospital now. The rest are all in community-based services. This just shows again the amount of money going towards police and corrections, Vermont is low, the national average is high, and we're also among the lowest in expenditures towards hospital care and Medicare. So, have I bragged enough yet? So this is just a small expenditure placing where we're bringing the emphasis of our dollars on the early intervention for children and their families.

Okay, now I'm sort of taking advantage of the opportunity to be here to share a new way of thinking that's come to my attention the last couple of years, I asked David a couple of years ago if he could find somebody to come talk to the group about this, and he said, 'Someday, you probably will do it.' So this may be old news to some of you, but it's something that I think is fairly new central framework that's beginning to sweep the country, and typically of Vermont, we're among the new, what are they called? The early adopters, and we're getting on board with this. I see this as the next wave of what we're applying to what we're already doing that will just be the whipped cream and the cherry on top from my point of view. I'm really very excited about this. And this is resiliency, which is nothing new.

When I go through this you may kind of, I call it the 'duh' factor, not anything new that any of us don't know but sometimes you have to be especially reminded of these things to kind of recapture them in a particular way because they work for us in our work. This is good news. The early work was around resiliency where we're moving in our thinking and our language from risk to resiliency, from problem solving to positive development, from pathology to wellness, from being reactive to being proactive, and there you might put from crisis management…education for a few, education for all, Eurocentrism, multiculturalism, and under, I heard this somewhere else so I stuck it in here on my list, from blaming to claiming responsibility.

There's a sense of really what we, things that I heard that I think said a lot to me, maybe it's a personal thing. And seeing people not as problems but people as resources. After all, who knows better how to solve a problem than the person themselves. To me, it's kind of going from looking at the glass half empty to the glass half full. Let's dare to hope. There are two sides of the coin, but you're looking at the sunny side up, instead of the bottom. Not to say that the risk factors and so on and so forth go away and this paradigm doesn't deal with those—it acknowledges they are certainly there, it's just a different twist on how you look at things. And also the thing that's nice about this is that this approach to working with people in health and human services can be applied in any context—it can be applied in the home, it can be applied in the school, it can be applied in the church community, it can be applied at your town meeting, so it's really something that I think anybody can take something away from and bring more to their environment. The last one that's not on here that I really like, a phrase that I heard that I also really like is in terms of children is looking at children not at risk, but children at promise, so that's a really nice one.

I'm just going to go on a little more with some of this now, and again I apologize if this feels like old hat to people. I just have to go to the research base to show people that this is not coming out of nowhere, but in the 1950s there was a big research study done by Emmy Warner and Denise Bluesmith in Hawaii on the island of Kauai on 700 babies. A third of these children were considered high risk, into multiple risk factors at birth, when their family or community context. Of these high-risk children, seventy were deemed invulnerable to the risks and they developed with no problems. They developed and went through life fine. They found that two main reasons for invulnerability were kind of an internal asset, which is that these children had outgoing social dispositions and that they were therefore able to recruit several sources of support for themselves, so they were resourceful. The other two thirds of this high-risk group, which is about 140 children, did develop problems, but the majority were doing well by their mid-thirties. In other words, there's a lot of self-correction in our lives. You can go through phases when you're in trouble, either emotionally or socially or whatever, and if you just give

people and children time, they work it through on their own terms and they come out okay. But they're saying that about five-sixths of the original high-risk group, the original seventy bounced back.

How does this process of bouncing back happen? They told researchers that someone along the way had reached out to them with these messages: you matter, it doesn't matter what you've done in the past, and that these resources were not just from family members, they're not necessarily, and probably in a high-risk situation it might be the last place that the children would get that input, but there's somebody—a neighbor, a teacher, a mentor—made that impact on them, and that really made a difference in their lives. If the children were involved with a program like the YMCA or Girl Scouts or Boy Scouts, it was the person who delivered the program, not the program itself, it was the person who said to the children, 'You matter, we love you, you're important to us, we're here, and we really want you to be here and we like having you involved with our activities." That the program kind of felt like an extended family to these children because they didn't get the nurturing at home, because they had another context to get that nurturing, whether it was in a classroom or a church or in a club or whatever it was. And that these children, in the end, developed some kind of competency. So, building competency in young people is really important, so they end up being able to find their niche in terms of earning a living or providing some kind of service that they get some kind of recognition for.

Another little summary of the research. Interventions that foster resiliency that were suggested from the work of Warner and Smith, to engage them in acts that require helpfulness, provide bonding similar to an extended family. When I'm going through this try and think maybe of some children that you know and what they do have going for them and what they don't have going for them and think of places that maybe you could help expand their opportunity. Be an optimist—a caring leader, a counselor, a facilitator. Encourage their participation. Provide more attentive interventions for those who are most vulnerable, which does say that you have to recognize that some are more vulnerable than others. This applies to all cases, but the more vulnerable, the more they need. Focus on assessing protective factors: their competencies, strengths, and sources of the environment that support in addition to assessing their weaknesses and deficits and risks. Assure that a caring connection continues once a young person leaves your classroom or your office or the support group or your program, even if it's sending them a Christmas card once a year. And avoid referring to children as high-risk, but rather that they come from a high-risk environment. That has something to do with labeling of children get labeled pretty early, they might have their burden on their back for a long time.

Now I'm going to do a little exercise to wake you all up, those of you that are nodding out. Everybody take a piece of paper—this won't take long—but everybody take a piece of paper, anything, just a scrap, an envelope out of your pocketbook or whatever, and across the top, draw a line straight line across, and draw a line down the middle. On your top left column, I want you to think of a child that you know that either that you're working with as a client, or maybe a family member, or could even be yourself, and on the left column you're going to write problems/challenges. Try to write down maybe two, three, four, whatever comes to mind in the amount of time that I'm going to give you, about that child, the problems, the challenges that face that child that concern you, that come to mind. So, you have two or three written down . Okay, on the right-hand column on the top, your heading will be strength and positive support, and I'd like you again, about the same individual, write two or three or four strengths or positive supports that they have going on in their lives. Do you still need more time? Whose exercise means anything to anybody in particular? Did anything click for them, or any realizations they'd like to share?

I've been in a couple of trainings where this was done with us, and I remember the children. The second time I did this about a child and I looked the left column and I looked at the right column, and by the time I got doing the right column I couldn't believe I was talking about the same child. That child has totally turned around for me in my outlook in what that child had going for him. The things that were problems and challenges seemed not so insurmountable. This child had a lot going for him internally and externally, and that there was hope, with lots of good nurturance the child could come along quite well.

I was at a training recently on this material and I'm just going to throw in a little from time to time some phrases or clips that were mentioned at the training that I liked, and this is one that I like. What's right with you is more important and more powerful than what's wrong with you. This is what's called the resiliency field, which talks about mitigating factors in the environment and the things that build resiliency in the environment, and this again you can apply to any kind of setting. You can use it in the home, in school, in the workplace. I think, Robert, you're doing consulting in the workplace, that you would say that some of these things would apply in the work setting, home or school.

Provide an opportunity for meaningful participation, set and communicate high expectations. I used to get told when my kids were younger than they are now, I remember one friend said, 'Boy, you run a tight ship.' And I said, 'Well, yeah, because I think children need to know what goes and what doesn't go, and when those are clear and they're high, then people tend to rise to those occasions and those expectations. Provide caring and support, and mitigating risk factors, increasing prosocial bonding—

really important, developing those interpersonal relationships, setting clear, specific boundaries, again, that's very similar, and teaching life skills.

I can remember getting to college and not remembering how to operate a checkbook. How did everybody else know that I didn't? Simple, little things that give more self-confidence, basically, the big things and the little things. Again this is just a summarization of what they had found important, or this is a compilation of a variety of research that they have found. Again, the positive adult-youth relationship, student participation, involving them, you know, if you're running program for youth, have them on your board. It's sort of obvious that they are the ones that know. Other people can plan for children, but they need to be involved and tell you what really is going to work, and then they're also more invested in the outcome as a success. Norms and high expectations, what goes and what doesn't, and if you expect high, you get high. Skill building, both academically and socially.

Somebody was giving me an example of just a simple thing of teaching children about timing, when you are interrupting, when you have something to say, as children get older they learn the skill of interrupting less and less and less, the need to interject into a conversation, that they wait for that pause or they raise their hand, or they wait, you know, two people are talking, they don't just barge in and say, 'Here's what I have to say.' They wait, they take you aside later and say, 'I didn't get the chance to talk to you then, but here's what I think about this, and I wanted to share that with you, and I thought what you had to say was really interesting,' and blah, blah, blah, whatever, so just social skills.

Information and support services within the school and across the community. These services and supports have to be in place to the extent that is possible. And other positive connections, including good connections with peers, both having activities and hobbies and just general learning inside or outside of school. I have tons of handouts here, so if any of this rings any bells for people if you'd like to pick up some more of this I brought down a lot of handouts.

There was recently, I just had to throw this in just to legitimize, this is such an esoteric group here, that there was an article in JAMA recently of a longitudinal study called the National Longitudinal Study on Adolescent Health, and actually the title is, actually this is an editorial, but the title is Protecting Adolescents from Harm, and it's again this is a lot of the same pieces that I've already reviewed, and my article is over there as well. The summary of this JAMA article or report is that connectedness is the greatest protection against all adolescent risk behavior. This includes substance abuse, early sexuality, dropping out of school, all those, the more connected and good connections kids have, and this really you can take all the way up to senior citizens, I mean, I'm saying a lot about kids, but it applies up and down and all around, in every

population that you can think of. These all are the same common sense to me. This shows you the family setting that children have experienced high parental expectations, a feeling of warmth, love and caring, and parental availability. If they can't get it at the home, then they need to find it somewhere else, that those relationships are critical. The more isolated the more in trouble. The school, in terms of children, another area where it's really important that they feel connected is that the teacher treat the students fairly, that they're close to people at the school and that they're part of the school and part of the school community. As much as I'm boasting and bragging about Vermont, we're certainly not impervious to a lot of these issues, and in the school that my kids go through, which is a pre-K, pre kindergarten through twelve, the morale in the upper grades is, as they get past fifth grade is kind of an inverse relationship. By the time the kids are in high school, the morale is pretty bad, and it's something that the whole community has been taking real serious.

In fact, talk about not being impervious, in the last couple of months, and my mother doesn't even know this, there was an incident where a group of boys who brought a gun to school, in a high-school aged group, and this is a school, again, as I said, that has children all the way down through pre-K and they were shooting BBs, it was just a BB gun, and they were shooting it into the play area, when there were no children there, but nonetheless, the fact is that they brought a gun onto school property. And we had a bomb threat last Monday. Somebody called the school up and said that there was going to be a bomb going off on Wednesday at 5:00 am. So, it happens. Jamin?

Jamin:

Wednesday the fifth.

Brenda Lindemann:

Wednesday the fifth, which was not the right date, so everybody was a little concerned about who was this person that didn't even have their days and dates together. It was very distressing to me, and my children were quite absorbed with this for several days, and were in tears one evening, you know, he didn't feel safe, and this is not okay for children to not feel safe in their homes and not feel safe in their schools. T

his is another, it's not that you really need to see this point but there are, again the research, there's a consensus among the researchers that there are developmental assets, both external and internal. Again I have handouts if you want to follow this up, and in fact on the back it's in Spanish. The more assets that children have, or that people have, the stronger and more resilient and resistant they will be in the difficult challenges in their lives. So these are the pieces if you want to take a look at developmental assets.

This is another summary of systems. I like to hammer the nails in all the way around. Resiliency and protective factors, a compilation and consolidation of the research again says that bonding, attachment and commitment to family, school, pro-social peers and community is critical, feeling of being loved, cared for and supported, and the opportunity to contribute to something in meaningful ways is really important.

I was at a teen pregnancy prevention conference the other day, and one of the speakers there was saying that contrary to Freud's theory that separation is an important stage for adolescents to go through, the feeling now is that that's wrong, wrong, wrong, that you get up early and you stay up late, no matter what age your children are, so that's that.

The last piece is this, as David mentioned, I'm working on the follow up to the President's summit, which was held about a year ago, and from all of the building research they've come up with basically what they call the five fundamental resources that all children have. If they have them they will be guaranteed to be successful, and that is the ongoing relationship with a caring adult, safe places for structured activities outside of the school setting, healthy start for healthy future, those are those healthy baby programs, Success by Six and so on and so forth, marketable skills through effective education, and, this is a little bit different twist, but this is opportunities for youth to serve and give back to their community. So that's my summary and I've been given the clock and that's what I have to offer.

David Satin:

It's really impressive that a whole state is so committed to prevention. Prevention as a perspective was very characteristic of the community mental health era, and Dr. Lindemann, when Rob Evans referred to the different perspective of the early days when HRS was not a treatment agency, it was a public health research project not so much on where mental illness came from, but what to do to prevent mental illness, and I know this perspective on clinical care, especially in hospitals, was this is where our failures went. They shouldn't be there. We should be doing something to prevent it. We see a whole state still committed to doing that, and more and more balls going into the court as other people found resources getting less and less, in the discussion you'll have to tell us more about where the resources came from for that.

Peter D. Kirwin, MSW, LICSW

Director, Town of Falmouth Human Services (FHS

Introduction by David G. Satin, M.D.

As a second discussant we turn to a town. We talked about an agency, we talked about a state, we turn now to a town, the town of Falmouth, in Cape Cod, Massachusetts. Peter Kerwin is a social worker and the director of Human Services Department at the town of Falmouth. He has his masters of social work from Boston University, and not only is the director of Falmouth Human Services but is an elected representative at the town meeting. He is a board member of the Falmouth Housing Trust, the Falmouth Service Center, the Pocassett Mental Health Center, and is a former member of Elder Services of Cape Cod and the Islands, the Cape Cod Association for Retarded Citizens, and the Housing Assistance Corporation. I go through all of these because it is a perspective on a person who is a part of his community, an active, functioning part of his community, as well as the director of one of his community agencies.

How does a small town find the will, the direction and the support to work with its town government, its community and other government social agencies which a town is responsible for working with, whereas an agency can choose to work with or not with. How can it accomplish this in times of downsizing, economizing and reinventing, i.e., disemboweling governmert? How do you do it?

Peter D. Kirwin, MSW, LICSW—HRS: Adaptation and Survival

What strikes me are the similarities in our experience, i.e., while HRS is a private non-profit and FHS is a municipal government department, both agencies have a history of clear service mission, committed boards and staff, and a tradition of community partnerships. More than any other factors these have allowed our agencies to go forward during changing times on the community mental health scene.

As a town agency our mission has been to serve those without mental health insurance or ability to pay for mental health services out of pocket, to provide gap filling services that no other agency can or will, to depend primarily on appropriations from town meeting to finance services, and to collaborate with state and county government, non-profit agencies, local business, academic, and religious institutions.

HRS: Current Flourishing

While HRS has developed new programs to respond to the managed care environment to survive, FHS has continued to serve those without insurance, who have

reached the limit of insurance benefits, and who cannot afford to pay out of pocket for outpatient mental health counseling. Even in the best of economic times or when publicly subsidized insurance is offered to more folks, there has continued to be a waiting list for our services. We see all applicants for service within four working days from the date of their initial call or request for service.

We have also limited our growth. We do not see nor have we ever seen children under the age of twelve. Our strategy has been to apportion a small amount of our budget to provide a mini grant to the local public/private partnership community mental health service to see children who might not be able to pay for services. The agency's founders historic choice was to become a part of the town's "human" infrastructure, to work politically to ensure its survival and to be viewed by the public as necessary as fire, police, or public works functions. This has proven to be a wise decision. Town meeting continues to fund us through the turmoil of taxpayer revolt (Proposition 2 ½) and economic uncertainty (recession of 1989-93).

A significant factor in FHS's ability to flourish has been the staff's ability to intuit major needs of the population and convene community leaders and citizens at forums to establish new programs that reduce stress and anxiety in the population it serves. Examples would be the creation of programs such as: the pregnant and parenting teen programs, the emergency food pantry, the local soup kitchen, the local housing partnership for shelter and home ownership opportunities for low/moderate income households, and support for latchkey after school day care programs.

HRS Policy: Who tells who what is needed and what will be done?

Unlike HRS, FHS has done a local needs assessment, participated in a regional needs assessment, and fought for and won the inclusion of a Health and Human Services element in the town's Local Comprehensive Plan. The latter has been approved by Town Meeting and therefore provides a social policy through which FHS can justify its raison d'etre. And while we would agree to some extent that "supply begets demand" as Rob Evans notes in his address, setting of service priorities in community mental health should also be based on empirical data provided by residents of the agency's service area.

Early on the Human Services Committee in Falmouth (9 members appointed by the Board of Selectmen) determined that a role of coordination of human services in the town was its legitimate domain. Through the years the message has been loud and clearly heard by state and county departments, non-profits and proprietary agencies that FHS would work cooperatively with all who agreed that cooperation rather than competition, priority setting based on fact, and resource allocation based on common sense and need were the town's standard for providing human services. Several agencies

that decided to do things their own way either have left town or are no longer functioning.

HRS Looking Ahead, Lessons and Implications

FHS has a history of continuity in its governing board and professional staff, a community that has committed itself to supporting human services through local government, a dedication to partnerships with other entities to develop education and services that emphasize prevention, and direct and indirect involvement in the political process which have seved it well for almost thirty years.

It is our perspective that via local, regional, and statewide networking and coalition building we have replaced the old boy politics of "to the winner goes the spoils" with a broader more democratice (although still pragmatic) political involvement that might be labeled "to the collaborators go the spoils". In fact on Cape Cod parachialism and provincialism are diminishing while collaboration and cooperation are in ascendence, quite contrary to HRS' experience.

Serving a mostly low income population for mental health services has left us generally free of having to respond to constant changes in the state mental health system, the private fee for service arrangements, and the proliferation of insurance companies with which other community mental health outpatient services must contend. And the morale in our agency is uniquely high due to job security (salaried with benefits as opposed to fee for service without benefits) and satisfaction.

Our experience could lull us into complacency. To avoid that we are constantly seeking improvement in services via feedback from those who use our agency, by challenging ourselves to intuit new trends in care, searching for additional community strengths and assets and continuing to build cooperative partnerships. This has been and we believe will continue to be a winning strategy that benefits those with the greatest need in our community. We hope that Erich Lindemann would have given his stamp of approval to our agency and its practices. Were he still alive we would seek that

Discussion

David Satin:

Again, a small operation that has found a way to flourish, and I wonder where all of this comes from. I was prepared to hear misery and doom, and here are three different areas where somebody is accomplishing something, and I wonder how you do it. Why don't we open this to a discussion among the panel members, and the rest of the people chime in when you have an experience or when you have a question.

Brenda Lindemann:

I wasn't quite sure what he was saying there, anxiety, was that they were investing in four years of college and weren't sure whether they were going to pay off, or what the anxiety was, and whether it was more than that.

Robert Evans:

Nobody is confident about the future, often their own future and certainly their kids future. That you can spend all your money to get your kid through the Ivy League but then what? And that actually, there is almost nobody in this country, I don't care how wealthy they are, who isn't a reengineering away, or a takeover at work, from being out. And the irony of having people who are making $250 thousand a year not being confident about the future is something no one would have predicted. And that people two generations ago were often poorer, by any relative standard, and yet more confident about the expansionist future of the country and having a place of their own than folks are today, and I think it's actually stunning, at least it is to me, anyway.

Brenda Lindemann:

What comes to my mind is a shift in what is valued... dollar and not... and not the soul.

Robert Evans:

Reagan may have Altzheimers, but he lives on, and you could see all over the place this kind of materialist emphasis which has never been absent in this country, but it seems much more pronounced.

Brenda Lindemann:

Right.

Robert Evans:

It seems to be… I mean, you know, really if you think of it yourself, how often do you use that microwave, but everybody's got to have one, and it was really interesting, this report that came out last week on how many kids have their own TVs now, so you don't even have to negotiate in the family what should we watch, you can just go to your own room…connected, watch your own TV.

Peter Kirwin:

I'd like to…reactions to, you talked about normal people who vouch for you on the board, and I thought I can expand that and say that our town meeting is 236 elected members from eight precincts, and those are our normal people who vouch for us, and those people support us almost unanimously, but because we have appreciated them and tried to educate them factually and give them the truth, and when you do that I think you get support from normal people, so I think you were right on.

Robert Evans:

But it's been crucial to the agency, but we have now actually at each of the board meetings we start off with…business a presentation by a staff member. Last month Dr.…came. The person talks about their work. The board gets to ask some questions, but they only last twenty minutes, but each spring, when they're recruiting board members, they're telling them about what it means to be a board member. First thing they always talk about is what they learned by being a trustee, and it's fascinating to hear that because it's not just out of the goodness of their hearts, folks can certainly… like that, but that there is actually something that they come to feel over time that they are part of something which has a history, actually a story in some ways, but where they actually learn something and get something, rather than just giving.

Peter Kirwin:

The second thing I wanted to react to, and that was your comments about your local newspaper and how the reporters have gotten younger, and that's also true in our community. The one thing I would like to add to it though is that our local newspaper, and I'm sure yours is, is extremely supportive editorially as well as articles, and in fact we work very hard to massage those young reporters. When they write something we like, we praise them. We ask our graduate student interns, the first thing they do when they come into our agency they have to write an article about themselves, and they have to go to the local newspaper and ask them to print it and to get their photograph taken and to put in the paper, and that's a very humbling experience, but it's a lesson in how to use the media, and it's really worked to our benefit. We've had, since I've been in the agency in 1983, over thirty student interns. There are thirty articles that have been written just on that one aspect of our agency in the last fifteen years.

Participant:

I just wanted to say I work with Peter in the Falmouth Community Services and I wanted to address this whole notion of connectedness, and working through the stages where I've been almost, for almost eighteen years now, and there's a whole importance of having the workplace as a center for connectedness and feeling cared for and that you matter, and that's such an important thing, and we don't have any transition on our staff. Everybody who comes to work for us now, and they never leave. Some have been there twelve years, and it's not because of the money, and we all believe in what we're doing, and you emphasized how important it is to have a sense of doing the right thing, and I just feel that it's a privilege to have an opportunity to do that in this culture, and in terms of the issue of anxiety, I can't… of the belongingness and a belief that you're doing something meaningful is such…an antidote to… anxiety so that by providing that kind of community in the workplace we're also providing a role model for the outside community and how people can…

Robert Evans:

I think the work is hard enough, and it's both a necessity but it's certainly a blessing if the conditions you're trying to promote outside sort of live by example inside, and it's very hard to do that in times of fierce deprivation. It's often very difficult. For example, if the people who fund you cut your budget and require the same amount of work out of you, and you have less time to do other things, but to me, actually, when I was thinking to myself, what are the crises of getting big? I worry about quality, but the first thing I think about is, what would it be like to come to work here? And it may be selfish after a long time, but in fact a lot of what sustains, what keeps people coming to work there, and it's going to be too different from what we value if we take away something that we…It would be a terrible loss, and some of us wouldn't pay it, so in there are big picture pieces not…the…make that sacrifice, but there's more selfish ones too. The picture's made a sacrifice all the way along, and one of the things you've gotten back is this, connection, you don't want to let that go.

Participant:

And I think the other half nobody mentioned is the opportunity for creativity. We're really encouraged at Falmouth Community Services with Peter to… any myriad of… get involved in any organization, so that there's a lot of opportunity for being creative, so there's no sense of burnout or getting bored.

Robert Evans:

You notice how few people can say that? How few people go to their workplaces and say something like that? You just can't put a price on that. It does, at least, I don't know

about you, but for us it created a problem which was not nice to talk about, and I took a lot of flak for it, but I began to feel like a coach who's got nothing but veterans on the team, and speed was not what it used to be, and actually a good team has a range of young and old, experienced and rookie, a whole variety, not just sort of ?? and that actually I felt we had to start thinking more seriously about what our investment in our agency's future would mean in terms of who was working there, and that it was only me and my compatriots of a certain age, and as time passed, especially because we do a lot of child work, one person said, 'We have folks who can get down on the floor, but they can't get back up,' so although one shouldn't be talking about such things in this day and age, we actually had to have a discussion about the need for reaching out in our staffing to sort of include some folks who were younger that some of us all.

Participant:

The way we do it is through our student interns.

Robert Evans:

But I didn't want to just have two clumps.

Participant:

But even the student interns were all our age.

Robert Evans:

Oh, well. But I feel more, I think more about the agency after I'm not there anymore, we can't all be in our golden age together. We have to have some investment in bringing some folks along who will make that same lengthy commitment, but we will start, so we've done a little bit of that, and it's taken some getting used to but I think it's been necessary. We didn't fire anybody, we just as we were adding, we were looking for, you know…

David Satin:

…affirmative action. I wonder about the issue of resources. The complaint these days is that there are fewer resources which is why people are cutting down on the quality of services, cutting down on the staffing, selecting, creaming, skimming the patient population and so on. It strikes me that these three examples are very independent organizations, very self-directed organizations, who are not beholden to outside resources and outside direction. I guess what occurs to me is what do you think, then, in retrospect about the era of massive outside resources, when the federal government was pouring, was drowning human services and mental health services in money and in planning and in coordination and in direction. Was that a bad era that we

are glad to be out of, or was that an era of great wealth and growth that we are having to struggle without? Which is better, and what how do you cope with both of them?

Peter Kirwin:

…terrible, but it makes me think of what our government was like in the sixties when we did have this largesse of finances that we were providing health and human services, and it's almost as if we did the same thing when we napalmed southeast Asia. We smothered our communities to some extent, and they weren't ready for it in many instances. They weren't ready for deinstitutionalization, we weren't ready for many of the inner city programs that were established overnight. Many of those have had very productive outcomes in terms of many people who came out of them and learned and had a para-professional career start in those places, but overall, as I look back, I don't know whether all those resources at one time in such a large lump was such a good idea.

Robert Evans:

Well, life was easier up to a point. It was a horrendous loss for us have to sort of endure the cutoffs. Once we got through with it, it's wonderful freedom not to mess with the state and all the red tape, it's an enormous relief to be able to live without it. I think there's something to be said also for trying to live locally, that it does keep you more in touch, that you're more in tune. It makes you worry more about what…a lot can be said for that. Since we were an outfit that used the resources that we got well and resisted a lot of the control that came with them, we actually, I thought, made, as an agency, very good use of some of those resources, and so you could make a case for doing that.

David Satin:

Even during the era of great funding?

Robert Evans:

Yes, because we actually took the money and spent it well and resisted a lot of the control that came with it, and so in a sense we kind of put it to good local use, as it were. I don't know that everybody was as able to do that, and I don't know how that all sort of all played out, and, you know, I think you can find excesses both ways. If there were excesses then, I think the way people are being bled now, even to have the head of managed care boasting than they're only spending 76 cents out of every dollar that they take in on patient care, and the rest is going to profit, it's really obscene, so the fact that people are starving out in the field trying to serve folks doesn't feel to me something we ought to feel good about. So if there's an excess that went the other way, which I think Peter's right about, I think there's an excess that's going on in the moment which is just,

to me, most immoral. Of any case it sort of trashes the notions about service and care and whatnot that I have held very dear, so I think you can see it's sort of hard both ways.

Peter Kirwin:

I'm not interested in the centralized control and the bureaucracy and the rest of all that stuff; on the other hand, the resources that came with it could be put to some good use.

David Satin:

Brenda, do you have any ideas?

Brenda Lindemann:

Well, the only thing that comes to mind, I worked in a health plan in California, and in the north shore, actually, of Massachusetts, and in both instances the model included community participation. That was one of the requirements in both situations, and I think, that's my limited experience around that, which I thought was very constructive and I think it was instructive to get roots, to learn the planning model, and to have a broad base where we could come together and work together towards a plan and a vision and a long-term process. I had mixed feelings when the funding ended, especially in terms of planning for hospitals, because I think that was really beginning of this whole downward spiral that we're involved in now.

Robert Evans:

But we asked to cut back on a bunch of hospital planning and controls, which look like free enterprise, and led to duplication of services and all sorts of stuff that got hospitals in trouble, and the old notion that, well, so the market adjusts itself, in company terms, the company then grew, but in this case what gets hurt when this kind of retrenchment happens is clients, not this corporation, so you have a different dimension added.

Peter Kirwin:

I think that there's poison each way.

David Satin:

Historically, I think it's interesting to think that the era of big government funding, big federal government funding and state government funding, was not necessarily the high point of community mental health. Erich Lindemann was working in community mental health before there was massive government funding. His style of community mental health was going around among the individual agencies: the town welfare agency,

the Visiting Nurse Association, the settlement house, the hospital, and getting them to talk to one another and getting them to find out their common problems and the resources that they could pool, and getting them to think through a program, and when all of this massive funding and regulation came through, I had a feeling that he was kind of drowned in it, he had a sense of loss of control and loss of perspective about what was going, and he was like a lot of us, was sort of bobbing along on the tide, trying to keep your head above water, but having lost a rudder, having lost a sense of direction, and that maybe now with this disaster of losing all those resources, we're sitting on our own bottoms again, and having to make do with inadequate resources, which was the beginning of community mental health. Is that a fair perspective, Betty, about what happened when massive federal funding came in, what it did to community mental health?

Brenda Lindemann:

I think that he did have a skepticism about…professional… strong …

Participant:

I was the manager of HRS during the first five-year grant from the grant foundation, and the first crisis that I was aware of was when the grant from the grant foundation ran out. We had $100 thousand a year, and now you have a million, ten times as much, but inflation has… all that, but I'm not sure, but I think maybe, if I'm correct, the first crisis was whether to…state's money…to replace the grant from private foundations.

Peter Kirwin:

MGH is doing it. MGH resources, and then state money came in and they went out.

Robert Evans:

You know, I think we all like freedom to do what we want and someone to give us the resources that we need, and I'd like the notion somehow of being locally controlled and beholden, which I think you were talking about developing, which, actually, I think Vermont is such an unusual place, it's smaller than Brooklyn in terms of people, but there is a sense there—I know from working with schools in the State Department of Education—there's a sense that everybody kind of knows somebody else in the state, it actually is a coherent place…

Brenda Lindemann:

That's right.

Robert Evans:

…so it's possible to think of a state in the same kind of way, communitarian sort of way. I think there is, for years, there's now, every clinic in Massachusetts all with the exception of us, into this quality assurance measuring. So you show up for your first appointment to the clinic, they're going to hand you a questionnaire that you have to bubble in things, so then they have you bubbling in things when you leave, and measure of progress, and we won't do that, actually have their first visit bubbling in stuff. But actually we do keep compulsively, we always have, about how many of our referrals come to us from existing or former clients, which we regard as a very important indicator of people's satisfaction. It's not the only thing we use, but we pay attention to that. And there's all sorts of stuff you can do if you think locally which isn't as systematized as this other stuff as it now stands for quality, even though it has nothing to do with that. That's very important to us. It's local knowledge that you have if you're there and you don't if you're not, if you haven't been there for a long time. It's stuff you just know about, and it's harder to codify, and it's federally, I mean, I don't know, but I think that's we're getting, anyway, and when an agency has that it has a different sense of connection and embeddedness and also responsibility and vulnerability. If they get mad at you, you'll know about it.

Peter Kirwin:

You'll be at my door yesterday.

Robert Evans:

That's right. Exactly.

Brenda Lindemann:

The other thread that I'm hearing, I think, would you describe my father..community development and community organizing… he certainly…Vermont does it, not so much on the same level, but they try to break every process, down at least to regional if not a town by town process, so that people do get involved from the bottom up as well as…

Peter Kirwin:

We got our affordable housing model from the Burlington Community Land Trust, which is the best in the country, in terms of both affordable housing for low and moderate income families. The other number…here—the state Housing Trust Fund to a wonderful resource. You know, I'm proud to say I work in three towns with no affordable housing, so no one could actually afford a home at this point.

Participant:

…approaching …comment…that you mentioned…great …in Germany…appreciate…unity of East Germany…of Europe…and in that time…go back to… understood…and I'm really happy that you, David, have brought… and that was my comment…mention…often…wonderful…survive…your name, you're the daughter of Dr. Lindemann?

Brenda Lindemann:

Brenda's my first name.

Robert Evans:

Me, too, I'm glad to hear you. I agree and I think what I meant by that, about the choosing to survive or whatever, I never doubted that it would be good for us to do it, and I never stopped wanting to, but I was not willing for us to be just anything, just a money making machine, say, or to survive by stopping service to our local people and just chasing dollars someplace because that would keep us employed, and at that point we were something else that wasn't what any of us had chosen, so it seemed to me, that's what I meant about being hopeful, one has something to work for that is important, that is worth your effort. You may not always be confident that you'll succeed, but if you have something that you know makes sense, then you have something to be hopeful about, and…never, ever…ever. There's always been a crucial distinction between…having…

Participant:

…who… she's Jewish and she's German, and she used to ride… through the park, and at that time…so separately…that I… I never could go to the park…I used to…of mine…bicycle…late sixties… lectures…would also appreciate…and now…Now my question for… type of book, a model…Germany…anyplace in Germany…I know that I am not ignorant… but…

Brenda Lindemann:

I went to a conference a few years ago in San Francisco about the…community, the national movement, and there was somebody who made a presentation about working down in the schools and the communities, but I don't remember where, but it sounded to me like there was this … of the kind of things going on… and the only other thing I know, I have a friend in Vermont whose husband is from Germany and they met in Germany, I'm not quite sure how, but she teaches about diversity and racism, you know, fascism, the whole arena, and has been invited to several, she has made inroads and has been invited to come back to Germany to do her little presentations in some of the school systems. That's it, I don't know the details of that but I could find out more about it.

David Satin:

Perhaps this is a good time to suspend the discussion, and to resume it next year at the Twenty Second Annual Erich Lindemann Memorial Lecture. Thank you, Rob, thank you, Brenda, thank you Peter for a lively discussion and a lot of education.