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

Table of Contents

Foreward 3

The Community Mental Health Center: Forty Years of Survival and Evolution 4

- Introduction by David G. Satin, MD 5
- Frances Mervyn, PhD 7
- Jackie Moore, PhD 9
  - Introduction by David G. Satin, MD 9
  - Jackie Moore, PhD 9
- Michelle Anzaldi 17
  - Introduction by David G. Satin, MD 17
  - Michelle Anzaldi 17
- Discussion 23

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 THIRTIETH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

The Community Mental Health Center: Forty Years of Survival and Evolution

This celebration of thirty Erich Lindemann Memorial Lectures will explore the community mental health center—symbol of the community mental health movement. They both have adapted and transformed over the years in response to the evolution of community mental health needs, social ideologies, and public resources. Through Erich Lindemann's image and words we will compare his concept of community mental health services with today's community mental health centers' concepts of mental health, their programs to implement them, and the forces that shape them. Community mental heath centers are still here, but in what form and for what purposes?

Speakers

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

Frances V. Mervyn, PhD, Executive Director *emerita*, The Human Relations Service, Inc.; Dean of Students, Massachusetts School of Professional Psychology

Jackie K. Moore, PhD, Chief Executive Officer, North Suffolk Mental Health Association

Michele Anzaldi, Site Director, Erich Lindemann Mental Health Center, Massachusetts Department of Mental Health

Moderator

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

Friday, April 13, 2007, 2:30 – 5:00 pm

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

Introduction by David G. Satin, MD

The 30th Lindemann Lecture is a milestone in the annual Erich Lindemann Memorial Lectures. It is fitting that we address an icon of Community Mental Health—the community mental health center—and the change in community mental health over these decades. What is its importance is in the current mental health picture?

There were and are many concepts of Community Mental Health, including:

- bringing traditional psychiatric treatment to more people
- caring for the severely and chronically mentally disabled
- and, despite rejection by some people,
- social factors are the business of mental health
- prevention of mental illness is possible

Erich Lindemann developed a concept of community mental health from the founding of the Wellesley Human Relations Service in 1948 through work at the Massachusetts General Hospital, nationally, and internationally until his death in 1974.

He conceived of mental health as:

a) a product of social relationships
b) addressing it through strengthening and remedying these relationships
c) working with the social environment (neighborhood, hospital, town, and society) to strengthen mental health and mitigating social. predicaments that threaten it.

Erich Lindemann developed the following concept of Community Mental Health as he outlined the training of psychiatrists for this work:

1. Need to learn how to work with a lot of other people on the team in a different way.
2. Need to learn how to "deal with" people in agencies and groups in the larger community.
3. Learn how to be concerned with hazardous situations and the components of hazardous conditions. Know what is non-psychiatric material and what psychiatry can contribute to this material.

4. Follow populations rather than an individual, value orientations of people, the social systems in which they are involved, and what can be done about some of the problems coming out of all of this.
5. Learn the epidemiological approach to the study of mental illness.
6. Change the basic attitude of therapeutic concern for individuals to that of populations.

[Lindemann, Erich; Sifneos, Peter; McNabola, Marie; von Felsinger, Michael; Klein, Donald; Perry, Sylvia; Gellert, Beth; Morris, Laura "Summary of Meeting with Faculty Connected with the Training Program in Community Mental Health (Massachusetts General Hospital, 7/12/56"]

Frances Mervyn, PhD

Executive Director emerita, The Human Relations Service, Inc.; Dean of Students, Massachusetts School of Professional Psychology

My talk encompasses the years 1968 -1980 at Human Relations Service-the agency where Lindemann brought to fruition his many creative ideas regarding a preventive orientation to mental health. I will trace Community Mental Health's (CMH) evolution in that time period.

I joined at a change point—I was hired as a state-paid psychologist under the Community Mental Health Centers Act, President John F. Kennedy-inspired 1963 legislation which focused on creating federally and state funded services in catchment areas across the nation designed to supply all the essential mental healath services for that populace.

The Wellesley Human Relations Service had been the leader in CMH, with its prevention/community health focus (consultation, education, community involvement, crisis intervention), and it had left the more traditional therapies to other agencies. Now it was being asked to re-embrace these aspects of care while continuing its original more preventatively-oriented, Lindemann-inspired services.

My experience was therefore a hybrid. We had system-wide school consultation programs in two communities and with clergy, held regular community meetings, stressed educational offerings, established a public health nursing consultation service and supported the Boston Institute for the Development of Infants and Parents, a primary prevention organization in its earliest incarnation. And we added long- and short-term psychotherapy. Until 1981, the agency was able to carry all these roles, until a new, Republican federal government dismantled the CMH structure, asserting that mental illness was in the brain and therefore not treatable through community resources.

At that point, Dr. Rob Evans, whom you will hear from shortly, had to forge a new version of mental health service without state or federal funding. It is a testament to the community and the work of Rob and others that HRS survived. Most CMH agencies, at this time, folded. But at HRS school consultation continued, and Rob's work with schools across the nation and beyond expanded. In these ways some of Lindemann's original intent has survived .Because I think it is so important for new members of our professions to know about this orientation to mental health I came to teach this philosophy and these strategies at the Massachusetts School of Professional Psychology.

In my view Community Mental Health encompasses three areas:

1. Prevention, in its focus on understanding community dynamics, enhancing community resources, and actively working with the community to support its healthy functioning. Creating conditions that promote wellbeing in individuals, families, schools, and community, is paramount in this philosophy.

2. A preventive, early intervention orientation to mental health problems, which stresses the need for public education about mental health, mental health consultation to schools and community, and crisis intervention: a short term intervention suitable for anyone experiencing a troubling response to a normal life crisis-—divorce, death, loss of job, etc.

3. Rehabilitation of the severely mentally ill.

Jackie Moore, PhD

Chief Executive Officer, North Suffolk Mental Health Association

Introduction by David G. Satin, MD

...Dr. Jackie Moore is the Executive Officer of the North Suffolk Mental Health Association, and has been an administrator in several mental health and community mental health facilities in this state and in Mississippi. She is a consultant to the Mississippi Department of Mental Health and has developed a curriculum in mental health therapy training. She also has a PhD from Florida State University and is a clinical psychologist in training and by trade. You have heard that the North Suffolk Mental Health Association is one of the earlier agencies with which Dr. Lindemann collaborated when he tried to move his ideas developed in Wellesley to implement them in Boston, and at the Massachusetts General Hospital. Jackie...

Jackie Moore, PhD

I'm very pleased to be here. You're not going to hear a real Southern accent; I lost that about 14 years ago when I came to Massachusetts. I too grew up in community mental health when it was starting out in the 70's. That was back when there was money, when there was money for mental health. I went to graduate school on a NIMH training stipend, which was a wonderful opportunity to be trained. There was not even any payback, you were not expected to do anything but go to school and do well, and then go out into the world and do good. They did get a community mental health person out of it, so I guess it was well worth it. And I also worked in some of those community mental health centers back in the 70's, the true federally funded community mental health centers, and they were interesting. I worked in one in Palm Beach County, Florida. We didn't serve people with chronic and persistent mental illnesses, it was a different kind of community mental health center. As far as fundraising goes, it was the pet fundraising of Palm Beach County, so we were rather well resourced. Then I also worked at one in Hillsborough County that was completely different. I'm at North Suffolk Mental Health now and I've been there for 2 years, and we are a community-based provider. We have tried to develop a community-based system of care, and we do a lot of things that are community mental health related. We do school-based care, we do home-based care, we do early intervention, we do outreach, we do crisis intervention, we do supported housing, we do some prevention work, and we have a strengthening families program. We have integrated substance abuse into our services and we are integrating primary care. We do disaster work, and we all have a role in the pandemic avian influenza (AI)

planning events in our communities. We collaborate with a number of organizations in the Chelsea, Winthrop, Revere, and East Boston communities.

So we work with other organizations in our towns, and we collaborate with MGH health centers at our high schools. We have so many sources of funding that I cant even tell you, the print is really little on our balance sheets and it's very long. It's a house of cards, as one of my colleagues calls it. We have so many funding streams, and we do all of these things. The really important community mental health things that we would like to be doing, such as prevention and community education, no one pays for. So the consultation, the community education, prevention- the things that could really make a difference in the mental health of communities- we have to piece together with what we do get paid for to see if we can do a little bit of it. It's very frustrating when somebody comes to you and says, "We have this need over here. We have these kids coming in, they are mentally ill, and we need somebody to come and see them." But they don't have insurance, and we would love to do that. We believe that is what our job is, but we have to pay people's salaries too so it's frustrating. I'm not going to talk about the frustrations of it though.

I would like to take a little walk through history, because I do think that the history of community mental health is an important thing to remember. There was a vision, and Fran talked about it a little bit. There were visions and goals and principles on which the community mental health movement was founded. The mechanism to get there didn't work, but we really can't discard the vision and the goals and the principles. So I would just like to, if you don't mind, take a little walk back to 1963 when President Kennedy signed the Mental Retardation Facilities and Community Mental Health Centers Construction Act. He signed that just a few weeks before he was assassinated actually, and I believe he recognized the importance of that event.

He said, "We as a nation have long neglected the mentally ill and the mentally retarded. This neglect must end if our nation is to live up to its own standards with compassion and dignity." In 1963, people who had mental illness in the United States confronted a system that was firmly rooted in the past. It was largely predicated on the assumption that people with mental illness were irreparably damaged. The focus, therefore, was not on treating people and in fact the focus was not on them at all. The focus was on custody and making sure that they were not too great of a burden on the rest of society. In the mid 1950's there were more than half a million people residing in state supported institutions. The average length of stay was measured in years, not months, not weeks, not days…in years. Most patients expected to spend their entire lives once they were put into an institution. Erich Lindemann, President Kennedy, I believe that these people thought, "This is not okay in this country. We are a country that is

founded on opportunity and freedom, and we cannot abide warehousing people for the rest of their lives with no hope."

So the Community Mental Health Act signaled a change in approach. It made our goal what it should have been all along- the treatment of people with mental illness in their communities, close to their homes, closer to families, closer to friends, and their jobs. Kennedy's concepts called for a community-based system that provided a range of services to meet the community's needs. These systems would ideally involve prevention; early diagnosis and outpatient treatment; centers close to the homes of the patients; prompt treatment when hospitalization was necessary; rapid restoration to patients use of life; using follow-up treatment techniques, flexible use of day care, residential treatment centers; to handle people both on their way into the hospital and on their way out; and also to keep people out of hospitals.

Rehabilitation efforts would be enhanced with well-functioning foster care programs, counseling and training programs, community employment services. And within these concepts, schools and health and welfare agencies and the courts as well as professional schools and societies would all develop new patterns of cooperation and action. The nation's community mental health program was to be centered around comprehensive community health centers, as Fran stated, in catchment areas. There were to be 3000 catchment areas and each one would serve 75,000 to 200,000 people. The mental health centers would provide a focus for community resources and community facilities for all aspects of mental health care for those catchment areas. And inherent in that is a commitment to the belief that most mental illnesses can either be cured or ameliorated so that long hospitalization is not needed. The hope was that these programs would go a long way towards reducing the tragedy of thousands of people living in hospitals for a lifetime.

Fran also talked about the 3 areas that the community mental health would encompass. It started with primary prevention and then secondary prevention, the early intervention concept, and then tertiary treatment and intervention. Well, what happened? Those are good goals, and that was really a remarkable vision. So what happened to the hope and promise of community mental health? Well, following the signing of the Community Mental Health Centers Act, state hospitals discharged patients with major psychiatric illnesses into our communities by the thousands. Mental health centers were underfunded and unprepared from the very beginning. First of all, there were only 1,500 of the 3,000, so we didn't even have all the ones we were supposed to have because the funding wasn't adequate. The programs and services in the community that were necessary, the kinds of support that people need, were not in place. So we had a disaster- the funding wasn't there to develop them, people were being discharged, and we had some problems in the community.

So services and systems were sort of pieced together to respond to some of the clinical, housing, vocational, and other needs that became apparent as people came out of hospitals and didn't have the kinds of supports that they needed. When they were originally created by Congress in 1963, it was supposed to enable CMHC's to serve all members of the community regardless of their ability to pay and thus create a mental health safety net. By consolidating federal mental health funding into block grants administered to state mental health authorities, it hastened the transition of CMHC's away from that safety net concept. Since 1981, CMHC's have not received any direct federal operating grants and the title "Community Mental Health Center" is no longer an official federal designation. Changes in funding as well as deinstitutionalization forced many of our community mental health centers to devote an increasing portion of their resources to individuals defined as "members of priority populations" or those who are most ill and in most need of care. When you don't have enough resources to go around, you have to ration and decide who gets them. Typically these priority populations have included adults with severe and persistent mental illness and severely emotionally disturbed children.

Enter managed care. Now I'm not going to bash managed care, it's a part of our history and history is what it is. Managed care was an effort to try to control costs and manage utilization so that care was getting to the people it was supposed to be getting to. It introduced a level of accountability, actually, that although we struggle with it sometimes it is an important part of making us always look at ourselves and our systems to make sure that what we are supposed to be doing is working. And if we are not doing that then we are not using our resources as efficiently and effectively as we could. So I think managed care and public managed care offered opportunities to the outpatient mental health delivery system and especially to centers that were providing community mental health services. As the inpatient services have been reduced, and they continue to be reduced across the country, outpatient facilities have provided greater amounts of care to more severely ill populations, and we can do this. We have considerable experience actually in managing high cost care and high-risk populations. And we have learned that people can live in the communities, they can be supported in the community. It's about finding the funding.

In fact, I would suggest that the community mental health providers have pioneered some of the basic concepts of managed behavioral health care. We provide in many cases, cost effective, comprehensive, community-based services. We have coordinated systems sometimes, with networks of care sometimes. We provide care in the least restrictive environment, which is an important part of what we do. And we have small fixed budgets that we work on. Recently, the president's new Freedom on the Commission of Mental Health described our nation's mental health system as being "in

shambles." The commission recognized that the efforts of providers are frequently frustrated by the systems in which we operate. And to their credit, they acknowledge that real lives are at stake. The commission's chair said, "Too many Americans suffer needless disability and millions of dollars are spent unproductively in a dysfunctional service system that cannot deliver the treatments that work so well."

Actually, in some ways that is true. We know a lot about how to enable people with mental illness to live healthy, productive lives but we don't always do what we know how to do. We can't always do what we know how to do. Sometimes it's because of funding, sometimes it's because of systems…We know a lot more than we are able to do. We need mental health delivery systems that reflect what we've learned about what works. We need insurance that treats the most important organ of all, the brain, on the same terms as the rest of the body. Instead of reimbursement rates that drive providers out of practice, we need incentives to increase the ranks of mental health professionals. Instead of a crisis-oriented approach, we need to build a system of care around prevention and early intervention. Instead of fragmentation and static funding streams, we need systems of care that are flexible enough to meet people's needs, whatever and wherever they may be so that they not only receive effective treatment, but also necessary supports. For children, systems of care are essential. For adults, housing and employment services must be routine. We know that these supports can be the difference between integrating people with serious mental illness into their communities or marginalizing them to the sidelines. Primary care providers must have the training and resources to properly identify and refer patients with mental health problems. We must further integrate treatment for individuals with co-occurring substance abuse and mental health problems.

The president's new Freedom Commission made 6 key recommendations. First, Americans must understand that mental health is essential to overall health. Mental health must be addressed with the same urgency as other medical problems, and that that stigma that discourages people from seeking care must be eliminated. The second recommendation, mental health care must be consumer and family-driven. Consumers needs, not bureaucratic requirements must drive the services they receive. Consumers and their families must be placed at the center of consumer decisions. The third recommendation, disparities in mental health services must be eliminated. In particular, members of minority groups and people of rural areas have worse access to care. Services must be designed that are culturally competent, acceptable, and effective to people of varied backgrounds. The fourth recommendation, early mental health screening, assessment, and referral to services must be common practice. Too often, services focus on living with a disability not the better outcomes associated with early intervention, early detection, assessment, and linkage with treatment that can prevent

mental health problems from compounding. The fifth recommendation, excellent mental health care must be delivered and research accelerated. Evidenced-based services must be the bulk of service delivery and promote recovery and ultimately to cure and prevent mental illness. And the sixth recommendation, technology must be used in order to access mental health care information. The power of computer technology and communications must be harnessed in order to improve access to communication and care and to improve quality and accountability. Might I suggest to you that from what I've heard about Erich Lindemann, the first five of those were recommendations that he probably made back in the day.

So where are we with mental health today? Well we are still underfunded, that's for sure. And there are days when it's very frustrating and we feel so fragmented that I don't know if we are ever going to figure out how to put the pieces together. But most days, I remain optimistic and my colleagues remain optimistic. We are hopeful that we can get this right. Most mental health provider agencies continue to provide that we are the mental health safety net for the communities that we serve. We are passionate in our commitment to community mental health and we are fortunate to have a talented and committed workforce, but it is a workforce that is dwindling at an alarming rate. We could spend a lot of time talking about that, we all could, and maybe that will be a topic for further conferences. We are businesses to be sure, but our real job is to provide access to treatment that works. Access means, to me, clearly marked pathways to services that are free of hoops, free of obstacles, and free of barriers. People who present for services knock on a lot of doors and sometimes they have to break them down to get in. That is not access. The wait for an intake appointment with a therapist might be 2-3 weeks, the wait for an appointment to see a psychiatrist might be 6-8 weeks, that is not access. Consider someone who is diagnosed with a serious physical illness such as cancer. Testing, diagnosis, consultation, including various experts with oncologists, nurses, raidologists, surgeons, and treatment planning- it all occurs in a matter of hours or days. It takes us two or three weeks to get a treatment plan, if we get one, but that is not access. So we have some work to do there.

Stigma is still a barrier to accessing treatment. Our efforts to provide information in education must be relentless. The stigma is so powerful that people chose to suffer with these illnesses in silence and in private rather than seek help. When they finally do seek help, it is incumbent upon us to facilitate rather than hinder their access. In everything we do we must inform, we must educate, and we must advocate. We must demonstrate the understanding and compassion we expect from our fellow citizens. The other part about what I said about access is treatment that works. The treatment and interventions that we provide must be evidence-informed and they must be demonstrated to be effective. We must understand the impact of violence and trauma on our clients and our

services must be culturally sensitive. Our outcome measures must be functional and we must evaluate our services and outcomes. Interventions that work can be disseminated and those that aren't working can be improved, but cant just go on anecdote or what we think might be working. We should be tracking how each individual responds to treatment and then alter treatment plans accordingly. Our decisions, clinical and administrative, should be informed by data. Our evaluation and scrutiny must be continuous and always focused on improving. We must never settle for stabilizing someone and counting success as keeping them out of the hospital. Recovery and rehabilitation principles are embedded in what we do. The goals are increasing resiliency and improving decision making. The focus is on strengths, talents, and positive traits rather than psychopathology. We have to believe in recovery and the possibility of recovery. We have to believe in our clients and their capacity to be resilient and to recover. Our services have to be accessible and flexible. We have to have meaningful consumer and family involvement. We have to provide education for our clients, their families, our communities, our colleagues, school systems, the courts, primary care, and the training programs that train our future workforce. Relapse prevention and management strategies that include crisis planning are important. We should work with our consumers to plan their treatment and determine how we and they will know if what we do is working for them, and we should alter our goals and objectives as they progress. We should be promoting their independence from us and their contribution to the communities in which they live. We have a role in the communities. Prevention is one, and it is not one of the things that is funded as much and it is not one of the things that we are able to do as much. Community education is another, and integration is another- and I think that we don't do those things so well because we don't have the opportunity to do them as much as we know we need to. One of the challenges that impact on community-based mental health is that for providers I think the challenges are reimbursement rates. Helping people who were trained in a time that I was and others, to embrace recovery and integrate rehabilitation into what we do. Another challenge is a shortage of trained providers. It is very hard for us to hire for folks to work in our centers. The lack of housing and employment supports is another challenge. It's sort of a tangled thicket, I call it a tangled thicket of disconnected programs. There are a lot of programs out there, there is a lot that is done in community mental health but getting them connected is sometimes difficult. The procurement system is fragmented and it leads to disconnected services and programs- we need to fix that.

We have dynamic and diverse communities- that is a plus and it is also a challenge. It is important for us to be aware of our communities. The communities that I serve Chelsea, Winthrop, Revere, and East Boston are very different from those that Rob services and we both can acknowledge that I believe. So it is important for us to

understand the individual in the context of the community in which they live. For clients and consumers, challenges are what they have always been- stigma, availability of affordable housing, employment opportunities, accessible and timely intervention, navigating a fragmented system of care, and poverty. More than 50 years ago, Lindemann through his insight created a model of community mental health that promoted wellness through prevention and awareness. It is still what we want to do, what we know we should do, and what we have to find a way to do. He believed in the relevance of community in establishing and maintaining wellness, and I believe that those principles as well as the principles of the community mental health movement of the 60's and 70's exist. The principles, the vision- it is important that we keep those alive and that we work on developing our systems of care to meet those goals. Thank you.

Dr. Satin:

Thank you Jackie. It's interesting that both Rob Evans and Jackie have talked about working in the era after community mental health was ideologically accepted and was financially supported. It seems to have taken the road of staying small, sufficient, and balancing clinical care with mental health consultation and prevention. And the North Suffolk Mental Health Association accepted the new era, it sounds like, by providing clinical care, competently managed, comprehensive, competent, clinical care for mental illness, which is a different way of coping with the realities of the current world.

Michelle Anzaldi

Site Director, Erich Lindemann Mental Health Center, Massachusetts Department of Mental Health

Introduction by David G. Satin, MD

I'm anxious to hear from Michelle about the Erich Lindemann Mental Health Center, which a great battle was fought to name this after Dr. Lindemann as a concrete memorial in more ways than one to his community mental health efforts. And we have a film of his talk at the dedication of the Lindemann Mental Health Center where he was hopeful but uncertain about whether or not this institution would embody his ideas of community mental health and was very active in planning in trying to bring the Massachusetts General Hospital into the community mental health field by collaboration with Lindemann Mental Health Center. She is the Psych Director of the Lindemann Mental Health Center of the Massachusetts Department of Mental Health. She has been the Manager of Services at several community mental health centers, has her Bachelor of Arts in Sociology and Psychology from Boston University, and is a candidate for a Master of Public Administrations degree at Suffolk University. I'm very glad to meet her and hear from her about the Lindemann Mental Health Center.

Michelle Anzaldi

They call me the closer. You know, we had our great speakers over here and they said a lot of things that I would have said, and so they've saved me because now I don't have to repeat them. I imagine I will repeat a few of them. I've been a long way with DMH. I worked on the inpatient units at Mass Mental Health Center and got my training as a mental health worker. You know, I've been all over the place with the Department of Mental Health starting out as a transitional youth and now I'm going to retire with it, I guess. I hope we do some work on our workforce though, as some of you mentioned. A couple of weeks ago, I sat around an executive room for the Department of Mental Health with you know, the Director of Forensics, the Director of Quality Management, the Area Director, all these people, and the youngest person in the room was 48 years old. Where's our replacements? We need to do something, we don't have enough of them. So that's a topic, work on replacing us for the next lecture I think. I'm sure everybody's tired and it is a Friday afternoon before a 3-day weekend, so I will be brief.

As I prepared for my contribution to the lecture today, I wrote a number of different versions. One where I sort of traced the career of Erich Lindemann and chronicled it with mental health, then I approached it by outlining the history of DMH, interjecting wherever I could Lindemann ideologies as they intersected and trying to keep in mind

the academic crowd that I have in front of me. However, each and every time I read what I had written, I was like, "What the hell am I trying to say?" And some of the people who know me, I'm a straight shooter, I really say what I think and sometimes I upset people but it's usually in the spirit of getting things done. And I believe in what we are doing and working very hard for our clients. So anyway, what am I trying to say? This wasn't an academic paper but the question was, "What is community mental health?" These folks have answered that. What did Erich Lindemann think it was? I think they've answered that too. But what are we doing and are we doing it? I don't know. Sometimes I think we are and sometimes I think we're not. Well I believe that we know he was ahead of his time, Erich Lindemann. While many of his colleagues were pondering the inner ideologies of the mind and mental disease, he was urging his colleagues to look outwardly rather than inside of them and to look at the individuals in terms of their life systems, their culture, their values, their relationships, their tragedies, and the conditions that contributed to the situations they live in. And he encouraged all of the students that he had from Harvard Medical School to look at it that way too. So he promoted the integration of psychiatry and sociology and it worked for me, that's the road I went.

I trace the history of the Department of Mental Health to establish the first institution in America for treating mentally ill, it was in Worcester in 1833 and then all of these big institutions spread out all over the country, and now we are back to reducing beds but that's a good thing I think. As Jackie said, people don't need to be locked up. We have a good understanding about mental illness now and I think we can help them in the community. I don't promote getting rid of all of the beds though, because we do still need those periodically. So I have both the historical and academic approach, according to me, I'm a person who grew up in the Department of Mental Health and experienced the system as it was evolving. I accompanied patients to the basement of Mass Mental Health Center and watched them get their ECT. It gives me the creeps…but some people needed that and actually got better. We had a lady at Mass Mental who was a professor at Cornell who was bipolar disordered and when she dipped so severely into depression that she couldn't get out of the bed, she had to come once per year and get her ECT at Mass Mental so that she could then function. So something about that ECT made her forget how depressed she was or something, but it worked for her.

Anyway, we learned to try to protect people from themselves and we did things like secluding people and restraining people, and sometimes we needed to in order to keep people from hurting themselves. But we were lucky that we did not have to do that that often, and we only did it when it was absolutely necessary. And I know that the department has been embarking over the last 10 years on a movement to reduce seclusion and restraint and are at the point where we are close to accomplishing that to

be restraint free. But what I learned the most was the hope and the resiliency and the amazing strength of these patients.

We helped extricate people from the state hospital in the late 70's and early 80's as Jackie mentioned, during the movement for deinstitutionalization. These people were scared to death. You would think yeah, lets open the doors and they will all run out, but we opened the doors and they didn't want to leave. It was all they knew, and they were scared to death. They were scared to death and just sort of paralyzed by, "What are they going to think of me? Are they going to accept me? No they're not. They all think we're crazy." And really, we were frightened about how the communities were going to receive them. We attempted to relay their fears and also at the same time making sure they knew that the communities weren't going to hurt them, and that was a difficult sell. I participated in many a community meeting where people were screaming, "How could you do this?" and we tried to explain to them about basic human rights and that people with illnesses had the right to live anywhere in the community just like they did. We tried to explain the concepts of inclusion and at the same time some of us were like keeping our fingers crossed. So in the 80's we worked collaboratively with community mental health centers, emergency rooms, school systems, other state agencies. And I think at this point, many of us look back on those days and when we were in them we complained a lot about the lack of resources. And DMH, we were competing with our sister organizations saying, "They're getting more than we are."

Of course, there was a group of advocates who promoted the divorce of the Department of Mental Health in separating mental retardation and mental illness because they thought we would get a bigger piece of the financial pie. And they were right actually, because what had happened before that was that the mental retardation folks had the Kennedy's, but they still didn't understand mental illness and stigma. But there was tremendous…generations worth of stigma attached to mental illness and people were ashamed. They thought it was their fault. I wonder why they said that, Freud said that right? It's all the family's fault. If Freud was saying it, maybe he's right. Okay. So anyway, with the advancements in medicine and people like Erich Lindemann we began to realize that it was a combination of things that lead to mental illness and it would take a whole community to champion people back to mental health and wellness.

Who here has never seen the mental health center?

Audience member:

Where is it?

Second Speaker:

There you go. It's down in the West End down near Government Center, sort of behind the Fleet Center. And part of the Lindemann Mental Health Center takes up the whole city block. It starts on Cambridge Street and it moves down and now occupies by the Group Insurance Commission, Department of Employment and Training. And if any of you have seen The Departed, it filmed that building in a lot of scenes. The police station looked out from that building and looked out at what is now the Edward Brooke Courthouse. And we never really finished it, we ran out of money. There was this grandiose idea and then they ran out of money. So then we ended up with this one staircase and now we refer to it as the staircase to no where because they didn't finish it.

But anyway, what did evolve in this building? It was a coalition of the state authority, great medical minds of Mass General, Harvard educators, and a lot of really hard working and caring people. And the North Suffolk Mental Health had a key role in that, and the building had a number of things in it. It had a clinic, one by North Suffolk, it had emergency services, it had inpatient beds, it had a case management team, day treatment programs, social club, a community pool, a gym, and an actual half-way house inside the building. And people worked together, and it was a real partnership. But as people mentioned, it did not last. So at one point the deinstutionalization was so bad and we had no place to go. They were dumping people out but we didn't have enough programs to support them, and it ended up with a lot of homeless mentally ill folks on the streets of Boston. So where are we going to put them? The Lindemann Center opened its arms and said, "We've got this gym. We will put them there temporarily until we can create some housing." And they put up beds, they had some dividers, so they put 50 mentally ill homeless individuals on the gym floor and they said it was temporary.

When I came to the Lindemann, it was 20 years and that shelter was still in the gym and so our commissioner at that time, Marylou Sutter said, "I want those people out of the gym." There was number of reasons, one was that she felt that the gym was meant for the clients and staff and it should be used as a gym. She wanted to turn it back into the gym for the community. But then we said, "Where are we going to move the shelter?" We have to also think about where these folks are going to go, we cant just dump them out. So we had to figure out a way of transitioning them out while we developed programs. We partnered with our folks at North Suffolk and some of our other larger venders, but we knew also needed another "temporary" house for them. So we moved the social club out of the building and we said, "Well we don't need the day treatment program here and we don't need the social club here because they should be out in the community where the people are." So we did that, we moved the day treatment program out and the social club out and we made room for the patients. We moved as many as possible out into the community.

So anyway, I think in the 90's we made that switch to recovery and rehabilitation and trying to switch from that caretaker role to more of a teaching and coaching role. We tried to teach people the skills that they needed to survive in the community. We moved away from the 50 minute hour and I know that the clinics weren't happy about it. Because what we did was we took a lot of money out of the clinics saying, "Well insurance can pay for that- therapy and medication. We want to spend our money on things that cant be reimbursed by insurance." And we had these people who had been in institutions that didn't have the skills to live in the community. It was one thing to have therapy once per week, but how do I wash my laundry? So we did put money into our programs like community rehab and support and supportive housing programs. And paying for these things so that somebody could go teach somebody how to use the train and go to ride the T with them, take the bus, or show them the route from their house to the clinic so that they could get to their appointments. They taught them how to do laundry and went to the laundry mat with them, took them to the grocery store and showed them how to shop for nutritional meals. These are everyday things that you and I take for granted. So we felt very good about the achievements that our clients were making and the advances in new medicines, but more than anything we learned from our clients. We learned from people like Pat Deegan who've showed us that people can recover and live well with mental illness. So we are moving towards the client, family-centered, strengths-based approach that Erich Lindemann told us about quite some time ago.

So there are a couple of things that didn't work so well. We dissolved the partnership clinics, I'm not quite sure the reasons why we did that. I don't know, I think it had to do with something like parity and pay scales and partners in the partnership clinics were making more or less than whomever. So anyway, you've got managed care and now here we are in 2007 and we are facing some significant challenges. We've got a very fragmented system, but we do have some thoughts and some direction- the president's commission as Jackie mentioned has given us a guideline of how to think about that. And the Department of Mental Health is in our design phase of the re-procurement of the entire community mental health system. It's long overdue, and I think that it is not finished. It is a work in progress. I spoke with our current commissioner the other day and, I guess, they're still unsure. But what they want to do is try to get back to the mission and as it is stated in our enabling statutes to promote mental health through early treatment, education, policy and regulation, so that all citizens of the Commonwealth may live full and productive lives. We need to get back to that.

So many of the EOHHS and other agencies will be looking to our partners in the private sectors to help us with this. People in our business really do work very, very hard and I think that it's frustrating when you don't feel that you have the tools to do what you

think you could do for people. I'm hoping that now with the decision that's imposed upon us from the Rosie D v. Romney case…I'm not sure how many people are familiar with this case but it was a class action suit brought against the Commonwealth. The governor, EOHHS, and the Medicaid program because they said that we didn't provide services to children and families as are outlined in the federal Medicaid statutes for early and periodic screening and others. But if we are participating in this Medicaid program, we are obligated to abide by those federal statutes and a number of advocates proved that in court- that we weren't doing what we should have been doing. They started that in 2001, and the decision came out in January of 2006, and they have come up with some remedies which I hope will bring us back to where we started and the notion that we are looking at the person. They come in the front door, they tell us what their problem is, and it may be something we can fix today or something that is a long-term issue. But we are looking at the person that comes in the door and we figure out how we are going to pay for it later. I hope that we will be able to do that. What we want for our clients is what anyone wants; a home, a job, a friend, and a date on Saturday night. Thank you.

Discussion

Dr. Satin:

Thank you. Now is the time when all of your ideas and reactions and feelings about all of this can come out. Let me start out by seeing if I have the right perspective. It sounded to me that Dr. Lindemann was saying that community mental health consists of community and mental health, it emphasizes mental health and supporting mental health, and preventing the casualties of community life by strengthening and understanding how the community works. And second is by providing support and encouragement and skills to the community caregivers to help deal with life so that people don't get sick from it. And he expanded from there to talk about larger social policies- what goes on in the society and the city, and in the community as in the family that makes for problems. Also, how can you inform people to do that in a different way.

I think what Fran was saying was that the human relations service, in its early days, followed that method. It provided more services than Lindemann was particularly interested in, but maintaining the concern for consultation, prevention, and outreach. After the deluge when community mental health and prevention and social issues were demoted and finances went elsewhere, the responses were three. One, the human relations service maintained its independence and its small manageable size and continued a balance of more clinical service but still consultation, prevention, and outreach. North Suffolk Mental Health Center Association was realistic enough to say, "We are in an era of the treatment of mental illness, but we will do it in a comprehensive, caring, and financially and organizationally competent way. The Erich Lindemann Mental Health Center as I heard our other speakers say, is dealing with the chronically and severely mentally ill- one of the definitions of community mental health. And dealing with it in politically, economically, administratively, and competently as they can given the changes in the government, economics, and policy. This is a spectrum and it makes me think how different Erich Lindemanns perspective was in terms of policies to maintain and advance mental health in comparison to the practical limitations. I don't know if that's a fair perspective?

Evans:

It's a very different world. For one, the notion of community doesn't nearly begin to make the sense that it did back then. Anywhere you go in the country, you see the same trend. When I first got to the human relations service, it was still maps in the kitchen with pin points for where all the people in town were where the intakes had come from. There were identifiable parts of the community- you know, one school was poorer than others- and now everything in Wellesley is ridiculously out of sight. Keeping a map

would make no sense to us anymore from that sort of public health sense. Lots of things that went into communities then, Lindemann was still studying like the West End or places where there were communities that got shattered. But people are raising kids now household by household and there are national trends that are very different, and I think the whole larger context is one in which the notion of serving a community, if you just think of it geographically, it's different than raising a village. We don't have those anymore, and it means that what you are working with and what you are trying to help is much more of a moving target. There's more turn over, there's more inconsistency, and the influences are much larger. And so there are a lot of things that make it much harder to be a parent raising kids, harder to be a caregiver trying to help people do that well.

Mervyn:

One of the things that I have learned after the demise of the community mental health centers is that Kennedy's idea was that if he could establish the community mental health centers across the country, his next vision was that that would be the place for national health care. And when I heard that, I got even more depressed because it seemed to me that the catchment area concept centering the essential services for mental health within a certain geographic area so that someone from Chelsea didn't have to go to Newton, seemed to me to be a very smart idea. And then to have that as a base for nationally supported health services…and of course I come from Canada so I'm used to that concept and I know in the United States it's not as popular for a variety of reasons. But it was a killer to know that particular piece of information and to know that had he not died, he would have fought for that next.

Audience Member:

Can we take another aspect of something that two or three of you brought up and if you don't want to, we will do it next year. But we are all at MSPP today and we have about 225 graduate students going into the doctoral program in clinical psychology and about a dozen students in our program in school psychology. We have many students who would like to train in community mental health, and I am a director of training here. One of my many responsibilities is to find new training sites and I have a terribly hard time finding training slots in community mental health centers.

Evans:

They are not reimbursable.

Audience Member:

That's right. So how do the schools and the clinics get together to find a way…I have a lot of people under the age of 48. In fact, most of my students are under the age of 48

and I would love that…in the spirit of Dr. Lindemann, thinking about how do we bring people in? How do we bring students who want to do this work into your clinics? How do we do that in a way that works with your reimbursement strategies, that makes the supervision work? How do we leverage the clinical delivery that the students are able to do versus the hours of supervision? That would, very selfishly, be a wonderful topic for my graduate students.

Mervyn:

We would love to talk with you. We do work with student interns as Rob said, one of the issues for us is reimbursement. We need to provide the supervision and our clinicians need to be productive. Any time that they are not seeing a client and getting paid for it, it is costing us money, and it's not that we don't want to it's that we cant afford it. We have to pay salaries.

Audience Member:

Aren't there jobs for the students once they are trained?

Mervyn:

Yes. There are jobs.

Evans:

Once they are licensed.

Mervyn:

Yes, once they are licensed there are jobs. Absolutely. Now they come out…I've got four young adults of my own, and they come out of school and make a lot more money than we pay. Because the reimbursement rates, as I said, not good. So they come out and they want to make a lot more than we start out paying them, but I believe that is something we can work on. It's absolutely something we have to address. The experience is vital to what they do. You don't learn, as anybody who has worked in the field knows, you don't learn what you do through books in school. You learn when you get out there and do it. So it's a critical part of their education.

Audience Member:

(inaudible)…Dr. Satin gave me permission. I wrote a book, my name is John Merryfield and I've worked for 17 years at the Concord Community Mental Health Center. Hearing this wonderful conversation is like déjà vu. What this is, is subtitled modestly "A History of the Concord Community Mental Health Center." And it has been wonderful and, of course, sad in all the idealism. Anecdotes kept coming back to

me…just one of them about grants. When the grant gods are smiling, it doesn't matter what you put on the paper. We had a hospital administrator come to me and say, "Can you put something on paper because this company wants to give us money for an alcohol counselor?" So I did, and we did. But later, when the money changed, you could write the Declaration of Independence and not get any money.

Another thing which you people represent is that wars are started by generals but finished by majors and colonels. It's not an accident that the people who are running the programs now are tough, smart, flexible, non-physicians, and generally are women with noble exceptions. And that's one of the things that has happened. I go on and on, but my wife says I cant. But I do want to read you from Appendix I, if I may, and I will tell you who the author is when I get to the end of it.

> January 28th, 1984.
> Dear John,
>
> Thank you for lending me this book. A friend who is sympathetic to the problem read it and gave me an extended account of it. My grandfather knew Dorothea Dix and I was brought up knowing about her pioneer work in getting the insane out of prisons. How terribly our government is acting. Please forgive my writing with this flared pen. Dr. Slanskis has told me that I'm 'legally blind,' but the degeneration of the retina may be stabilized.
>
> Best wishes to you and your work,
> Abigail A. Elliot

Abby Elliot was the driving force that got the Concord Community Mental Health Center started, and she collected some people in her parlor and they plotted over a period of years how to get a health center going. And then they had a blitz with Hillburg money and there was a hospital that built an inpatient unit. One other point- I don't know if you can see this, but this is a picture on the cover and it's a Georgian building with a tower and the only clue is that the windows are boarded up. And that is the McLaughlin Administrative Building at Med State, which is closed. And Mary Lou Sutters was running it when it was closed. So anyway, it is a case history and I encourage you to read it if you don't want to reinvent the wheel.

Audience Member:

Is there an advocacy group or a lobbying group that could mobilize for getting reimbursable? That may be a naïve question but…

Evans:

There used to be and they used to have an office, but they are no longer there.

Mervyn:

It's difficult to answer your question directly. Not that I know of, but there are advocacy groups and I'm sure if there were enough people to go and say, "This is an issue," they might take it up.

Evans:

But you would have to think twice because a lot of people fought for years for what we all parity. And we got that through and what the companies did because they were going to have to cover more treatment is that they cut the reimbursement rates, so it actually came out of our pockets. It didn't actually result in any improvements in our revenues, so one of the things that you would have to think twice about is whether in fact getting more services would also translate into other reductions like that. I don't know, but it was a classic case of finally getting after many years what you want and then it turning out to not help.

Audience Member:

Well, we'll pay for 3rd and 4th year clinical psychology students.

Evans:

Yes, and we do. We do many creative things that we are not at liberty to mention here. But it's a little bit.

Mervyn:

It depends on the payer. Some pay, some don't. So you have to know the client coming in the door, if their insurance pays for it and who it pays for. It's complicated. I'm not…I'm willing to think this through. People have to think about it, it's a huge issue. It's huge for us, and I don't know if there's foundation money. I don't know what we can do, but we got to figure it out. We have to figure it out.

Speaker 1:

Well, imagine this. You just sent your kid through college, so its four years $40,000, and then the kid goes to grad school and says, "I'd really like to be a psychologist in a community mental health center. I'd like to make $32 an hour and not have any benefits." I mean, you're touching on something crucial but the ground that has been lost is *enormous*, it's not small. And so the other dilemma is that when you are servicing a population that is demonstrably more challenging than it used to be in many ways,

serving them with 3rd year students is a much bigger proposition than it used to be. It's one thing to have a family where there is a little stress because of a move or there is dislocation, but it's not just what you pay people. There's liability issues, there's all kinds of stuff. So you are looking at just a completely different climate than what you used to have. It isn't only what you can pay people and get them reimbursed, its also, you know, for what population would they be suitable? And how would you make sure that quality of stuff is being attended to? And most people are the same, they think its good to get people trained but they want to be seen by a pro.

Fran Mervyn:

And people in Wellesley and Weston, for example, are more likely to want someone who is more senior…

Evans:

Right, but anybody who reads The Globe would have seen the Dr. White Coat thing this week where you make sure you see how long the coat is…

Audience Member:

Unless you are at Mass General where they are all short.

Dr. Satin:

I love the opportunity to say, In the old days…the pay at the Department of Mental Health where I worked was not great, but what was exciting and what drew a lot of good people was that it was creative. You were developing new ideas, new programs, and there was idealism. There was an opportunity to serve the public, make a change in society and that was worth a lot of income. And people were eager to have that opportunity. I don't think that what is missing now is just the money, I think it is also the flexibility and the creativity and the opportunity to make social change. Because the flexibility has to do with the way that the administrative structure is set up, to not allow what they will allow. And the idealism has to do with the ideology.

I don't know how much interest there is now with making society better and wiping out poverty or mental illness or discrimination. I think people are more focused on the individual, the biology, the practical interests of the profession and not on those other things. I think that is what squeezes out the opportunity to do things. We have some people here who were there in the old days, who had the opportunity to do some of these projects. Joe Devlan was a social worker and was involved in the South Shore Project about prevention in young preschool children growing up ill.

Moore:

I think we are trying to head back there and I think there is creativity and there is energy for this. And I think the leaders in Massachusetts at the present time are very much embracing a need for change on a lot of levels.

Audience Member:

Is there evidence that can be presented about what things work for whom?

Dr. Satin:

If there are some people who need to go, please do, but if there are more people who would like to stay we would like more questions and experience. Thank you very much for coming and sharing your ideas, and we hope to see you here at the next Lindemann Lecture.