

Insights and Innovations in Community Mental Health

The Erich Lindemann Memorial Lectures

**organized and edited by
The Erich Lindemann Memorial Lecture Committee**

hosted by William James College



**WILLIAM JAMES
COLLEGE**

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 1976. 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 insights 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 approach, 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 FIRST ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

Community Mental Health in Historical Perspective

Speaker

Gerald Caplan, MD, Director of Child Psychiatry Emeritus, Hadassah Medical Center, Jerusalem, Israel, Jerusalem Institute for the Study of Psychological Stress, Israel

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Gerald Caplan, MD

*Director of Child Psychiatry Emeritus, Hadassah Medical Center, Jerusalem, Israel,
Jerusalem Institute for the Study of Psychological Stress, Israel*

I want to begin today's lecture by reading an excerpt from the Bertrand Roberts Memorial Lecture which I gave at Yale Medical School on March 3rd, 1969. It was based on an epilogue I wrote for my daughter Ruth's book, *Psychiatry and the Community in Nineteenth Century America*.

In the 1830s and 1840s alienists in this country, influenced by their European colleagues, developed a multifactorial theory of the causation of mental illness. They believed that psychological and sociocultural factors (in their terminology "moral" causes) in addition to other purely physical forces, produce the brain lesions responsible for mental alienation. And they evolved a system of population-oriented prevention and treatment, based on this awareness of the power of environment in molding mental health. This was brought about by the humane influence of the staff, by small peer group social pressure, and by work programs and religious services. The story of this movement is fairly well known and has been documented in other writings. The special contribution of my daughter's book is not only its analysis of the ironic similarity of these ideas and practices to the community psychiatry of our own time, but its description of the vicissitudes of these concepts and programs in the past. The book shows that they remained fashionable only for about twenty years and then fell out of favor. They appeared again around 1880, and were "rediscovered" by Adolph Meyer and some of his colleagues in the early years of our century. These ideas had a fourth flowering in the 1920s and 1930s and once again gave way to an individual patient unifactorial system between 1940 and 1960. The much-heralded 'third psychiatric revolution' of community psychiatry in the 1960s is the fifth reincarnation of these old ideas in the past century and a half.

And in that lecture in 1969 I posed two main questions: "1) Can we prevent, retard, or attenuate the fall from favor of community psychiatry in our generation, or must we face a repetition of the cyclic pattern of the past? 2) Assuming we are not successful in preventing our decline, can we do anything to tide ourselves over during the ebb phase, so that as many of our gains as possible are kept and so that we, or our successors, will be better able to move forward when the tide eventually begins to flow again toward our present community philosophy?"

Now I want very briefly to list some of the main reasons adduced by my daughter in her book for the decline of population-oriented programs in the nineteenth century:

1. Shortage of sophisticated and skilled manpower due to the naivete of clinicians about community dynamics and due to the relative absence of training programs.
2. Shortage of resources due to economic vicissitudes.
3. Departure from a multi-factorial, open-systems approach to an exclusive focus on one parameter of etiology bound to one type of treatment or service.
4. Confusion of words and good intentions for action; promising proposals not put to the test of reality.
5. Overselling by inflated promises followed by frustration and disappointment of the public and their leaders by non-delivery.
6. Unwillingness of mental health workers to accept the realities of political life, accountability and governmental control. Poor communication and mutual distrust of psychiatrists and politicians based on value system discrepancies.
7. Lack of contact and communication between mental health workers and their four kinds of publics: community leaders, who must give sanction; people in need; unsatisfied patients; and unserved potential client populations.
8. Lack of sensitivity to criticism and dissent; instead a tendency to escape from the difficulties of professional reality into guild preoccupations and satisfactions.
9. Lack of attention and resources for program evaluation.
10. Ignorance of history and failure to learn from the past experience of others. "As each generation rediscovered the ideas of its predecessors it also repeated actions and attitudes that had previously doomed such programs."

In 1969 I already foresaw the probability that the cycle would soon repeat itself, and I wrote:

When the tide of public and professional interest ebbs, all gains of the recent past are usually not blotted out. There are enough deviant individuals and institutions in our pluralistic and largely decentralized society so that we can rely on a goodly number refusing to go with the tide. They maintain their ways, even though their resources, their status and their opportunities for major development are reduced. When eventually the tide turns, they emerge from relative obscurity, and the ideas and practices they have kept alive become part of the new trend and provide a basis for rapid progress.

Such a bastion of moral treatment ideas and practices was Northampton Hospital in Massachusetts under Pliny Earle in the mid-nineteenth century. In our own day, schools of public health provided house-room for psychiatrists with a community orientation during the postwar era, when academic psychiatry was overwhelmingly committed to the depth-psychological focus on individual patients. When Erich Lindemann went from Harvard School of Public Health to Harvard Medical School in 1954, he had to devote his major energies to fostering the dominant individual-oriented philosophy... When I made

a similar move in 1964, ten years later, I received a ready welcome precisely because I could bring a population-oriented research and teaching program into a medical school where this was now in great demand.

And I went on to suggest that we should try to optimize the process of promoting "secluded enclaves" which can safeguard threatened ways of thinking and practice, some of which will have lasting value for long-term development.

My 1969 prediction was amply fulfilled, beginning in 1973 when the previous Administration tried, although unsuccessfully, to terminate support for the Community Mental Health Centers. And in 1975 a Yale professor of psychiatry, David F. Musto, wrote a paper entitled, "Whatever happened to community mental health?" in which he reviewed the reasons for the demise of community mental health as a movement and as a set of services in this country. Assuming that Musto is correct, what do we do in the present ebb-tide phase?

There are two obvious alternatives. One: we can keep on fighting - keep on lobbying for continued Federal and State support. We can go on plugging away; go on trying to organize community research and training programs; there's a possibility we may have some limited success. But the climate right now is a great deal worse: the Federal workers are now accustomed to requiring more and more controls, with more and more bureaucratic implications; so that now, legitimately from their point of view, we will have to spend more and more time on fund-raising and accounting.

I want to refer to an excellent paper by Stanley C. Silber, "Strategies for developing multiservice funding for Community Mental Health Centers" written in 1974, before the Administration's war on funding for the Centers had been lost. In this article Mr. Silber, who worked for the National Institute for Mental Health, predicted the early ending of categorical Federal grants and he recommended an aggressive search for alternative funding, mainly third party payments by the various insurance systems, and by taking the community mental health centers into the social service programs, into the rehabilitation programs, Federal and State; and he lists a whole range of other sources of Federal support, many of them labeled mental health but certainly not community mental health—labeled in general with labels from the health, education and welfare field. He recommended that we increase our technical assistance units for all community mental health programs to keep abreast of the opportunities on the regional, state, county and private philanthropy levels. He cited with approval the fact that in 1974 twenty-two community mental health centers in Kentucky were operating in the black with an average of twenty-five separate sources of financial support for each center.

If the first alternative is to keep on fighting, the second alternative is to run away; to give up population-oriented ideas, to side with the majority (after all, they may be right - we can't prove that they're not) to go with the tide of public opinion, to move down third-

party avenues. Where this will take us has already become very clear - it will take us to individual-patient-oriented medical care programs which facilitate accounting for medical service; and we will turn away from any focus on populations, because you can't be paid for that nowadays. I say no to the second alternative.

Coming back again to the Epilogue to my daughter's book, I wrote in 1969:

Should we not, therefore...give thought...to what we can do to ensure the maximum protection for those core people, ideas and practices that eventually can continue to raise the level of community care for the mentally disordered after the next cycle.

Of course, in the absence of valid evaluative methods, we have no way of being sure which of our current approaches is worth saving for the future. Capacity for survival is often related to the level of commitment of an individual or group to certain ideas and to the strength, obstinacy or conservatism of the workers in maintaining their values and traditions in the face of pressures to assimilation, and not necessarily to ultimate truth or to what will be proved valuable by a future generation.

On the other hand, I believe that this book does provide some rough guidelines for what by hindsight we can perceive to have been useful in the past and that we can extrapolate for the present and the future...I believe that at least a tentative answer lies in four concepts: ideology, protected social structure or sanctuary, elite cadre, and reference group.

And now I want to talk more fully about these four concepts. First, ideology in our case means a commitment to the following set of concepts and values: a population orientation, a multifactorial open-systems etiology, and a corresponding multifactorial, open-systems service map. I'm not referring now just to community mental health centers but to the main concept of community psychiatry, namely, that the community mental health centers and other institutions, including the mental hospitals, are part of a total system that is geared to serving the needs of its population. We must emphasize, in talking about our ideology, that we are not talking about a closed system, but an open system; we must continue to study in order to refine old models and add new ones.

Second, sanctuary: how to maintain the centers which continue to operate with a population orientation and how to keep the wolf from the door. Now I propose to express an article of faith: I believe that viability demands smallness. I believe that we should, in as many places as possible, move away from what Mr. Silber was recommending in his article. I believe that we should move away from Federal bounty and should realize that Federal funding, even of the community mental health centers, has accounted for a small proportion of the funding of these programs in this country. (The Federal government organizes its statistics in such a way that it is practically impossible to tell what that proportion is, because their statistical reporting refers only to those centers which are being supported or partly supported by Federal funds rather than to the totality of

community mental health centers in the country.) Bertram Brown (Director of the National Institute of Mental Health) and his associates used their mandate of national leadership to change radically the pattern of community mental health services throughout the country on the basis of very small amounts of Federal money - a fantastic achievement. They stimulated the states to pour into their Mental Health Centers the five required services: consultation, education and the rest, on the basis of the largess of Congress - \$150 mil

lion to be spent over three years. There was hardly a state in the nation that without Federal spending would have considered spending such amounts of money on its own.

Anyway, I would now advise us - not all of us but some of us - to turn our backs on Federal and multisource funding, which will inevitably lead, as it has led in the past, to large, unstable programs which mirror every wind that blows out of Washington. We should differentiate between vertical and horizontal forces that impinge upon the local community services. The vertical forces come from the Federal, regional and state governments in the form of resources and prescriptions, including those of the community mental health centers; and the horizontal forces are the impulses and resources that come from the individual locality. What I advocate here is that as much as possible, programs should remain small; that they should turn a deaf ear to the blandishments of the Feds and, usually, of the governments of the large states; and that they should seek no overwhelming funding by endowments.

My concept of the importance of sanctuary has been enlarged in the last two years because of my discovery of the American hinterland, what some people call Middle America. Until recently I knew very little about the United States outside of Washington, the east coast, the west coast and a big city or two in the middle. I'd never been to the hinterland for a number of reasons, including the fact that they never invited me to come because they weren't very interested in what I was talking about. The Middle West was conservative and quite slow to accept the community mental health movement; but gradually representative people who had been exposed in Washington or other big centers to the population-oriented psychiatry ideas discovered that they liked them, and came back home to sow the seeds which developed little by little. They were still conservative: they tried to run their programs without, if at all possible, Federal and state support; they began to run them with local tax funds, local philanthropic funds, or sometimes with almost no funds at all, at least for the time being. These people were forced to maintain close links with their publics. They couldn't stay alive or develop if they turned their backs on the local leaders or the local populations; if they weren't sensitive to their needs; if they weren't sensitive to their criticisms, and dissents.

When I began, two or three years ago, and my colleagues too, to get invitations to places like Miles City, Montana; Flint, Michigan; Erie, Pennsylvania; Champlain, Illinois

- some of which I had never heard of, or couldn't place on a map - I discovered that these people in the hinterland were unaware of the academic world I was used to, except for the common world of community psychiatry. They were forced by their situation to improvise; they had become very skilled people. And a discussion with them, for example about school consultation, showed them to be very sophisticated in regard to technique issues.

I want to emphasize what I found out in the small towns in the rural areas that may affect your programs, too: They have their problems, and the morale is quite low. Professionally they felt rather lonely. Also, don't forget that on the local level there are quite rapid and arbitrary shifts due to local politics. Small-town politics are not cleaner than big-town, State, or Federal politics. Recently I was impressed and disturbed when a number of very good programs in small towns or semi-rural areas caved in suddenly. For example, a staff member is obligated to the community leader who gave him his job; after a year he resigns, unable to stand up against the local political pressure, which has nothing to do with any kind of accounting or evaluation of his professional functioning. "Around here we appoint local people who are relatives of the chairman or members of the board; and if you don't understand our culture, go somewhere else."

And that brings me to the third item: elite cadre. In the United States the term doesn't go down so well. I'm not talking about the European attitude toward the elite, namely, that you are elite by birth, by belonging to a privileged family: I'm talking about the group of vital men and women of leadership caliber who are attracted by ideology and the challenge of practice. I'm talking about the world of the small town in Middle America - not necessarily in the Middle West because I'm also talking about Kentucky, about rural Pennsylvania, I'm even talking about rural Massachusetts. A fascinating book by Milton Mazer, *People and Predicaments* describes a program on Martha's Vineyard, typical of the kind I'm talking about. Although he applied for and received Federal funds, for which he qualified on the basis of some rather interesting epidemiological research, he started the program on a shoestring, receiving most of his support from the small-town residents.

Lastly, reference groups. I'm referring to an association of like-minded people who support and guide each other, and whose opinions of each other determine their relative status. They develop and improve their ideas; they consolidate their own identity and status so that they are better able to withstand pressures and seductions of prevailing opinions, and also the pressures deriving from local political relationships. In the early days of community mental health, some of the reference groups were: the Peace Corps; the Harvard Visiting Faculty Seminar, Len Duhl's "Space Cadets" at NIMH in which Erich Lindemann played a part; the Harvard Inter-University Forum; the Harvard Training Program, first at the School of Public Health and then at MGH and the Medical

School. Commissioner Oken in his introduction this afternoon talked about the two hundred graduates of our Harvard Training Program. Those two hundred graduates, in the course of twenty years located all over the world, are still bound together in a network. I don't know whether they meet together, but it's important for people in this network to know what the others think and do.

Nowadays these reference groups, most of which originated in the past, from the early stages of the community mental health movement, need to be replaced. When I go around lecturing in the little places I am an emissary of reference-group thinking. For a number of years we have held at the Harvard Laboratory of Community Psychiatry three-day seminars in which we convey the multiple advantages of community practice. We circularize community mental health programs and nursing, psychology and social work programs all over the country to solicit participants. We have been fascinated to discover that the fifty people who in accidental ways have been convened in each of these seminars, who were sufficiently motivated to come at their own expense in order to learn what we believe to be the latest advances in community science and practice, very rapidly built bridges with each other. These practitioners, most of them from rural or small-town areas, felt very lonely where they were; they thought that what they were doing was inferior to what was being taught at Harvard; and they didn't believe me when I told them, "I want to hear from you, what you are doing, just as much as you want to hear what I've been thinking." But at the seminar they began to talk to each other and to discover that what was being done in one rural area was not so dissimilar to what was being done in another area in another part of the country. They shared problems, and interestingly enough, they shared techniques; each of them has improved his own competence under the pressure of circumstances of the local situation and innovated what were for them novel ideas and novel techniques; and—lo and behold!—what they worked out in one place was very similar to what was being developed in other places.

What I am finding among these young people, who had not been formally well-educated in population-oriented psychiatry but had improvised to help themselves under the pressure of their situation, is a hunger for new concepts, and a hunger for the assurance that they are on track. They are skilled practitioners, but most of them are not themselves systematic abstract thinkers or conceptualizers. They remind me of an experience I had a few months ago when I went to Norway at the invitation of the Norwegian Department of Mental Health to give some seminars on mental health consultation. This was a follow-up to a previous visit in the early sixties, when I had shared with the Norwegians the thinking of our Harvard group, which had been translated by Bert Brown into the regulations of the Federal Community Mental Health Act. The Norwegians had been very interested in those ideas, which were quite new to them. And when I went back recently, I found that they had in Norway a population-

oriented system based upon the American ideas of 1960-63 which was better than anything we have on a mass scale in this country. I found very high sophistication, very high skill, but apparently they hadn't innovated any new concepts. And this reminds me of what I find in many places in the United States: no new conceptualizing such as you find in Mazer's book. When you are talking about what developed on Martha's Vineyard, especially with such a man as Mazer who is able to build on the concepts of some of the Harvard and Columbia sociologists and anthropologists, it's alive, it's exciting. Practitioners are a different kind of thing; they develop techniques, not conceptual models.

In closing, I repeat the question that came from Yale: "Whatever happened to community mental health?" And the answer from Harvard goes, "It blew out!" Community mental health pretty well died in academia, it pretty well died at Yale. It blew out except for nooks and crannies here and there in Boston, New York, Chicago, and San Francisco. But community mental health is in fact alive and well in small towns in rural America. It's alive and well in Mt. Whittier, Iowa; in Erie, Pennsylvania, where they have the best organized community mental health program I've met anywhere, for instance linking the mental health center with the police so that a psychologist and a social worker go with policemen in their squad car to answer calls of domestic abuse. Community mental health is alive and well in places like that; and surely a huge reservoir of population-oriented practice, which we have never had in the past, is ready to flow when the tide changes.

When will the tide change? Well, I am not going to predict the time as I did before, but I am convinced that the cycle will repeat; that we will be doing once again what we have done five times before—three times in the 19th century and twice in the twentieth; and that when that happens we will start at a much higher level than we ever started in the past because of this reservoir of practice in the conservative parts of the country, which is not interested in moving with the immediate trend, and which has lain outside the big governmental sources of power. I was accused of undue pessimism in 1969; I hope I won't be accused of undue optimism in 1976, but that is how I see it.