The Private Practice of Community Psychiatry

BY WARREN T. VAUGHAN, JR., M.D., DONALD E. NEWMAN, M.D., ALLAN LEVY, M.D., AND SAMUEL MARTY, M.D.

The successful incorporation of the private practice of psychiatry into a system of community mental health care was attributable to several factors. They included an affluent catchment area; support from hospital administration and staff, private mental health practitioners, and a state-county finance program; and attempts to eliminate schisms that have traditionally separated private and public sectors of psychiatry. The success of this program has implications for the development of mental health services in the 1970s.

THIS IS AN ACCOUNT of the successful development by private practitioners of a comprehensive community mental health center at Peninsula Hospital and Medical Center, Burlingame, Calif. The center serves a four-city catchment area of 94,000 persons 15 miles south of San Francisco. It has developed a full spectrum of services including mental health consultation and education and private-office-based outpatient services as well as center-based inpatient, emergency, and partial care services.

The catchment area contains relatively few disadvantaged ethnic minority families or individuals. The 1970 census reported more than 2,500 persons with Spanish surnames in the catchment area, but only several hundred Orientals or blacks. The hospital district embraces a wider area than the assigned catchment area, comprising a total population of more than 200,000 persons. A California hospital district is a public agency that raises money by taxation and bond issues for capital construction and equipment costs. Patient care and treatment itself must be paid for at cost through other revenue sources, such as private funds, insurance, Medicare, Medicaid, and CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

In June 1963 the executive committee of Peninsula Hospital's professional staff appointed an ad hoc committee on psychiatric services and asked one of us (W.T.V., Jr.) to serve as technical consultant and co-chairman of the committee together with the chairman of the department of medicine. The committee's task was to develop a plan for full inclusion of psychiatry into the professional services of Peninsula Hospital. A year later, in July 1964, a 12-bed inpatient unit called the Mental Health Unit was opened, with one of us (D.E.N.) serving as director.

In August 1964 the first meeting of the psychiatric section of the department of medicine was held, attended by the seven psychiatrists then on the professional staff of the hospital. In the fall of 1964 funding for mental health centers became available under federal community mental health center legislation; and in December 1964 representatives of the hospital began to meet with the Mental Health Division of the San Mateo County Department of Health and Welfare to explore the possibility of developing a comprehensive community mental health center at Peninsula Hospital. A preliminary plan was drawn up that provided a wide range of community-based services incorporating ideas and principles such as accessibility, continuity of care, and collaboration with other professionals—principles painstakingly developed by mental health planners in the 1950s and early 1960s (1–5). In March 1965 the staff psychiatrists at Peninsula Hospital voted to take responsibility for developing a comprehensive community mental health center, and the board of directors of the hospital district voted to proceed with plans for a center in conjunction with the building of a new eight-story wing.

A construction grant application, approved by local health groups, was submitted to NIMH later in the year. It was accompanied by a resolution from the County Board of Supervisors expressing their intention to contract with Peninsula Hospital District to provide comprehensive mental health services to the communities yet to be designated as the catchment area for the new mental health center.

DEVELOPMENT OF SERVICES

The center opened in March 1969. In June 1969 the professional staff voted bylaw changes establishing a department of psychiatry and an affiliate membership to the professional staff for licensed clinical social workers and psychologists in private practice. The new department of psychiatry organized itself with an executive committee and a number of other committees including committees on medical audit, proctorship, utilization re-

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The authors are with Peninsula Hospital Community Mental Health Center, 1783 El Camino Real, Burlingame, Calif. 94010, where Dr. Vaughan is Chief of Community Services, Dr. Newman is Director, Dr. Levy is past Chairman of the Department of Psychiatry, and Dr. Marty is now chairman of the Department of Psychiatry.

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view, research and new programs, and continuing education.

The center was awarded a staffing grant beginning September 1969, and in October 1969 it began providing a full range of psychiatric and mental health services to its designated four-city catchment area under provisions of a $500,000 contract with the San Mateo County Department of Health and Welfare. The new center became the service center for region II of the county's new regional center program. Indirect services to the catchment area, comprising community organization work, mental health consultation, and education, have been paid for under the contract. Direct patient care and treatment is paid for by a number of means, one of which is full or partial payment for hospital care and professional services for financially eligible individuals and families under the county contract.

California's Short-Doyle Act, as amended in 1969, provides the legal and fiscal means for contracts with private providers, such as ours with San Mateo County.

From January through December 1971 the center provided 8,451 days of inpatient care to 956 persons. Of these, 180 came under the county contract and 282 under Medicaid or Medicare. The remaining 494 patients had private insurance or other coverage. During 1971 the center provided 12,390 sessions of partial care to 1,592 patients, of whom 566 were covered by the county contract and 545 by Medicaid or Medicare. The remaining 481 patients had insurance or other private means. Fifty-seven percent of these patients and 77 percent of the partial-care patients were from the designated catchment area. A total of 1,173 patient visits were made to the psychiatric emergency service, which is staffed by a specially trained crisis intervention team and an attending psychiatrist on call 24 hours a day. Sixty-three percent of these visits were made by patients within our designated catchment area.

The center delivered 6,820 sessions of individual, group, and family therapy to 899 outpatients in private practitioners' offices under the provisions of the county contract. Indirect services, provided primarily by salaried center personnel, included in 1970–1971 more than 600 hours of staff time spent in consultation and education work with elementary and high school personnel. Monthly group meetings with school psychologists and guidance personnel, police and probation workers, and the clergy were developed during 1970–1971. We are now expanding our concept of indirect services to include such programs as a teen-age drop-in center and parent education programs.

A citizens advisory committee was established by the hospital board of directors in 1969. By the spring of 1971 it had become effectively organized and played a vital role in mobilizing citizen interest and support at the time of a serious mental health budget crisis, which for a time threatened the center's county contract. In December 1970 the hospital board purchased an adjacent office building, which it has remodeled to provide a social milieu and group therapy center for the treatment of children, adolescents, and their families. This new facility opened in the summer of 1971. The citizens advisory committee has responded to these developments with the establishment of two subcommittees—a subcommittee on children and youth services and a subcommittee on financing and long-range planning.

By July 1971 the center had survived its first two years and its first major crisis. The professional staff had grown from the original seven psychiatrists to 45 attending psychiatrists and 45 affiliated nonphysician licensed mental health practitioners. To the basic question, "Can a group of private practitioners join together to develop and run a comprehensive community mental health center?" we can now report, "yes." The fact that this is possible seems to us to be of extraordinary importance as we move during the 1970s into: 1) the further development and strengthening of community-based programs of care and treatment for psychiatric patients, 2) the development of new arrangements for payment for services under government-sponsored plans as well as private insurance and other prepayment plans for groups of individuals and families, and 3) the implementation of preventive psychiatry through community action and collaboration with other professionals and agencies concerned with families and children.

Every patient at our center has a private attending mental health practitioner. He is paid on a fee-for-service basis for services to patients under the contract, with the hospital district serving as fiscal intermediary, much as Blue Shield serves in this capacity for Medicare. We have developed a center intake and referral service for the catchment area that, in addition to the emergency service, serves as a bridge between the center's salaried professionals and the private practitioners who assume clinical responsibility for all patients. Patients can come into the system at various levels of care—for emergency services, inpatient admission, and outpatient consultation. They can receive services with a minimum of delay and with built-in continuity of care.

In February 1971 the professional staff voted to set up a peer review committee for prior authorization and utilization review of all cases in which the hospital bill and professional fees were being paid for in whole or in part through the county contract. The need for this became apparent by October 1970, when we found that contract funds allocated to the catchment area were being spent at a much too rapid rate when there was minimal case monitoring by the center itself. One year's experience of reviewing over 263 cases involving more than 65 private practitioners indicates on the whole a very positive response on the part of the practitioners.

The usual administrative approach to case review, involving impersonal third-party intrusion into clinical practice and the therapist-patient relationship, has been replaced by a focus on developing a balance between clinical needs and financial realities in a case conference atmosphere, with development of treatment plans linked to explicit treatment goals. This experience has many implications for other groups of private practitioners who may group together as a hospital staff, or in medical or psychiatric societies or foundations, to take responsibility for

contracted mental health services to designated groups of people.

FACTORS CONTRIBUTING TO SUCCESS

We can readily identify four factors that have contributed to the success of the center.

1. Peninsula Hospital is located in an affluent community with well-established patterns of private health care delivery. This factor has undoubtedly contributed to the success of the center; however, it does not mean that this private practice model cannot also be used in less affluent areas.

2. The professional staff and hospital administration supported the development of the center. A public hospital district is a rather small administrative unit; in contrast to a large county or state administrative structure it has a capacity for administrative flexibility that maximizes its ability to innovate in program development, use of personnel, and staff development.

3. We have a favorable manpower situation and an interested citizenry. A decade of pioneering in community mental health services for San Mateo County has successfully reduced the stigma surrounding mental health care and has developed a felt need within the community for services close to home. This has resulted in an influx of well over 100 private mental health practitioners to San Mateo County since 1958, most of them interested in the development of a broad spectrum of community-based direct and indirect mental health services (6).

4. We must take special note of the presence of a state-county program for mental health services, which is financed by a state-county contribution of funds on a 90 to ten basis and which makes possible such contract services as ours (7, 8).

These favorable conditions certainly now exist in other communities in California and across the nation. In our opinion, however, they are not sufficient in themselves for the creation of a mental health center along the private practice model. In addition, at least four familiar schisms in professional practice must be bridged. They are as follows:

Schism I: Isolated private office practice versus closed-staff private psychiatric hospital practice;

Schism II: Office practice of psychiatry versus traditional medical practice centered in general hospitals;

Schism III: Private fee-for-service office and hospital practice of psychiatry versus public psychiatric services in hospitals and clinics with salaried professional personnel; and

Schism IV: Patient-centered psychiatric treatment services versus community-centered mental health promotion and preventive services for specific population groups.

Privately practicing psychiatrists have welcomed the opportunity to become members of a "community of professionals" based at the general hospital. In the 1950s and early 1960s, private patients who required hospitalization were usually referred to one of several private sanitariums in the community. Patients without financial means were referred to the county hospital or directly to the state hospital. These institutions, with traditionally closed staffs, took complete medical and psychiatric responsibility for the patient until he was returned to the community.

This situation (schism I) contributed to breaks in continuity of care for psychiatric patients despite encouragement by the private sanitariums and public services for the referring physician or psychiatrist to follow his patient during the course of hospitalization. Thus private psychiatrists welcomed the opportunity to attend their own patients in a therapeutic milieu (mental health unit) in the general hospital, with easy access to professional colleagues, both psychiatric and nonpsychiatric, and ease of involvement of patients and relatives in the therapy program. For these psychiatrists the private sanitariums and state hospitals have thus become a valuable resource for selected patients, and the general hospital setting has become a new resource suited to a wide spectrum of individuals in need of a short-term stay in a therapeutic milieu as part of their treatment.

There has traditionally been a wide schism (schism II) between the general medical and the psychiatric communities, with minimal use of psychiatric consultation and referral and, after referral, little continued involvement of the nonpsychiatric physician in treatment and planning for aftercare. It was this schism that led the physicians at Peninsula Hospital and Medical Center to enthusiastically support the establishment of an inpatient psychiatric unit in the hospital and to insist that nonpsychiatric physicians be allowed to admit patients to the unit for the social milieu and group psychotherapy provided by the center. Strong feelings were expressed that the inpatient unit should not adopt the tradition of separate inpatient and outpatient attending physicians and therapists (schism I) and that it should avoid the nonpsychiatric physician's lack of involvement (schism II).

Communication between psychiatrists and nonpsychiatric physicians has greatly increased at Peninsula Hospital since 1964. Many more consultations occur, with psychiatrists visiting such areas as emergency services, intensive care, coronary care, orthopedic rehabilitation, and pediatrics. Psychiatrists who had rarely left their offices now attend staff meetings, see patients in the hospital as consultants, and, of most importance, are continuing to treat their regressed patients with the aid of a team of mental health professionals in a therapeutic milieu. An increasing number of nonpsychiatric physicians have learned how to work with the therapeutic community and have remained with their patients, thus providing continuity, support, and remarkably good aftercare planning. At times this has been a slow and painful process, but it is important to note that *there has been no alternative to collaboration available.* No one else will take responsibility for the patient except the admitting physician and other attending physicians who may be called in by him, the patient, or the family.

Psychiatrists have been acutely aware of the isolation between the private sector and public mental health ser-

vices and of the existence of two patient care systems, public and private, at the state level as well as at the local level (schism III). Feelings have been strongly expressed by our psychiatrists that there should be one standard of care, care close to home, and continuity of care. There should be a broad range of community services available to everyone regardless of financial status, adequacy of health insurance, or severity of illness. Our goal has become one of eliminating the indigent patient concept and separate facilities for persons who receive public financial assistance for needed psychiatric care. With our system of fee-for-service with third-party payments, financial eligibility and manner of payment become more simply a matter of concern only to the finance office.

There is a single facility and standard of care for all in the community. We can thus avoid the long waits in clinic corridors and impersonal responses familiar to many in years gone by—conditions that remove from patients their dignity and sense of personal worth. The feeling of self-worth incorporated in our system can be seen as an essential element of our treatment program, and it probably explains in part the acceptance of our approach by the users and the community as a whole.

Indirect mental health consultation and education services and the involvement of the community in direct services through collaboration in many joint endeavors and at many different levels are now serving to bridge schism IV, the gap between mental health professionals and other human service professionals in the community.

IMPLICATIONS FOR THE 1970s

The fact that a comprehensive community mental health center can be developed by private practitioners gives us hope that mental health programs and psychiatric patients can indeed be included in first-class programs and as first-class patients in a national health plan. Third-party payments for services rendered, accountability through peer review, and fiscal responsibility and periodic audit of clinical and community programs with the application of cost-benefit analysis will highlight health care services in the 1970s. We submit that private practitioners can develop community-based clinical and community services that meet these requirements for health care delivery in the 1970s. Furthermore, the cost is no more and perhaps will prove to be significantly less than the cost of comparable services provided by public clinics and hospitals.

We hope that other communities of professionals will join in similar efforts to develop new types of mental health delivery systems, which can use the skills and interests of the increasing number of privately practicing mental health professionals across the country.

REFERENCES

1. Elements of a Community Mental Health Program. New York, Milbank Memorial Fund, 1956
2. Programs for Community Mental Health. New York, Milbank Memorial Fund, 1957
3. Progress and Problems of Community Mental Health Services. New York, Milbank Memorial Fund, 1959
4. Joint Commission on Mental Illness and Health: Action for Mental Health. New York, Basic Books, 1961
5. Schwartz S, Schwartz G: Social Approaches to Mental Patient Care. New York, Columbia University Press, 1964
6. Lamb HR, Heath D, Downing JJ: Handbook of Community Mental Health Practice. San Francisco, Jossey-Bass, 1969
7. Beach WB Jr, David A: Government and Medicine, I. The Short-Doyle Program, Past, Present and Future. Calif Med 109:398–402, 1968
8. Brickman HR: Government and Medicine, II. California Short-Doyle Program. Calif Med 109:403–408, 1968