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

Best Practice Models for Commuity Service to Diverse Families 4

Introduction by David G. Satin, MD 5

Margarita Alegria, PhD 6

Introduction by David G. Satin, MD 6

Margarita Alegria, PhD 6

Ed K.S. Wang, PsyD 15

Introduction by David G. Satin, MD 15

Ed K.S. Wang, PsyD 15

Robert Evans, EdD 24

Introduction by David G. Satin, MD 24

Robert Evans, EdD 24

Discussion 31

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 THIRTY FOURTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Best Practice Models for Commuity Service to Diverse Families

The structure and culture of families has greatly diversified, and that diversity is being increasingly recognized. Are planning and services for their mental health geared to this diversity and meeting its needs? Have more appropriate plans and services been or are they being developed? Are mental health standards, goals, and practices relative to the various cultural, ethnic, racial, sexual, and family structure populations, or are there universal standards and goals that apply to all families and their children? This Erich Lindemann Memorial Lecture presents a rich array of experience, knowledge, skills, values, and theory shedding light on thse very timely questions.

Speakers

Margarita Alegria, PhD, Director, Center for Multicultural Mental Health Research, Cambridge Health Alliance; Professor of Psychology, Department of Psychiatry, Harvard Medical School

Robert Evans, EdD, Executive Director of The Human Relations Service, Wellesley, Massachusetts

Ed K. S. Wang, PsyD, Director, Office of Multicultural Affairs, Massachusetts Deparment of Mental Health; Clinical Instructor, Department of Psychiatry, Harvard Medical School

Moderator

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

June 3, 2011, 2:30 – 5:00 pm

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

Introduction by David G. Satin, MD

Welcome everyone. Today we have speakers who will be presenting on best practice models for community services with diverse populations. Our first speaker, Dr. Margarita Alegria, will be speaking about research in community health services. Next we will hear from Dr. Robert Evans who will be speaking about the delivery of services in a community agency. Then we will hear from Dr. Ed Wang who will be speaking about government policy and support for families and children. Finally, we will end by having a panel discussion among the speakers with you, the audience, where we can answer questions and discuss these topics further.

To get us started today, I have a few thoughts. The world around us and our lives are constantly evolving. People are not what they used to be, families are not what they used to be, and children are not what they used to be. Is this adequately recognized by mental health programs, agencies, and practitioners? Is the community providing appropriate mental health services to families in the community, or are they attuned more narrowly to only some types of family structures and needs? Are there mental health processes and needs that are universal and thus mental health standards and approaches that remain valid in different eras and for different families? We need guidance with these questions and practices, and look to a panel of professionals to bring thought and experience to illuminate them.

Margarita Alegria, PhD

Director, Center for Multicultural Mental Health Research, Cambridge Health Alliance; Professor of Psychology, Department of Psychiatry, Harvard Medical School

Introduction by David G. Satin, MD

Our first speaker is Margarita Alegria, Ph.D. She holds psychology degrees with summa cum laude honors from Georgetown University, magna cum laude honors from the University of Puerto Rico, and a doctorate from Temple University. She is a Professor at the Harvard Medical School and the Director of the Center for Multicultural Mental Health Research at the Cambridge Health Alliance. She is a member of the American Psychological Association's Presidential Task Force on Immigration, and the Massachusetts Children's Behavioral Health Advisory Council. Some of her publications include, "Social determinants of mental health treatment among Haitian, African American, and White youth in community health centers," and "What do patients say they want from mental health providers: A qualitative inquiry across race and ethnicity."

Margarita Alegria, PhD

Well, good afternoon. I'm very happy to be here, because I typically stay in an office and do not get the chance to really talk to frontline providers. Most of my recent work with the Center has been working with frontline providers to see how disparities becomes embedded in the clinical patient interaction. We have been doing studies for the past five years looking at what happens in clinical care that contributes to ethnic and racial minorities receiving such poor care. What I'm going to talk about today is a paper that we actually did. This was a workshop that we had and we had consumer advocacy groups, frontline providers, and clinicians talking to each other asking questions such as, "Where did we go wrong?" This is part of one of the papers that came out, but I'm going to talk about what we call "one size does not fit all."

One of the things that I think is happening is that today's professionals are really not well-prepared for the tsunami that came from demographic shifts in the population. They were really not prepared and I think our materials, our training programs are completely off from where we need to be in terms of that. They are really interacting with families whose race, culture, and dynamics are so different from their own that it is very hard to ask them to really understand these families in the context of where they are coming from. Even in the year 2000, 6 out of every 10 babies born in New York City had at least 1 foreign-born parent. If you look at the latest census data it is amazing. Most of these families are coming from Latin America and, therefore, they have very different

conceptualizations of what mental health is, what interactions with family are, what discipline is, and what respect is. And I think that this really has a toll in terms of clinicians trying to figure out what to do with these families.

Those families, because they have a very different perspectives may have different views on how mental health should be treated and approached. There may be tension with the clinician who might have very difference perspectives of their own that they base their decisions on. One of the things we are analyzing now is the idea that people should be participating in their own care. Some families tell us, "I don't want to participate, I want you to tell me exactly what I need to do to fix this kid." They don't want participation. But everyone here is patient-centered, and we need to have shared decision-making. However, some of them tell us that they do not really want that that, they are in turmoil and they want someone to help them out.

There is a similar thing with the dynamic of talking and how much talking they want and how much direct advice they want. They want more direct approach and not necessarily, "Tell me what you are feeling, tell me how you're feeling about this." They do not necessarily want that approach. The other thing we see is that they are thinking about spirituality, supernatural causes, and issues of how the whole is more important than the pieces. They think very holistically. For example, some people tell us, "I feel it here. I feel my brain is getting packed full." A Haitian woman told us, "pack full of problems, and I feel it here." And if you start telling her, "No, you don't feel it here, it's here," you are completely missing the boat, and I think that that's part of the problem that we are confronting.

I think if you look at what we have been doing for the last five years, we have been seeing that they have very different conceptions of the recognition of mental illness. That's not very different because if you look at the data from the U.S., most people do not recognize that they have a problem either. Even among those that recognize it, the biggest barrier to get to care is that people are self-reliant. They think they can solve their problem by themselves and it takes a very long time for people to recognize a problem, particularly if the problem came in childhood. So it's not very strange, but the biggest problem that we have is that most of these people that came from developing countries, around 75% to 80%. They have never been treated, so coming and being socialized in mental health as a preventive, or even as an early intervention, is very different because the people that get to care are people in their home countires are those that are extremely sick. So trying to change the idea that you can go to care early on so that you do not get very sick is an important concept.

One of the clinicians was telling me how she deals with the Haitian population in terms telling them the importance of getting early to care. If you tell them "It's really for your well-being," that's really not going to work. I work very much in the importance of

remittances to your home country. If you don't come here, you are not going to be well enough to be able to help your family in your country of origin, so it's really important to come and talk to me to get well because then you will able to function and receive a salary. This is a different a concept of how we would structure health seeking, the recognition of mental illness, and appropriate mental health care. Some people are having a lot of problems in thinking about what is appropriate care. If you think how many people stay in care, we've actually been doing studies showing that we lose 40% of patients in their second visit. So people go to their first visit and then we have a 40% drop out immediately. This is actually across the country and is not particular to Boston. We have been doing this study in North Carolina, New Jersey, New York, and Minnesota and have found the same across the board- 40%.

One of the issues that the speaker before talked about is that families themselves are very much changing. The families that clinicians learned to treat early on in their careers are not the families that we are seeing in our clinics today. If you look at the data, 34% of U.S. children in 2009 resided in single-parent households, however, if you look at the rates for ethnic and racial minorities the numbers are very different. It's only 24% of White families that live in single-parent households, but it's 67% of African-American, 43% of American-Indian, 16% of Asian, and 40% of Latino. So the numbers are very different.

Another thing that I think is quite important is where those families live. If you think about where the families live, the neighborhoods where they live are completely different. We haven't gone there yet to see what is happening there. For example, there's excellent literature showing that in neighborhoods with high rates of violence, parents have completely different strategies than you would use in other less violent neighborhoods, or rural neighborhoods where everyone knows each other and there is more safety. So there is a changing composition of families and the neighborhoods where they are interacting really make a difference.

One of the things we found out in our study about mental risk was that the neighborhood where you live matters tremendously in relation to your risk for mental illness. So if you lived in an unsafe neighborhood, your risk for mental illness is dramatically higher, especially for anxiety disorders and for substance use disorders. The risk changes if you live in high-risk neighborhoods.

If you look at neighborhood conditions, there's been very excellent data. Even though people talk about biological markers, and we are doing all of this research using very fancy things on genomes, if you look at the neighborhoods they are very predictive of high levels of mental illness or low levels of mental illness in the community and emotional problems in youth. It's what people are started to call hazardous environments, and hazardous environments really increase children's' chances for

anxiety and trauma. In the sense that they are very hypervigilant, and that hypervigilance also is reactive and looks like Attention Deficit Disorder but it is not necessarily Attention Deficit Disorder because these kids have to be in total alert at all times.

One of the things that I think is very important for clinicians that work with diverse families and do not want to over pathologize the family is that they need to go into these environments and see what the conditions are. This also creates the possibility of identifying potential neighborhood supports that could also be used in treatment. It takes a village, and the CDC has now implemented what it calls "community supports" to work from a population-based perspective. So if you put resources in at the community level to give support to these families, it really changes the dynamic of health and this is more about population-based approach, which is very important.

One of the things that I recommend to clinicians, especially the early career clinicians, is to go and visit the communities. We have a clinician in one of our clinics that was seeing a lot of women with panic attacks, and she was really surprised that she had so many people that worked in the same factory. So she said, "let me go to the factory and see what's going there." She went to the factory and found that there was almost no ventilation, no windows, that people were completely crowded and working in extremely tight environments. They were very stressed out because of productivity and the conditions of work were really part of the problem. These women were reacting to a very negative working environment in Boston with an unfortunate a sweatshop type of approach. So this is really what was triggering the panic attacks that she was seeing in many of her clients. So I think going to the environment is quite important.

The other thing I wanted to mention is that people do not recognize that many of these ethnic and racial minority youth are disproportionately more likely to have interactions with the justice system, or have family members that have interactions with the justice system. Therefore they are very mistrustful of institutions and for very good reasons. I mean one of the things we see is that they expect greater injustice. In Chelsea, one of my post-docs did a photo voice project where she asked kids to take pictures of things that created violence, and things that created peace in their communities. She gave them cameras and audio recordings and the surprising thing was that some of the pictures of violence were patrol cars of policemen. So people thought of them as contributing to violence and thought of other things like community agencies that were more community-based as being the peaceful agents.

If you think about differences in language, they bring tremendous problems in terms of the interaction and how people can communicate. We published two papers looking at the effects of language differences between the provider and the patient, and they bring so many problems of misdiagnosis, losing information about suicidality, and obtaining

wrong information about side effects. So not sharing the same language, and sometimes even the slang. I can tell you that I am originally from Puerto Rico, and as you can imagine when I came to live in Boston, I could not believe the slang. I was at a loss for what to say when someone used slang and said something like, "You ran your stockings." And I was like, "You ran your stockings? What does that mean?" You know, things like that. The other issue is the use of acronyms. You know, I would be in meetings and everyone is MCS. And you are like, "Who is MCS?" and you feel like, "I don't want to ask because I'm going to look dumb." But it is so common to use acronyms, and people use them as if everyone should know. And if you don't know, you are not part of the in-group. I think that's the sort of thing that really turns people off in relation to who belongs and who does not belong in these groups.

I think the traditional approach of service delivery is extremely ill-prepared to deal with these populations. Mainly because these service systems still believe that they are going to be treating a predominantly English-speaking, White population, and that is not going to be the case. They are also very unresponsive to the needs of this population. One of the things we are finding in our study is where we are offering people therapy by phone versus therapy in person. And people love the idea of using the phone because they don't have to make the 30 arrangements that they have. They don't have to deal with issues of transportation, missing their jobs, explaining to their employer why they are taking an hour and a half every two weeks to go and visit someone. It really makes a difference in how we think about the traditional approach. If you have a 9am-5pm job, there are only a few times available to you. I think that changing the approach of how we offer services and what we can offer is going to be very different.

So I think we have a failing system. I'm going to zoom through this but if you think about the statistics, ethnic and racial minority children receive an average of half as many counseling sessions. In the study that we did with the Cambridge Health Alliance we looked at Haitian, African-American, and White kids in the same system, with the same insurance, with the same type of providers, so it's not a difference there. Results showed that the White children got more visits, African-American children got less, and Haitian kids got the least amount of visits.

As compared to non-Latino Whites, you can see that they have lower rates of mental health service use and make fewer office visits. Especially for hyperactivity and depression the rates of service use are dramatically lower, which is very problematic because these are two very prevalent conditions for kids. They are also less likely to receive combinations of treatments. They typically only receive one type of treatment as opposed to combinations of treatments. I obviously think that this shows that we are really failing ethnic and racial minority children in how we are providing these services

and what we are providing. The dropout rates, for example, for the Haitian kids were dramatically high.

The other part I should say is we make such a little effort to answer questions of what are we going to be offering. You would be amazed at the data. We videotaped sessions and what we found was that basically no one explained what was going to happen in therapy- no one. So people have no clue about what is going to be coming. We know that if you tell people that on the next visit they will be doing "x," the chances of people coming back are much higher, but we do not do that.

I don't think we are paying any attention to culture, context, and diversity. I think that we are very politically correct and everyone says that they do and they are all for it. However, I think if you videotape sessions and look at the differences, you would be in awe about how different we treat different groups of people. The interesting finding is that we don't know about it. I have to tell you, one of the interesting findings from this study was that we asked patients about their perceptions and assumptions about their providers. For example, "What do you think the religion of your provider is?" "What do you think their age is?" "What do you think their income is?" "What do you think their education is?" Then we did the same thing for providers about their patients. What we found was that providers tended to underestimate their ethnic and racial minority patients, and that patients tended to overestimate their providers. Patients believed that their providers were wealthier and more educated than they actually were, which is a really interesting phenomenon of how the stereotypes happen very early on.

So why do I think learning about our patient matters, and why does culture matter? I think mental health is a social construct. It is created in the interactions that we have. That's why when you look at rates of ADHD, one interesting paper that we published looked at how different the rates were for certain conditions depending on the country. ADHD, because of the hyperactivity and inattention is very much higher in Asian countries and is much lower in certain other countries that do not have high expectations of behaving in closed environments and how you should respond. So, it is all part of the expectation. There has been very interesting work in Hawai'i showing that clinicians, depending on where they came from, had different ways of judging whether kids have ADHD or not. There is a lot that comes from the clinician themselves that does not have to do with the patient. To give you more, one of the things we found in this study was…I told you about videotaping and we had clinician give us the diagnosis of the patient based on their assessment. Then we had another clinician look at that same videotape and blindly give us the assessment to that patient. What I can tell you is the concordance between those two clinicians was actually very low, unless it was substance abuse- very, very low.

I think when we talk about cultural diversity, we are really talking about the interactions between patient and provider, which happens in routines, how people behave, and in their expectations of one another. It really is not shared knowledge. The more distant we are from people we treat from different cultures, the more we have to create an image of what we think that is, and typically we create that image based on very few cues. We use skin color, language, and how people dress. You might be surprised to find how important it is what people are wearing and how they act when they're coming into the session, which precipitates a lot of images in clinicians' eyes.

I want to be very clear that I really admire clinicians and I was a clinician for a very long time. There was a clinician that had a man come in and he had a lot of tattoos. And initially the clinician said, "I'm not going to treat this person, I don't do substance abuse. I'm going to refer him because he's really not going to be a good interaction with me." The interesting finding was that the man started crying because he actually had a trauma history, and it changed from "this is a substance abuser" to "this is a trauma victim." The dynamics completely changed the interaction after that happened. So we all have stereotypes- we all make assumptions in the interaction. The stereotypes are not only from the provider- patients also have stereotypes about their providers and it comes in the interaction, but they are changeable. I think that that's the most important piece- they are changeable.

It really varies tremendously how providers deal with difference in cultures. Some providers spend a lot of time trying to assess the differences in culture between them and and the patient. Other people just zoom through it and assume, "I'm just treating an illness, and therefore I don't need to really know that much about the patient because it's the illness I'm treating." So that is a very different perspective. But what we see is, how people then weigh the information and interpret the information from provider to provider varies tremendously. That why we see differences in how people score and decide on a diagnosis.

So I think it's very important to learn and see how we can help clinicians test their assumptions. It's amazing how we have many assumptions we have when we are in clinical care, but we do not typically test them. We just make them and keep on doing them. I think that one of the cues to really improving the care we provide especially for ethnic/racial populations is testing our assumptions. One very interesting thing that happened: we had all of these questions in the ethnic/racial studies about culture and how people saw their culture, and how they thought culture should be thought about in the interaction.

It's interesting that for some people, they might have come from an Italian family but the culture that mattered to them was that they were raised by a police family. The culture of a police family was very different than the culture of other people, and they

talked about how that culture influenced their behavior, how they talked to other people, and their idea of coming to care. So culture can mean many, many different things- it does not have to be only ethnicity and race. It could be you know your upbringing in this place versus another, so I think it's very important to try to understand what we mean.

It is not an individual level thing, but one of the things we can think about is what sorts of things that are important to people. One of the things we found in this study was that clinicians focus on what was important to their patients and it really made a big difference. Some other interesting things that came up, for example, some people were coming to a mental health visit because they were pushed or referred by family members who wanted them to come. They did not see mental health as the most important thing. Addressing this as a part of the interaction is very important. For some people, even the idea of being able to talk to their mental health practitioner about a physical illness that they had, and how they had lost identity due to this illness was more important than treating their depression symptoms. So thinking about what is most important to the patients is really important.

If you ask people what their approach is to life, what their core beliefs are, and what their goals are in treatment, you can address culture directly in treatment. You would be surprised how few people ask, "What are your goals in treatment?" Very few people ask that question. I think that it is really important to ask people about their main interactions. What's their family like? "Tell me a little bit about how your family interacts?" What things they do? How they share each other? We do not ask these questions. A lot of people say that they are very family-focused, but if you look at interactions in session very few people ask questions like; What's your family like? How do they interact? What sort of things do they do? How do they work? That is an assessment of culture in itself, because family is central to culture especially for children. Although there's family-centered treatments, I would say that very few people are actually thinking about interacting with the family as a whole family.

At an organizational level we also talked about the importance of paying attention to this. I think there needs to be some very basic changes at the organizational level. You can not just tell people to be aware of culture, be diverse, or take these cultural awareness courses. That is really not going to cut it. I'm sorry to say, I have a very negative view of cultural awareness training workshops, because I actually don't think they help. I think to really to get into it, you have to explore what is different, and what you can learn from others. They are the expert on themselves, so I think organizations have to think very differently about how are we going to create the workforce that is going to be able to pay attention to these issues, and not just on a superficial level.

I think we need to work with organizations to can change the dynamics of supervision, for example. I think supervision is basic. Having people being supervised

and actually hearing and seeing the therapeutic interaction, and how it changed depending on who was there and what they were talking about. These very subtle messages that we give to people in terms of who they are and how we are treating them, it is important to have people observe that and give feedback. So overall, I think it is really important to have cultural sensitivity and awareness, but I do not think it should be a course. I think it is a lifelong proposition of learning as you go and we should build in more supervision for ongoing care.

I think looking at enacted culture, rather than I telling you "I'm Puerto Rican." Actually, what aspects of Puerto Rican culture do I share and what do I not share? I might be Puerto Rican and have a lot of other customs that came from where I was raised, and not necessarily from the country itself. You want to see enacted culture. I think we need a paradigm shift if we're going to offer services to ethnic/racial populations. And I think it should be in our responsibility to look at our retention rates. Our competencies should be judged based on how many people we retain in our care. We rarely do that.

I also think doing community and family partnerships is important so people trust us and think of us as helping agents. Some of our clients talked about, "I'm their paycheck." They did not see us as helping agents, and we know from the literature that the best predictor of outcomes and care is the relationship between the provider and the patient. That's the best predictor, so I think it is quite important. I think we need a public health framework. We can not continue with fee-for-service clinical care, because I think it is not going to be good enough. We should be focusing on competencies and looking at the powerful resiliencies of these families rather than their pathology. We tend to over pathologize these families without looking at their resiliencies. We need to look at what the supports are in their communities and in their families that we can use. Obviously, integrating prevention and early intervention programs is important. Overall, we need to change the organizational culture to improve the care that we provide, and this has to be at an administrative level as well as the clinical level.

My time is up. So, I think we need a transformational change that really matches the services that we are offering with their unique needs. Thank you very much.

Ed K.S. Wang, PsyD

Director, Office of Multicultural Affairs, Massachusetts Department of Mental Health; Clinical Instructor, Department of Psychiatry, Harvard Medical School

Introduction by David G. Satin, MD

Our second speaker is Ed K.S. Wang, Psy.D. He is a Clinical Instructor at the Harvard Medical School and Director of the Office of Multicultural Affairs in the Massachusetts Department of Mental Health. His teaching focus is on clinical competence in working with culturally diverse clients. Dr. Wang…

Ed K.S. Wang, PsyD

Hello to you all. It is a Friday afternoon at 3:30pm, and I am really glad that you all stayed put and are not yawning. I hardly see a single yawn. Part of it is partly Dr. Alegria's presentation. She is a go-to person for me when it comes to looking at research, evidenced-based treatment practice, as well as her kind of understanding about the issues of cultural-linguistic populations in terms of care. What I am going to look at in some aspects is from a policy level and certainly reflects some of the things that she talked about, but we still have a long way to go.

Massachusetts has always been seen as a cutting-edge state, maybe because of our close proximity to Washington DC but I think that it is more than that. It is the excellence and the innovation that all of us have had, and many of you have probably been doing some of these things much longer than I have done.

So, anyway- I cannot do her slides, because I am not as sharp as Maggie (laughter). But let me start with mine, just to give you a sense of who I am. I think my focus at times is very narrow, but I think you have to understand where I'm coming from because the constituents that I represent have for many years now had seriously mentally disabled adults with dysfunctions, many challenges, and then also the seriously emotionally disturbed children and their families. These are the individuals have multiple complex needs, so the way that I look at the design of a program at the policy level is a little different at times because of the nature who I represent as a member of the State Mental Health Authority. So that's number one. The other thing is that I think that you have to know that I am a trained clinical psychologist, and I very much base my experience on Maslow's hierarchy of needs, again, due to the nature of the clientele that I provide services for.

About 28 years ago, I was a practicing Masters-level psychologist working on my doctoral degree. Yes, I am not one of those gifted children that entered college at 12-

years-old. I went to a school of professional psychology, University of Denver, when I was 16-years-old. No, I wasn't that. I actually look a little bit older than the way that I present or the way I looked. So I went through the same rights of passage getting my bachelor, then my masters, my doctorate and so forth in clinical psychology, just like any one of you. But I practiced 28 years ago as a very young clinician and thought that I was very well equipped and knew all the theories: personality, psychopathology theories, and so forth. At my first job, I was assigned to a client in Denver and make the long story short, what I learned was that all the theories about how to do treatment, and all the developmental theories and psychopathology theory, it really does not work. (laughter) Because this person I was working with was homeless. She was in many senses rejected and abandoned by her family because of her mental illness. She was a paranoid schizophrenic, and the fact was that her family disowned her and she became homeless.

So the 3 things that I did for her that she told me later on when I saw her about 6 or 7 years ago. She said, "3 things that I remember that you did that helped me. One was that when my toenails are getting almost becoming in-grown, you helped me by cleaning out the trash can in the office and putting some warm water in the trash can, so that I can put my foot in to be comfortable. Then you helped me to clip a little bit of my toenails." She said, "I remember you helped me when I called you and you came. Because I found a mattress that people had abandoned. You came and helped me to carry the mattress to an industrial neighborhood so I could put it down and have a bed." So without further going into the details- those were the things that made an impact for her. Not my brilliant psychotherapy. And the third thing that she said was, "You really helped me when I was stabilized, and you found me a job. You found me a job and I stayed on the job, as a matter of fact." 6 or 7 years later when I visited her, she was happy and she looked so different because she was working. And that was what helped her.

I just want to give you a sense of how that shaped me in terms of who I am as someone that is planning policy and so forth, I do not at all minimize what we do as clinical psychologists, social workers, or other professionals. That is important, and our theories, background, and evidence-based treatments are extremely important. But on the other hand, the clients that I represent and continue to represent are those have complex needs. If you cannot have a roof over your head, if you are hungry all the time, if your healthcare is not going to be taken care of it is very, very hard for individual to recover.

The other piece that I want to mention is something that I do it all the time which is that I always emphasize promotion, prevention and intervention. Even though legislatively and budget-wise we are so focused in terms of the 27,000 clients that we serve at the Department of Mental Health who require and need our services. But I always think we need to go back, we need to go back as a state mental health authority

and think about prevention. It is too late when you start doing tertiary intervention. It is way too late.

OK, so the other one that I always want to make a pitch about is that I am always very interested in the social-emotional, cognitive development of children and adolescents. I would rather talk about social-emotional and cognitive development of our children of our next generation in our country. So these are the things that I would like to quickly focus on and not spend a lot of detail on it. For the purpose of today, I want to address the issues of the zeitgeist, family diversity, reduction of protective factors, and rising risk factors. We are going to talk a little bit about what specifically they are, provide some examples, policy system and practice, and finally tipping point. And I think you are part of it. You are it- a part of the tipping point.

So the zeitgeist, what is it? The spirit of the time. For those studies experimental psychology, this term impressed me because I didn't know how to speak German but it is a German word. (laughter) It is so meaningful. It is the spirit of the time. Politics, spiritual environment, social environment, and many more create that environment. We cannot talk about today's topic without asking, "What is our zeitgeist at this point in time?" We have an African-American/Black president, right? So that's a change in terms of the social, political, and racial environment. I am just using one example It is the zeitgeist that it is very important for us to think about. What is the zeitgeist of Massachusetts? Healthcare reform- we better pay attention to that because we are all involved and we pay tax dollars for it. We also want to talk about Children Behavioral Health Initiatives, or CBHI. We have to pay attention to it, because of the impact on our children, adolescents, and young adults. ObamaCare- I think we have to really pay attention to it. The good news is that no matter what happens in the future, whether Obama is going to be the next president or not next president, the fact is that healthcare reform is going to happen. It is going to happen with maybe with differences across states.

It is going to happen in Massachusetts. It has happened now for a number of years. And we have some so- see some good results. Of course, we are concerned about the care, so we have to pay attention to that. We cannot talk about diversity or services if we think that that they are going to happen in a vacuum. We are all part of that process. Dr. Alegria mentioned a little bit about another area that I think we need to pay attention to, which is integration of behavioral health and primary care. We need to pay a lot attention to that. It is happening, we see it in the the Affordable Care Act. Those languages are there, and it is happening. Now how fast it is going to happen? And of course, what is that based on? Resources. We are continuing to ask providers to provide quality services with less resources. I think that is going to continue. So that is the

zeitgeist. That is what we need to pay attention to- the spirit of the time, where we are for today's topic.

Family diversity- I think this is an area that was well discussed by Dr. Alegria. I don't think we have to talk a bit more. But I just want to mention that in my work, it is not only talking about race and diversity. We talk about single-parenthood, we talk about parents and/or children with physical and other form of disabilities, LGBTQ parents or children, and military families which is another big one right now that we have to talk about. I could go on a list of in terms of the family diversity that we have to address, and it goes to your question. If we deal with so much diversity, how do you manage? How do you, as a clinicians or as policy makers, manage that type of diversity in our country? And I just want to again mention that we have over a hundred ethnic groups. What the Institute of Medicine talks about are granular ethnic groups. Anything from an individual from Ghana to Iraq to Cambodia, and cross back to Chile, and cross back to Haiti, and so forth. We have over 100 ethnic groups in Massachusetts, we are the 7th state in the country that has that kind of diversity, and we are a very small state. We only have about 6 million people, but we have one of the largest regarding diversity. We are ranked #7 after Texas, California, and some other big states.

One more thing that I am always interested in is what is called a four-to-one family. In policy, you imagine this child right here has to take care of 4 grandparents. This child here, so to speak, has to take care of 2 parents. China has a one child policy. Can you look at the impact- I am not going to talk about how controversial it is in terms of the policy itself, I am purely talking about in terms of how that is changing the structure of a society.

OK, let's move onto reduction of protective factors and rising of risk factors. This is an area that I think we all know and I think that Dr. Alegria also mentioned this. I just want to highlight a couple of other things. She talks about violence and trauma, definitely complex trauma is the result of violence, community violence, domestic violence, gang violence, and so forth. As a matter of fact, there are a lot of good studies related to the outcome of these intergenerational transmissions of violence and models of care provided for various individuals. Poverty, the whole economic downturn, all of us have been affected to varying degrees through social and cultural displacements, the breaking down of gender roles. Particularly for refugees and immigrants families- adjustment, acculturation, language barriers, and cultural identity.

So, with the reductions of the protective factors and the increase of risk factors in many ways, we also have to look at that. I want to point to 4 things about the resilience factors that I think are very beneficial to look at. I always think that religious and spiritual involvement are resilience factors. When we have a disaster, whether a natural disaster or man made disaster, the most common question from a victim is "What are we

doing wrong? Why me?" That is hard to answer. But ultimately, if you work with trauma victims it is spirituality that can answer those questions and give some a sense of peace and recovery. Greater social participation- We know that the reduction of social participation to isolation can be very costly. The role of altruism- there are a number of authors who have written about that and I don't know whether it is evidence-based, the practice of taking care of others. Volunteerism, or altruistic behavior, tends to heal an individual, a community, and a society. I actually love seeing kids starting getting involved.

Best practices and the system of care model- this is what I was asked to talk about. The five A's- that is my criteria when I look at practices and presenting models and so forth. The five A's are accessibility, affordability, acceptability, availability and appropriateness. So these are a few specific examples that I am pretty proud of- The Department of Mental Health, Community-based Flexible Support, this Asian collaborative which uses a bilingual, bicultural model. A clinician might not able to speak the same language or understand the culture would be working side by side with a basically a bilingual, bicultural broker in various aspect of services. The flexible support services are going back to what I said earlier about complex needs. The client needs more than just medication. They need things such as supportive counseling and so forth. I think that is one model that we are doing well in Massachusetts, except we only have one program that is in the Boston-metro area. We would love to see out in Springfield, Holyoke, southeast areas of Massachusetts, Fall River, New Bedford. All we need is some resources, right?

Health promotoras- I think this is something that we really need to pay attention to as it ties that back into healthcare reform. We do have actually have our own version of community health workers. I don't know if we specifically have health promotoras for Latino populations in Massachusetts. (inaudible) Yeah, so we do. Good.

Children's Behavioral Health Initiative- it is here to stay. It is not going away and I think that we need to look at it as specialized community services agencies. For instance, we have one in Roxbury that is run by Children's Services of Roxbury. I think we need to pay attention to that in terms of what they do. But one specific area I think we need to pay attention to is the wrap around model. How many of you know about the wrap around model? Okay, a number of you are here know about it so I am not going to go into detail. What it does, though, is makes our services in many ways much more culturally and linguistically appropriate and it follows the five A's that I mentioned earlier.

Community health centers- I am biased because I was trained and worked in a community health center in Massachusetts way back about 20 years ago. I am biased, because I think it is a gateway to care especially for immigrants, refugees, and those

cannot afford care. The other thing that Dr. Alegria mentioned is place-based care, I think that is also important to think about. There are a lot of place-based initiatives coming from the federal government right now, specifically developed by President Obama, taking the leadership and then trickling down into health and human services. I think place-based is unique in that it requires individuals or organizations to really get to know where they are, what they do in that specific community. It is very difficult to write a broad policy that can actually satisfy and be appropriate for everyone in every community, but if you can go into a place-based approach, then things are working. An example of a place-based is Geoffrey Canada and the Harlem Children's Zone. You know, the "one street, one neighborhood at a time." If you look at that development from the beginning to now, you can see how the place-based kind of initiative works specifically for that area.

The system of care model is a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children and their families. There are a lot of systems of care models across the country. Massachusetts currently has one called "My Child in Boston" that is specifically focused on how do coordinate, link up services that wrap around that individual, the kids and the family. I think we need to replicate that even more, you know in our setting, and I want to give you a little evidence of that. I am not a researcher, but I always pretend that I am one.

This wrap-around model system of care was developed about 17 years ago, and at least for about 12 years now it has been followed through for an evaluation process by an agency called Macro International. It has a tremendous amount of data within that, but I just want to show you a couple of things. I notice that Dr. Alegria is smiling. She might have some comment on that. (laughter) We all know a little bit on the other side, but anyway- summary of school attendance and performance, something more concrete on the functional level. If you look at this- program entry, 6 Months and 12 Months. What happened if you look at attending less than 60% of the time for the student? At the time of program entry, 43%, and 6 months later, 20% in terms of attending less than 60%. Improvement. If you look at failing half or more classes: program entry, 56%; 6 months later, 32%. So, as you can see by descending order these are the outcomes of this particular model called system of care. Youth suicide- program entry, 13%; and it reduced to 5% in 12 months. I always take a look at these data and try to use it as a guide in terms of will this be something that we want to invest in the long run?

Another practice model is the Cultural Assessment Formulation. It basically has a 2 x 2 matrix with 4 quadrants. Cultural and social economic identity- this is basically a narrative model. I like narrative stories, and I encourage clients to tell me about themselves in a way that they can freely tell me about themselves using their own level of

comfort. Perception of mental distress- I have changed that now, I stole that from Arthur Kleinman. Many of you probably know him very well, and this is basically his explanatory model. But rather than perception of mental distress, I changed the word from mental "distress" to "suffering." Expression of symptoms- that is the idiom of distress from the DSM-IV-TR, the help-seeking behaviors, and then there are whole sets of questions for each of these quadrants.

CANS is an interesting one. I have to tell you this story- I have to confess. One day I got a marching order saying that, "You need to take a look at this CANS instrument that Massachusetts is working on." I said, "Okay, I don't know anything about the CANS." So I googled it and started looking around. Then I gave Dr. John Lyons a call, and said, "I am being instructed to look at your instrument, particularly in the area of cultural considerations." So anyway, make the long story short, we did the first run of the CANS questions. It was done in a weekend with me on the phone and him in New Jersey where he does his work. It was really no good, but the marching order was, "Get it done! Have it ready!" Okay. (laughter) So few months later I said, "Wait a minute here, the way that we put this together, it is not even half baked. It is probably 1/16th baked." So ultimately, there was a group of individuals several months later that all sat down, and we went through that. I don't know whether it is the same version that is online now, but it will be online soon. It actually focus on issues of discrimination, relationships between system and family, agreement about the child's needs and restraints, cultural identity and then cultural differences within the families, and these are the five questions. I have to say that with a team of folks working on it, including community providers and so forth, it is better than the earlier version.

Policy system and practice- this is what I usually do and this is me. I can be the donkey some days, or I can be the guy that leading the donkey. (laughter) I call that a day in the life of a policy planner. Actually at times in the past, I did have someone shadow me. I had such interesting comments from them after the day, and sometimes I wonder, "What am I doing here?" These are the things that I look at- best practice models. I give you a little bit about the system of care as I give you the model. Then of course policy and research, and I will leave that to Dr. Alegria.

One of the things that we have to do is to conceptualize disparity nowadays. Disparities are here to stay, which is a good thing. But if you look at that, these are the outcomes, the measures so to speak from prevalence to access to quality and so forth. Let me give you a little bit more of a complicated version. (laughter) That is what disparities are about. I have consulted for a Cambodian family where the father was disabled, definitely had complex trauma, PTSD, and major depression. The mother was having lot of physical illness issues and was going to be disabled. There were three children- one was in the juvenile justice system and one was currently at home. There were certainly

child protective issues and so forth. And then a very difficult relationship with a lot of domestic violence. If you look at that family, I can actually go through all these circles of disparities about this family, maybe with a few exceptions. Thank God, no HIV, no cancer, no obesity. There was cardiovascular disease, potential housing issues, and low income definitely. If you look at all the things- that is what disparity is about. And I will jump on that shorthand approach in terms of understanding, understanding individuals and families. We also have a tendency of a shorthand approach to understanding disparities. We just think, "Oh, they're poor." That's it. But there are a lot of other things come with poverty and that is what disparities are about.

So this is a big problem, breaking down the silos. Now if you have all these disparities, guess what? We have a wonderful state government system. For health problems, you go to Department of Public Health or you go to this other system. If it is child issues, you go to that system. If you have mental health, you go to that system. But that is a problem, all of these systems. It is a problem of government. Each of us have our legislation, each of us have our policies, each of us have our regulations, and each of us has our dedicated way of financing, structuring, and so forth. But that creates silos. When we talk about complex needs of diverse family or any family, I think that's where government fails. Do I have a solution? No I don't. (laughter) I do think that there are a number of activities now in Massachusetts with the idea with the leadership of the governor is to break down these silos, but the kids, I think they got it.

One way to do this is with the Department of Mental Health. We have cultural-linguistic competence section plans that we focus in 7 areas. We actually took out Human Resources because that got centralized under the Romney administration, I think. So, basically start with community partnership, leadership, training, education, services, information, and data and research. Pictorially, just give you a sense of these 6 domains. Each one has a number of activities, and I also like to really look at the leadership structure. So I look at what that structure can do in terms of certain specific activities under the 6 domains of our activities and so forth. I am not going into details of that.

So the tipping point- you are it. What are the 3 things for the tipping point? First of all, it takes only a few people. I think that we have more than a few people. The sea of change has already happened in terms of disparities. We are not talking about when Margaret Mead said only a few people. We have more than a few people. The timing is perfect in terms of this country right now. Part of it is driven by diversity, I think. You walk out on the street and you notice the difference. When you live in a neighborhood, you look around and you see changes of the neighborhood. It is perfect timing. Culture and language matters- these are just kind of broader thoughts. I think that you all play a role, whether you are a practitioner or you are supervisors for MSPP or you are students

of MSPP, and so forth. You play a significant role in terms of education and training, and also in terms of the diversity of workforce.

Culture and language does matters in our society. What does that mean? I don't know. If you ask me two generations later, when there's much more interracial marriages, and kids that are, you know, like mine. Can you let these kids down? We have some of the science, and we have some of the interventions. We have enough ideas, we have enough perspective, and we have enough evidence-based treatments to do something. Let's stop talking. You know, I always hate when I walk into these meetings, whether it is at the state level or a national meeting. I look at these 20 people and I say, "Gosh, how much money and time for us to sit together, and keep talking and talking and talking and develop a plan, develop a policy, and you know probably 95% are going to be shelved anyway." So thank you to all of you.

Robert Evans, EdD

Executive Director of The Human Relations Service, Wellesley, Massachusetts

Introduction by David G. Satin, MD

Our last speaker is Robert Evans, Ed.D. His education was at Princeton University, and he earned a Doctorate in Education from Harvard University. He is the Executive Director of the Human Relations Service of Wellesley and is proudly one of Erich Lindemann's professional descendants. He is a former high school and pre-school teacher as well as a child and family therapist. For 35 years, he has been a clinical and organizational psychologist working with school teachers, administrators, school boards, and parents. His work is focused on change and resistance to change in schools and organizations. Among his publications are "The Human Side of School Change," and "Family Matters: How School Can Nope with the Crisis in Child Rearing."

Robert Evans, EdD

Thank you. I am Erich Lindemann's administrative descendant, one of two actually in the room since my predecessor, Fran Mervyn, is here as well. I've been at the Human Relations Service a lot longer than Eric Lindemann was, but like everybody else who has been there I still stand in his shadow. As I was sitting and listening, I was thinking several things. One- My God, why did I agree to appear? (laughter) Because most of what you have heard about I don't have the credentials to talk about. We at HRS serve three communities that are among the ten wealthiest and Whitest in Massachusetts; Wellesley, Weston, and Wayland. We see a lot of international college students, but they are mostly college students of considerable means. So I don't have credentials about poverty or diversity or lots of things that we have been talking about.

Secondly, David, back to thumbing through the old study about the populations that got dispersed in the West End- Erich Lindemann was interested in decades ago. So there was a whole ethnic community that got displaced to build that stuff, and the mental illness indicator skyrocketed among them when the community was shattered and the people were moved. You had a kind of microcosm way back when immigration was a very different deal than it is now. The second thing I thought about as I was listening was that there were but there were a lot that both of you described as important to helping people, which actually is also true of working with a plain and ordinary, wealthy White suburban population. I mean that work actually depends on what kind of relationship you can make with somebody. It depends a lot on actually knowing these people and

having some kind of genuine interest in these people, even if you share a lot of the same assumptions and background things in common.

But the larger thing I was grappling with as I was listening has happened to me previous times when I have been a participant in one of the Lindemann lectures here. And that is I am always torn between that question you were just talking about, David- money and values. It is one thing to say what a need is and what is something we have some evidence that works about. It is something else to be able to do it and by able to do it, I mean have the money to do it, but also the wear-with-all as a practitioner to do it. It often seems to me that the almost any kind of problem you look at is one that you where you can ask, "Well, isn't it awful that it is like this?" or, "Isn't it surprising that it is not worse?" And how you see this of course depends very much on your own history and immediate experience, as well as the population you work with and everything else. But at least in the trajectory of my life, I have found myself going from somebody who only asked the first question, to somebody who increasingly asks the second one. That may just be a function of getting older and no longer imagining that I can reshape the world the way I would like it to be, and if we just worked a little harder it would all coalesce in some kind of ideal way. Or it may be the kind of realism that you get through experience, I'm not sure. But the contribution I suppose I could offer here is a couple of things.

First, I want to say that if you just for a moment broaden a little further up in the Good Year Blimp and look down, so you are not focusing on specific sub-populations of any kind, but just sort of the country more broadly, Ed was talking a lot about taking up sort of the kid's perspective. So if you ask yourself the question, "What is really good for kids? What do they actually need?" I think at certain fundamental levels, there are some things that are pretty universal, even though they get delivered in very different ways by different cultures. For example, every kid needs a minimum level of nurturance or they do not grow up. Every kid growing up in any family or culture or community needs to have some kind of structure that provides some indications of what you do and what you do not do. Cultures have very different views about that, extremely different views. In the absence of something that is coherent, a child's development is really compromised. In one way or another, all children as they grow up need a chance to interact with the world, find out what happens when you do this or you say that or whatever, and to learn from the consequences of their actions, decisions, choices, etc.

Again, this is handled very differently by different cultures, but if you see those as sort of three basic developmental areas about which there is a lot of knowledge that says that at least if you're going to grow up here, these things really matter. Then from that perspective we think about a family nestled inside its community as being in the business of raising actually not children but parents that are raising future parents. If you look at the American developmental scene from that perspective, even when you get to the

precincts that my clinic serves, what you can see is that actually the odds are getting longer against healthy development.

We have more kids. In my life I have worked in 1,500 schools in the U.S., from the wealthiest to the poorest and from the most hotshot suburbs to the inner cities. But anywhere you go, when you talk to people in the frontlines who teach, when you talk to pediatricians, if you talk with clergy and ask them about the kinds of changes they see, everybody describes pretty much the same trend. It is not the same intensity, it does not take the same shape in every group, but you see the same trend. We have more kids who grow up less nurtured, on average, who come to school less nurtured on average. This is true not just if their parents are so poor that they need to have three or four jobs to make ends meet, it is also true of the parents who are so wealthy that they would not need any job.

We have more kids who come to school, for example, who are less able even in the places where they are more ready to read and less able to form a line. Now you can have room for a lot of cultural diversity, but you can not run a school if the little kids can't line up. You have to learn to line up. Interestingly, I was talking to someone the other day who has worked in an inner city school for a long time, and in a couple of charter schools in other states, and asked her what kinds of things she thought her schools had been most successful at. She said that she thought they had done some really good teaching, but that what they found they had to actually teach them things that you used to take for granted, like looking at somebody when you say, "Hello." Well, you know there are there are cultural places in this country where you don't do that, and it is not seen as a sign of rudeness or disrespect. In some places it is a matter of safety, that you actually don't do that.

What you do see, even in the wealthiest precincts, is fewer and fewer kids who are expected to live with and learn from the consequences of things they say and do. When Massachusetts, pushed by the Boston Globe, went ape about bullying we ended up writing a law that gave the school zero additional authority and a ton of additional responsibility. No principal in Massachusetts has any more authority now than she had two years ago to do anything about a kid who bullies. What every principal will tell you is what happens when you call up now to say you know you're son has been bullying somebody. Nobody says anymore, "I'll get right on that." What they say is, "That's not true," or "The other kid deserved it." This cuts across a whole swath of cultural backgrounds- Black, White, Hispanic, etc. When I think in these terms, I am less convinced about whether the zeitgeist is right, and more worried about whether the tipping point is actually headed in the other direction. Not because I disagree about the need or the fact that there is a bunch of us who see the need, but that we represent nonetheless a significant minority. I have to say, given where I am in my life now in my

career, I feel that I am a part of a much smaller minority than I used to be in terms of the appreciation of the needs of this kind and services for kids.

The other thing I think about is that it seems increasingly clear to me that how we act and the decisions we make, whether it is as a practitioner, sitting with a family, or at the policy level…Tip O'Neil always used to love to say when he was in Washington: "Where you stand depends on where you sit." And I think there's a way in which the perspective really is crucial. You know Shakespeare wrote about this over and over. Jean Piaget used to talk about the "American question," because he would go around the world when he was newly on the international stage, and his theory of the stages of cognitive development stuff was you know sweeping the academic world. He used to say that only in America would he get this question, "How do we speed these up?" Everybody else around the world saw what he presented it as, the unrolling of what happens naturally. Here the question was, "What do we do?" There's a way, of course, in which this captures both the American genius- the "can do, and we're gonna do" and a way in which it captures the American delusion that somehow everything has a solution.

Now, I think about this because a couple years ago I realized that in listening to Matt King, who had been the superintendent of schools in Wellesley, that there is a distinction is between problems and dilemmas. What he says is that a problem has a solution and you fix it, and a dilemma is built into life and you cope with it, but you don't fix it permanently. So a problem is like the muffler on your car is dragging. You get it replaced, and it is fixed. A dilemma is like being a parent- it is incurable. You have children. That is what we say, you have a child but you have to let them go. You love them, but you could kill them. They make you feel proud and fulfilled, but terrified and furious. It is wonderful being with them, and it is fabulous getting away from them and there is no cure. You can't read a book that fixes this. You are not helpless, you cope. But the distinction is this- you don't cope once and then it's done.

We were just making the list of all the things that would be good to do, that's one list. And I haven't heard much today that I would disagree with so far. I think on the contrary, we have heard very good lists. But when I think about what it would be like to do that. You said, for example, that just that some of that standard cultural training stuff just doesn't cut much ice, and I thought you were a 100% right about that. But then if we say, "Well, what would it take to actually get people so much more knowledgeable in that more kind of visceral way you are talking about?" Suddenly things get a lot more complex. That's expensive. It costs somebody time or tuition, or I don't know what to be able to acquire that. And how many different cultural sensitivities should you have? And where would we specialize and stuff like that? And when you get to Ed's level, which is at the policy level, how would we begin to acknowledge enough of a need, given the change

in our population, that we would actually fund the kinds of training that would be required?

And my experience is that once you take any kind of serious preventive or population-based approach to your work, then the potential to feel guilty and inadequate is limitless. The kind of people who teach in school and work in mental health, I always think of them as the kind of people who thought seriously about the convent or the monastery. But at the last minute, contemplating the full list of vows, the chastity was too much to tolerate so they turned away, you all of you, and you settled for all of us. And we settled for the second most sacrificial job we could find and it says community mental health (audience laughter). Low paid, under-resourced, and with a mission that is almost limitless (audience laughter). If you take the school as a microcosm, if I stacked up on this table right here the amount of curriculum we expect covered versus 30 years ago, it's about twice as high. I am not saying the kids learn twice as much, I'm saying we expect the schools to cover twice as much. If we made the list of what the vaunted 21st century skills that you hear about all over the place, as compared to say the 20th century skills, well that's up too. So what about the readiness and the supports in families in communities, even the wealthy communities, and the answer is that they are moving down and not up, as I see it. By down, I mean more people living under higher levels of stress and less available and able to provide for kids some of the essentials that would undergird the extra levels of achievement that we are expecting.

So what it means is that anybody who engages in the effort to help the development and growth- whether it's of a child or a family or a community or a school- is having to close a larger gap, because the expectations have risen but the supports have declined. At best they have held about level. This to me is the definition of how you create stress. So a part of what concerns me a great deal is not just do we have enough good ideas, or do we actually know? I think the evidence we have all heard is pretty persuasive to me, I assume that we actually know a lot of stuff that we didn't used to know and that would make a real difference. I don't just mean the money, but the personal wear-with-all to make the kind of investment on a sustained basis, not just now and then. They are all thinking about how to reduce the reimbursement rates, which is what they've all been doing, but the tuition here is not going down. The students who graduate here graduate with much larger debt loads than I did when I graduated.

So it seems to me…a couple of things. First, I have to be honest- I find it hard to see much in the larger scope of things that inspires a lot of optimism about this. Many years ago, George Albee put a book together, Primary Prevention: An Idea Whose Time Has Come. I remember it was a bunch of readings about prevention, and at that point in the country we were spending one cent out of every mental health dollar on prevention. There are times when I feel like those of us who keep the flame are a dying sect or at least

a minor one, because it is harder to make a persuasive case beyond a room like this about the kinds of things that would be necessary.

What that suggests to me is a couple of things. One is that the stance one should take is neither to give up and say 'Uh,' nor to assume that you could just heal the sick, raise the dead, and become a sort of paragon of multicultural sensitivity and treatment excellence. It seems to me what we do is we set a high goal and we try not to give up on it. We do what a good teacher would do, which is we look for the movement from where we were to where we are. Actually this is always the truer measure of progress, not the apparent need. It is the movement. So, it seems to me, I am much more of an incrementalist than I used to be, at the personal level and actually at the organizational level as well. I am these days more glad to see movement in the right direction than sometimes surprised that we haven't gotten there faster. If you are not careful, that's an easy way to just cop out. But the alternative is that you just do a lot of pie in the sky that does not actually have a chance of leading anywhere, and then the people that take it seriously just feel worse. Or, alternatively, we make promises we can't keep and then the people who hold the purse strings say, "Well we are not giving you anymore." That is what we do to a lot of schools now these days.

Second, I honestly think that many of the things that would strengthen families of any kind are things are that have very little to do with mental health. They have much more to do with things like jobs, housing, community safety, and other things- several of which you referred to in the first part of your remarks when you were talking about that. It is not that mental health isn't important or that treatment shouldn't be available or the rest of it, but that an awful lot of what is undermining the family are things that are not immediately within the grasp of the professional, family, or even sometimes the block. Because when you get to Geoffrey Canada, who makes nearly half a million dollars doing what he's doing, they have a lot of drop outs there in that school in Harlem. Some of the success they have is because they are spending the kind of money per kid that you spend at a private school, because they are funded by a lot of wealthy people. I mean, my hat's off to him and all the rest of it, but he is not St. Paul, and you know they have some resources that a lot of the rest of us do not have.

So, the conclusions and then I will stop so that we can get to our collective discussion. One, I think the issues are endemic. Issues about family and about kids growing up are endemic. While it's clear that there are gross disparities between the wealthy and the poor and so on, the picture to me is not that encouraging anywhere, even in the places that are advantaged. Second, I think those of us who are in the business of trying to help need to find ways now and then grapple with this dilemma between our wishes, hopes, perceptions of need, and the realities of what we can do

collectively and individually. I also think there are problems, weaknesses, vulnerabilities, and also strengths and resiliencies.

One of the things that a lifetime of work at the Human Relations Service has taught me, is that especially in the most difficult of circumstances, you have to be looking for the strengths, you have to find a way to mobilize them, you have to wonder where they are. I thought that was implicit in a lot of what you said, which was not misreading families because you misunderstand their culture. You talked overtly about resilience and an awful lot of what happens when people need mental health help is that they are demoralized, and one of the things that un-demoralizes them is somebody who is interested in them fully. That includes the strengths they have available, the things that are meaningful, the sources of something in their life that suggests there is more to them than a problem or a disability. The other piece about it is when you do the work, the risk as we all know is that you end up demoralized yourself, because you go home late on a Friday, right? (audience laughter) Having listened to stuff like I am saying now, having spent the week already trying to heal the sick and raise the dead, I think there are times when we need to remind ourselves that no matter what the odds are, we have got to do for us what we try to do for them. We have to find the strengths now and then, and not because we are trying to pretend that things are not serious, difficult, and hard, but because we know that if you are going to make any kind of progress, you do not just attack weaknesses, you have got to build on strengths. Thanks.

Discussion

David Satin:

I guess you're going to have to raise your voices, because we're not going to have enough microphones for everybody. Are there things that you wanted to say, or that you were sitting on until you had the chance to do it?

Margarita Alegria:

I would like to give would like to leave some time for the audience.

David Satin:

Everybody is part of the panel. I know that, Dr. Alegria, you were rising to my bait about what happens to people who come to school, come to a mental health program (psychology, psychiatry, nursing, social work, etc.) with cultural competence, and then have to figure out what to do with it in the professional school, and what they end up being taught to practice.

Margarita Alegria:

Just to respond to that, I actually want to rephrase that, because I actually am a believer that no one comes with cultural competence. I actually have the people that I teach read something that is called "The myth of cultural competence," because I think that people believe that they can achieve it. I am actually a believer of cultural humility, that you never achieve cultural competence and what you really do is develop cultural humility in approaching people knowing that you don't know.

Audience Member:

It's a dilemma?

Margarita Alegria:

It's a dilemma. (laughter) I think that falls in the dilemma category.

Audience Member:

I wanted to ask the panel- while I take Dr. Sander's point that conversations about money are conversations about values, do you believe that we as a society currently have sufficient resources to do a much better job with families if we made a dramatic reallocation? For instance, taking the military budget and devoting it to helping families, or we would need significantly new financial resources in order to make a dent in what families need?

Robert Evans:

Oh, You are the policy guy! (laughter).

Ed Wang:

But I am not a financial guy. (laughter).

Robert Evans:

Well, I will say one piece about it. I do not think actually that it is just finances. If you think about what the model is going forward for being a successful professional person, it includes a life that is increasingly work-centered, increasingly focused around innovation, which by definition means devaluing stuff that went on before, right? It is a way of living that also has built in the assumption of an "onward and upward" mentality about material things. The plus side, of course, is that it keeps people motivated but the downside is you never know when you have enough. So even if we imagined a significant allocation towards services, I think it would conceivably improve our ability say to work with that population that Ed and DMH were talking about.

Margarita Alegria:

I completely agree, one of the things that I was very surprised to see was that anxiety is lower when both parents are immigrant parents, but both had to be immigrant parents. When we did focus groups we found out that the expectations are lower of what success is. So I completely agree that I do not think it is an issue of more money invested into the system. I think it is really changing our perspective of what are healthy expectations.

Ed Wang:

I think from the government side, we do have government that is very siloed in terms of various agencies. And especially for those populations that do have complex needs, the better coordination, the more consistent the policy alignment and services, then there is no wrong door. That's not asking for more money. You just have to tighten those resources to able to provide services to clients, and I think that I myself would truly believe that we can do that, but we do have to then break down those silos and say what is the more effective way. In some sense, we do have very huge government and it is very difficult. Even though the needs or the standard expectation is lower, you are going to several agencies to get that. So I think, yes, we can actually make that better coordination with no new dollars.

Audience Member:

What are we going to do about greed? Everybody wants to be a millionaire. (laughter) Everybody, anybody see the movie Too Big to Fail? What are we going to do with just greed? Because if we get rid of all this money in the banks, people with 5 houses and jets and stuff and spread that around, it is plenty of money to address these issues. So part of the zeitgeist I think is just plain old greed, and we need more of people who are willing to just eat enough for them and leave some for somebody else, and to me that is the essence of the problem. (laughter)

Audience Member:

Can I say something? That to me is like…I don't know if anyone has ever lived in other countries, but we are such individualists in this country and this is capitalism. This is this is what we do. You know, we are not into each other, it's like, "No, me for myself- me first." There's this amazing series called Unnatural Causes, I don't know if you have heard of it on PBS? It's about health disparities, and when people come from other countries, they're actually healthier, even if they came from poor countries- mental health wise and physically- because there are people around them and there is a collectivist culture. Then they come here and they move into these inner cities. The people I work with are Dominicans and Puerto Rican and they are isolated, they are in fear for their lives, and their children are in gangs. They are working 3 jobs or they are home alone. The isolation…I mean, I don't know how you change capitalism.

Audience Member:

But you don't!

Robert Evans:

Capitalism, to be quite honest with you, is one of the reasons they are here.

Audience Member:

Right! But that's no longer really…I mean the dream is gone. That's not happening anymore.

Robert Evans:

Yeah, but it ain't that good there and this is the dilemma- greed has a rich history in America.

Audience Member:

Yes, so it does! I know it does! (laughter)

Robert Evans:

Anyway, we can all speculate but actually, there is not much anyone is going to be doing about that here.

Ed Wang:

I think that it is a good point about greed. You will get me energized to focus on that, but I am not going to go there because it I think it just takes too much time. I am just going to respond to what Rob said earlier and just for your thought, maybe 20 years from now. I think what Rob said…it's to me about the American pragmatism, the "we can do" attitude and I think that's a good thing. I really think that it is a good thing that "we can do." The result of that is innovation and I think that it is a very positive thing that we have that value. That is part of the zeitgeist. I think that in addition to the American or the United States pragmatism, now there are 2 areas I think we need to focus on. I am getting a little bit philosophical here, but I think it is worth it to think about. It is the ecological and phenomenological aspect of understanding of who we are, where we are, how we are doing, and the phenomena that impose on this country because of diversity. We do not have answers for that, but I think if we can look at all 3 perspectives, then that is a new generation about this country. It's what we are about.

Audience Member:

Well, I would like to respond to this. I think that is a lovely strengths-based focus on the dilemma, and I think we can get a lot more mileage forward in following the arrow wherever it goes if we have that strength-based focus. You know, we can see some of these positive changes in communities that are planned communities, where there is mixed use and inter-subjectivity in people, which I think may speak to more feminist values being incorporated into the thinking. For example, the integration of the medical home or the community behavioral health with medical, which involves more inter-subjectivity and more empathy. When you have more empathy and more interdependence between people, you will have more collective culture and you do not need socialism or capitalism. You know, it's not just about economics, it's also how we set up our society.

Margarita Alegria:

I guess I have to say I am way more optimistic, way more optimistic. What I wanted to say is that I think we are very stuck on very traditional models of service delivery, and I think that is going to dramatically change. I think the idea of peer models of care, the idea of paraprofessionals doing the actual first layer and then moving supervision to higher levels for more complicated cases is going to dramatically change. People in in countries like India, Vikram Patel just did a very innovative trial where he trained paraprofessionals to provide the care, and they got as good results as the clinicians doing

the same care. I think that the idea of like dental assistants- who before thought that dental assistants would give you pretty much your whole dental care for the majority of us? I think that it is going to change. I am way more optimistic that people will have greater access to better care and it will be more democratized rather than just certain groups getting the care.

Audience Member:

I was interested particularly in what you brought up about prevention. I work in a clinic in which we are trying to identify young adults or teens that are at-risk for serious mental illness and trying to engage them in the idea of prevention in the early stages. I was wondering if folks had any tips or advice for how we can start to think about providing better care. I think we have already noticed that we provide our best care to those that are highly educated with lots of resources, and if you have any ideas that would help our clinic, I would appreciate it.

Margarita Alegria:

Well, I go back to what Rob was saying in terms of the sense of belonging. You know programs that have a sense of belonging, it is a very important preventive way of decreasing the chances of mental health problems. I also think why I am more optimistic is because I think people are learning more that they have to take a role in their care. That even with the homes and the integrated care, I think that more and more of us are going to have to be hanging onto our health files and really learning what do we have? How can it be treated? What are the best strategies? And so activation is going to be paramount. So, teaching that early will be important.

Ed Wang:

Dudley Square Neighborhood Initiative is currently doing a Boston Promising Initiative, and if you look at how the whole community is embracing that specific initiative to increase graduation rate, reduce the drop out rate, and so forth, it is a very good thing. To me, there are these already existing models that are being practiced in the field. The question is why they are only one program here, one program there, rather than across the state and across the country? So, do we have the type of resources to do it all? Massachusetts, somehow we want to also want to customize, and the whole idea of customizing, it costs money! (laughter) I think that is our also our kind of values. You know, that is the individualism. We want to do our own thing. But there are strengths, and there are also weaknesses, maybe in terms of how we can do that because it is very costly to create single models across the country that are fitting for that particular city, or small neighborhoods.

Audience Member:

In terms of the dilemma that you spoke about, Rob, one of the things that I think about is that the greed culture is inconsistent with people who are interested in mental health, so how to get more people…

Robert Evans:

How to get more greedy people interested in mental health?

Audience Member:

No! (laughter) The other way around. (laughter) What I am saying is that we are all here, a culture of people who don't make the big bucks in anything we do. I think maybe I have some optimism too, that the younger generations are becoming more ecologically and more public health oriented but it seems to be a problem- the greed versus the values.

Robert Evans:

Mhm. Yup.

Audience Member:

Have we exhausted them?

David Satin:

I will assume that people need more time to digest and to come up with answers, which they will present next year at the 35th Annual Erich Lindemann Memorial Lecture. I want to thank you all for coming and for participating, and thank you to our panel for donating their time and their experience, and I hope the mutual stimulation was rewarding.