TKC CEO David Lauterbach Speaks to the State of Community Mental Health in ProJo

October 26, 2014 – R.I.'s community mental health system became a victim of its own success (by The Providence Journal's G. Wayne Miller)

The state's community mental health system originated in an era when people with mental illness, here and nationally, were warehoused under inhumane circumstances in public psychiatric hospitals. Once admitted, few were ever released.

Paupers' cemeteries on the grounds of these old institutions attest to hundreds of thousands of lives that were swallowed and disappeared.

Long before it closed, the Institute of Mental Health, Rhode Island's public psychiatric hospital, was the subject of damning exposés. Beginning in the 1930s, The Providence Journal chronicled squalid and crowded conditions — what one photo caption called "the inertia of despair" — and patients who sat idly, dozed on benches or were locked in solitary confinement in tiny rooms, some sleeping on the floor, their illnesses worsening. At its peak, in the 1950s, some 3,500 patients lived at the IMH.

In 1979, following another Journal investigation of abuse and neglect, what is now known as the Mental Health Association of Rhode Island called for the IMH to be abolished.

By then, it was no longer unrealistic. Scandals there and at similar institutions around the United States gave incentive to expanding the non-hospital system, which President John F. Kennedy had promoted with the signing of the national Community Mental Health Act three weeks before he was assassinated in late November 1963.

Led by Thomas D. Romeo, head of the state Department of Mental Health, Retardation and Hospitals (predecessor of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals), and with the support of General Assembly champions including the late Paul V. Sherlock, longtime member of the House Finance Committee, Rhode Island expanded its community system in the 1980s. Voters cast their assent by approving millions in bonds to finance and build centers and group homes.

The smallest state became nationally renowned for its efforts to move people out of public psychiatric hospitals — and provide the help needed to keep them from entering in the first place.

"You can see in a comparison of similar states with similar size how one can do a better job," Neal B. Brown, director of the National Institute of Mental Health's community support program, told The Journal in a 1984 series about deinstitutionalization. "Rhode Island is doing a better job. A tremendous amount has been done in the last few years."

In 1994, the IMH's final few patients were transferred to the care of what is now called Eleanor Slater Hospital, a 495-bed system with locations at Cranston's John O. Pastore Center and Burrillville's Zambarano unit.

But eventually, advocates say, progress stalled.

"I've actually often said that was a curse, because what happened is the General Assembly got very complacent and said, 'Oh, we're number one! You guys did a great job so we can go solve some other problem,' " says Mental Health Consumer Advocates head James McNulty.

There indeed were other problems.

The economy declined as Rhode Island's traditional manufacturing base eroded, and state and local budgets became miserly. A public that for one golden period had opened its heart — and wallets — lost interest. Except for those providing and receiving services, community mental health ceased to be a noble cause.

And there was another unfavorable development: the overall system of U.S health care became increasingly expensive and convoluted, and community mental health suffered disproportionately, advocates say.

Today, even a provider as large as the $43-million Providence Center scrambles for money. Like most centers, it relies on a labyrinth of sources: local, state and federal dollars, including from Medicare and Medicaid; private, corporate and foundation contributions; private insurance and client fees; and now, the Affordable Care Act, or Obamacare.

"The payer issue is a mishmash," says president and chief executive Dale K. Klatzker. "It's the whole craziness of how we have to contort ourselves to adjust the mechanisms — as opposed to the funding mechanisms really meeting the needs of the people that they're intended to support. It's nuts."

Sitting in his office at his North Main Street headquarters, Klatzker points to a suite occupied by more than a dozen administrative employees.

"Basically, they spend the entire day chasing the dollar. It adds no value. I'd rather use them to do other things than spend money on them processing bills and paper. … It's an incredibly complicated, unnecessary set of obstacles in order to finance what should be."

David S. Lauterbach, head of Warwick's Kent Center for Human and Organizational Development, shares Klatzker's frustration. Lauterbach says that when Kent's board chairman, Mark Delaney, chief financial officer for multi-million-dollar Hexagon Metrology Inc., examines center funding sources, "he scratches his head."

The paperwork is equally or more confusing for some clients who must enroll in programs such as Medicaid or Medicare before receiving services, Lauterbach says.

“They can’t navigate this,” he says. “They need our help.”

The same bureaucratic convolutions hamper BHDDH.

“The way we fund this thing is we push it all together and stir it around and then say, ‘We can now cover this and that,’” says department director Craig S. Stenning.

Says his deputy, Rebecca Ross: “We’re always trying to patchwork things together. You get a funding source here and you see a need, so you want to take those dollars and apply it there, but it just makes things very complicated.”

Stenning endorses a new philosophy of care throughout the state system.

“We see the community mental health centers treating individuals in a holistic way to be sure their serious mental and physical health-care needs are met at the same time,” he says. “With emphasis on recovery, the centers will help create healthy lives that include family, friends and employers. As a result, some individuals may no longer need to rely on these centers.”

He does not propose consolidating the state’s eight community centers.

But a single system, says Klatzker, might be appropriate.

“There are counties in Texas that are bigger than the entire state of Rhode Island that have one or maybe two delivery networks for mental health services,” he says.

Given Rhode Islanders’ preference for multiple — and, some say, redundant — fire departments, school districts and other municipal services throughout its 39 cities and towns, getting the state to adopt a more centralized system would be difficult, Klatzker says.

“It’s not the general behavior of people in Rhode Island to do that,” he says. “We have 39 of everything.”

Another impediment, he says, may be providers themselves — but that, at least, could be overcome, he asserts.

“It’s incumbent upon providers to step out of their own self-interests and organize themselves so that they’re focused on what the consumer needs,” he says. “It can happen. But it takes leadership, it takes prudent risk, it takes people saying, ‘Even if this means I lose my job, it’s still better for the patients in the community.’ ”

Rhode Island cannot resolve its public mental health issues, Klatzker, Lauterbach and others agree, without a commitment from the next governor and staff, and the leaders of the General Assembly.

So far in this election year, mental health has been barely whispered. Except for those rare cases of violence by a mentally ill person or the death of a celebrity like Robin Williams, this has been the case for years.

“All the focus seems to be on business and the economy, which I understand,” Lauterbach says. “We need to have a healthier economy. But I think you measure the quality of a state by how well it cares about its most needy.”

Mental Health Association of Rhode Island executive director Susan C. Jacobsen recalls how easily the General Assembly eliminated tolls on the Sakonnet River Bridge once public outrage reached a boiling point. Some $2 million that had been invested in an E-ZPass camera-monitoring system was lost, without protest.

“It’s who’s powerful in our society, right?” says Jacobsen.

Says state Mental Health Advocate Megan N. Clingham, “Whenever I go and try to advocate for more services, I’m told, ‘Well, you have to show how you’re going to save money.’ It’s not, ‘You have to show how you are going to treat people humanely and do the morally right thing.’

“This is a matter of basic human dignity; it’s a matter of responsibility to our fellow citizens, to our fellow human beings, who we see suffering — and who we turn a blind eye to. It’s the state’s responsibility and we’re not fulfilling it.”

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