



From Individual to Community:  
Changing the Culture of Practice in Children's Mental Health

An interview with Ron Manderscheid, a national leader on mental health and substance abuse and member of FrameWorks' Board of Directors.

In April 2010, FrameWorks' Jane Feinberg interviewed Dr. Ron Manderscheid, the Executive Director of the National Association of County Behavioral Health and Developmental Disabilities Directors (NACBHDD). For over three decades, Manderscheid has been working to improve mental health and substance abuse care from both inside and outside government. In this interview he discusses his career in the world of practice, and how it relates to FrameWorks' intensive research investigation into American thinking about children's mental health.

*Jane Feinberg: Your career reflects a unique depth and breadth of experience in the world of practice, and so I'd like to ask you a big question—what, if anything, has changed in how practitioners think and talk about child mental health?*

Ron Manderscheid: There's been tremendous change in the past 50 years in how we look at mental health, especially children's mental health. For many, many years, building up into the 1970's and 80's, we focused only on mental illness; even today, we have very, very elaborate—and very expensive--systems to code mental illness.

Then starting in the late 60's, early 70's, with the beginnings of the consumer movement in mental health, and with the broad process of deinstitutionalization, in which many people with mental illness were in the community, we began to change. Instead of focusing purely on mental illness, we said we needed to understand positive functioning of people in the community. So we began to look at the factors of positive functioning. But we soon realized that a person is not simply the sum of their functions, but rather an integrated entity with a point of view.

So we moved into what I would call "person-centered care," whereby we started emphasizing the positive factors in a person's life. By emphasizing the negative factors, we recognized that we were reinforcing the problems. We also moved from a kind of a partial focus to a holistic focus. For adults, the concept that tied that all together was the concept of "recovery." For children, the concept was "resiliency".

Thirty years ago, I co-authored an article in which we argued that health is not the other end of the spectrum as illness. In other words, health is a completely separate dimension. That way of thinking has continued to evolve, and in the past few years, the Centers for Disease Control (CDC) has been working with a group of professionals, including myself, to define “measures of well being” and “measures of quality of life.” So, we’ve come just a very long way because both adults and children do much better with this approach.

*Feinberg: Why are they doing so much better?*

Manderscheid: Because we have allowed them to take more responsibility for themselves. In the olden days, the doctor was the ultimate authority. It was a paternalistic model. Well, that has changed. Now the model is shared authority.

*Feinberg: I’m reminded of my grandmother. When we asked her how she was doing, she would tell us what her doctor said.*

Manderscheid: Yes, exactly. She didn’t have any opinion of her own. My grandmother was the same way. Well, that model is different. A practical example of how this evolution in thinking has played out: for 10 years, a group of us worked with teachers, counselors and social workers in the Washington D.C. schools. When we first started that work, we talked about how a teacher in a classroom recognizes depression or anxiety in a child, and then what resources are available to do something about that. Over time, our conversations evolved from talking about those illnesses, to talking about the concept of “resiliency” and how the teacher, the classroom, and the school could promote resiliency and understand its connection to children’s academic performance.

What I’m talking about is a cultural shift in practice, and it has an impact on all of the professionals in the field and every child who comes into the public systems, including the schools. This shift is also at the beginning of making its way into the classrooms that are training the next generation of providers, though there is still a huge amount of work to be done in that arena.

*Feinberg: What is the work that needs to be done?*

Manderscheid: Well, instead of continuing to train psychiatrists elaborately in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders), and how you recognize every single symptom of every single major disorder, we also ought to be training psychiatrists in recovery, resiliency, and the role of the community in enhancing well being. These are not part of the medical education for psychiatrists, nor are they a part of the training protocol for a social worker or psychologist. So in effect, what our training represents sociologically is a cultural lag. Our culture around care has moved on, but our training has stayed the same. So people are trained in the old model, and then they go in and try to apply the old model and it doesn’t work very well. So I think there’s a huge amount of work that needs to be done in reworking our curricula in medical school, and in the graduate schools so that they better reflect where the

culture is around the concepts of positive health, resiliency, positive participation and shared decision making.

*Feinberg: What led to this cultural shift in practice?*

Manderscheid: A number of factors. Principal among these is a creation of a large-scale national consumer movement in mental health, and a family movement in mental health, in which the family member did not feel that the care being given to their loved ones was helping. And so, between 1970 and 1985, we went through this transition, whereby we brought the consumers of care to the table. At first, the professionals didn't like it because they viewed this as an intrusion on their professional role. But we persisted. Today, the advisory groups of the National Institutes of Health, SAMHSA, HRSA, CDC, and others all have consumer representation, whether it's around mental health or substance abuse.

*Feinberg: This was also a time of general social upheaval in the U.S. Was that a contributing factor?*

Manderscheid: Yes, exactly.

*Feinberg: As you know, FrameWorks is currently investigating how Americans in the culture at large think about mental health, specifically children's mental health. How do the dominant models trickle down to the public?*

Manderscheid: So the culture of practice has changed, but let's say I'm a person who came through the system trained in the traditional model of psychiatry. So I come to you, the client, looking to give you an individual fix. If the client has, let's say, bipolar disorder, I'm going to prescribe Lithium, and then we'll test by trial and error. That point of view treats the client purely as an individual and does not see him as part of a broader culture, or part of a broader framework because I, the psychiatrist, was never trained in any of those concepts. Some of the most stigmatizing people we have around behavioral health issues are our own providers, not all of them, but some of them, who have internalized this model around individual responsibility. It presumes that it's the client's fault that he is suffering, that he's kind of a lagger, and doesn't want to get a job or participate in the community. And then this influences the psychiatrist's behavior toward the client and his treatment, which gets communicated subconsciously to the client. In the end, the client internalizes the provider's point of view and blames himself for being mentally ill.

*Feinberg: Do you think that people really can re-think their individualistic models of health care?*

Manderscheid: Well, for example, the new healthcare bill contains interventions for promoting positive health. Changing the mental models toward positive interventions to promote health is the appropriate purview of behavior health. Behavior change is the appropriate purview of behavior healthcare. And behavior change is a function of the culture you're in, of your community and social group, and it's a function of interventions we do with people.

A case in point: I'm currently working with an advisory group to the U.S. Secretary of Health and Human Services on a project called "Healthy People 2020." Its goal is to put together health goals for the U.S. for the year 2020, along with the measures and the accompanying interventions. Our advisory committee said to the Secretary, 'we don't want the traditional model of looking at the epidemiology of the disorder, and saying, there are too many people who are depressed, we want to reduce the rate of depression in the United States by 5% over 10 years. We won't get anywhere with this traditional model because at the end of 10 years the depression rate will still be the same.'

We realized that the whole model had to change. In the end, the model we have adopted is radical because it says that we need to start with the "social and physical determinants of health". So, if I want to look at the issue of why someone has bipolar disorder, where I need to start looking is not at that person, but at his community and at his culture. And if I want to do health promotion for someone who is not ill, I don't start initially with that individual. I need to start with his social group and community. To take this to a practical level, I did some work recently with a neighborhood in Washington D.C. called "Wheeler Terrace" in Ward 8. That neighborhood has the highest crime rate, the lowest rate of graduation from high school, the highest level of drug use, the highest level of HIV, and so on. We told the community that we wanted to work with them in defining what they could do to improve the social determinants of health in their community. We thought they might wonder if we were coming in from outer space somewhere, but that did not prove to be true. These people understood what we were saying intuitively, immediately. They said, 'we want to work with you; we want to protect our children. We understand what needs to be done. You can go on any corner in this community and buy drugs, buy alcohol, go into a bar, get sex. There's not a single place in this community you can go to buy fruit.' Within this destitute community, there was an amazing level of understanding and interest in this community approach. So all of the theoretical work we've done on the social and physical determinants of health has a reality out there in the community that's very exciting.

*Feinberg: This really gets to the difference between the public health approach, and an approach that is more about the community as an aggregate of individuals.*

Manderscheid: Yes, exactly. In effect, we have introduced a new public health community model, which essentially changes the frame that HHS was using to approach this project. And that culture change at HHS is still underway. It's not complete, but it's underway.

*Feinberg: If the culture within practice has shifted, and the training for providers begins to shift, how do we then take the message to the larger American community?*

Manderscheid: As you know, I work at the National Association of Counties. There are 3,068 counties in the U.S. Virtually every one of those counties, in some way or another, operates a public health program, a social service program, a mental health program, a substance abuse program, a developmental disability program, and so on.

I could envision going to the 500 counties I deal with, and identify what I would call some leading edge counties that would be willing to engage in a project to change their local

communication into the community. So when the Director of Behavioral Health goes before the county council, he or she talks about mental health in a different way. And I think it would be very exciting.

*Feinberg: If you had to envision the best kind of future for this new model, and this paradigm shift, and how it would play out in the public arena, what does it look like?*

Manderscheid: If we want to actually make a difference in the work we're doing on the social and physical determinants of health, we cannot leave it to HHS to do. We have to have a vehicle and the tools to touch every community in the United States. There are wonderful information technology tools available that can be used right now to engage communities, to engage people in communities, to make best practices available to them, to link them to other communities that are doing interesting things. This system has not yet been built, but it's on the drawing boards and it's called Healthy People Online, a national IT infrastructure to drive that type of thinking into every community, ranging from places like L.A. county to the most rural county in Ohio. It will allow people to become public health advocates for their community and work together on the issues that are most relevant to them. I believe this is actually achievable in the next five years if we stay the course.

#### About Ron Manderscheid:

**Ron Manderscheid** is the Executive Director of the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) and an Adjunct Faculty Member at the Johns Hopkins Bloomberg School of Public Health. A sociologist with a specialization in social psychology and statistics, Dr. Manderscheid previously served as Branch Chief, Survey and Analysis Branch, for the federal Center for Mental Health Services (CMHS), SAMSA. Dr. Manderscheid currently serves on the Governing Council of the American Public Health Association (APHA) and is past Chair of the APHA Mental Health Section. He has also served as Chairperson of the Sociological Practice Section of the American Sociological Association, and as President of the Washington Academy of Sciences. He has served as principal editor for eight editions of *Mental Health, United States*. During the Clinton National Health Care Reform debate, Dr. Manderscheid served as Senior Policy Advisor on National Health Care Reform in the Office of the Assistant Secretary for Health at the U.S. Department of Health and Human Services. At that time, Dr. Manderscheid was also a member of the Mental Health and Substance Abuse Work Group of the President's Task Force on Health Care Reform.