Family Mental Health Maintenance: A New Approach to Primary Prevention

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The authors describe an approach to primary prevention in which indirect services are redefined to include community services aimed at promoting mental health and preventing emotional and mental disorders. At the Peninsula Hospital Community Mental Health Center such services are family-focused and include consultation, education, collaboration with other agencies, and early intervention with children and families with special needs. The authors describe some of the programs that have been developed and discuss how mental health centers can conceivably, under contract, develop such community services for health maintenance organizations and other prepayment plans that provide comprehensive health maintenance and medical care.

■In recent years three developments in the organization and financing of mental health services have encouraged the Peninsula Hospital Community Mental Health Center to take a fresh look at indirect services. Increasingly, public agencies are purchasing medical care, including mental health services, through contracts with other agencies; insurance coverage of psychiatric services is increasing nationwide; and the development of health maintenance organizations and prepaid health plans is being stimulated by federal grants. These developments have resulted in a nationwide increase in the number of organizations that contract to deliver comprehensive health services to designated consumer groups.

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Several questions emerge in the face of these developments. First, how can comprehensive mental health services be included in health-care packages for consumer groups? How can we reconceptualize primary prevention services so that we can include effective, low-cost preventive services in mental health packages for consumer groups? How can we make full use of our increasing knowledge and our increasing mental health manpower in new forms of mental health services that focus on families and children? How can we include in our health packages programs of mental health promotion and specific prevention of emotional and mental disorders for specific population groups?

Developments at the Peninsula Hospital Community Mental Health Center bear on those challenges. In October 1969 the center obtained a contract to provide mental health services to a catchment area, and subsequently developed a number of new services that we view as prototype elements of a family mental health maintenance program for a specific population group.

The center serves a catchment area of 95,000 people under a contract with the San Mateo County Department of Mental Health and Welfare. The contract provides limited state and local funds under Short-Doyle legislation for the five essential services of a community mental health center. The center is an administrative division of the Peninsula Hospital and Medical Center, a 387-bed general medical and surgical hospital. The mental health center administers the county contract and has developed center-based services, including emergency room services with a crisis intervention team; inpatient services; and a number of day treatment programs for adults, adolescents, and children. It also provides the indirect services of mental health consultation and education to community agencies and allied professionals.

The contract funds are budgeted to support, in the main, direct services to patients otherwise unable to pay for them. Other sources of funding for direct services include Medicare and Medicaid funds, insurance payments, and fees paid directly by patients. These fiscal arrangements, especially our contract for Short-Doyle and Medicaid services, make available a wide range of

direct services to any individual or family in our catchment area. Thus we can view our program as a prototype for the mental health component of a health maintenance organization for a designated population group. Our population group, of course, consists of all individuals and families in our catchment area, especially those who are eligible, through a uniform statewide financial screening process, for partial or full coverage of all direct services under the contract.

Professional services to patients are provided by the 85 privately practicing psychiatrists, psychologists, and social workers who make up the professional staff of the hospital's department of psychiatry. They assume the clinical responsibilities for care and treatment of individuals and families referred to them by the referral service of the center or through the emergency room, which is covered 24 hours a day by private attending psychiatrists. Center outpatients are seen in the professionals' private offices. After five years' experience with the contract, we have demonstrated that the private sector, in collaboration with an organized mental health center, can deliver a full range of clinical and community services under contract at a cost that compares favorably with services provided by traditional public mental health agencies.[1]

THE PEER REVIEW MECHANISM

After the first 12 months of services under the contract, the department of psychiatry realized that costs of inpatient services and of nonselective long-term individual psychotherapy were so great that the limited funds available under the contract were being exhausted. Accordingly, the department established a peer review system for utilization review of both inpatient and day treatment and for prior authorization of outpatient office psychotherapy beyond six visits.

Two and a half years of experience with the system have demonstrated that hospitalization, both inpatient and day patient, can be used as needed, and that, given limited funds, top quality office psychotherapy can still be provided when costs of professional services are monitored and kept under control by the professional community itself. The hospital's three peer review committees—the adult outpatient psychotherapy review committee, the children's and adolescent outpatient psychotherapy review committee, and the inpatient and day patient utilization review committee—have, in essence, succeeded in developing a system to balance clinical needs against fiscal reality.[2,3]

Peer review has actively stimulated the development of alternatives to the expensive weekly psychotherapy hour for chronic, dependent, often severely mentally handicapped individuals who will need services for an indefinite period. The center has developed low-cost therapy programs for those chronic patients, such as community-based milieu therapy programs costing less than $20 a week.

We have also reduced the use of expensive inpatient days from 2418 days for 290 Short-Doyle financed admissions in 1970 to 1348 days for 160 admissions in 1973. That was accomplished by more effective use of crisis intervention and increased use of our day treatment program for acutely disturbed patients, as well as for patients in transition from inpatient to outpatient status and chronic patients in need of long-range programs of supportive care and social rehabilitation. These new programs and approaches to care of chronic patients and our vigorous use of alternative sources for purchase of care, especially Medicaid funds for direct services under the Aid to the Totally Disabled program, relaxed some of the pressure on our mental health contract funds. Thus more funds became available to purchase outpatient treatment for children, youth, and less disturbed adults, and to develop indirect services. A federal staffing grant has aided in financing the center staff needed to develop our variety of direct and indirect service programs.

DEVELOPING INDIRECT SERVICES

In 1971 we began to consider how indirect, community-oriented services to promote mental health and prevent mental illness might be effectively developed and financed within the framework of our HMO prototype. In the spring of 1972, we wrote a proposal for a federal child-service staffing grant in which we outlined a variety of programs of prevention and, most important, mental health promotion. The grant was funded beginning in September 1972.

Our approach to indirect services extends the role of the mental health professional beyond the traditional roles of a mental health consultant and a resource person in educational programs for allied professionals. It brings mental health professionals into contact with consumers, especially parents and children, in center programs that are health oriented, rather than illness oriented; in programs in which there are no designated patients; and in programs where no labels are affixed to those participating in them.

We have divided our spectrum of services into direct services, in which there are an identified patient and a private professional fee, and community services, which include all other services. In the latter category are programs that have the familiar goals of mental health promotion, specific prevention, and early identification and prompt referral to diagnostic and treatment resources.[4]

[1] W. T. Vaughan, Jr., *et al.*, "The Private Practice of Community Psychiatry," *American Journal of Psychiatry*, Vol. 130, January 1973, pp. 24-27.

[2] D. E. Newman, "Peer Review: A California Model," *Psychiatric Annals*, Vol. 4, January 1974, pp. 75–85.

[3] A. Levy, "Private Peer Review for Fiscal Control of Publicly Funded Programs," *Hospital & Community Psychiatry*, Vol. 25, April 1974, pp. 235–238.

[4] H. R. Leavell and E. G. Clark, *Preventive Medicine for the Doctor in His Community: An Epidemiological Approach*, 3rd edition, McGraw-Hill, New York City, 1965.

Our center's approach to indirect services brings mental health professionals into contact with consumers in programs that are health oriented rather than illness oriented, and in which there are no designated patients.

Our community programs are divided into four separate areas, according to whether they are aimed at preschool children, grade-school children, youth (including high school and junior college students), or adults. In each area a coordinator is responsible for program development; he or she is a member of the children's, youth, or adult unit and is answerable to a service chief. Thus our community services are kept closely allied with our clinical services.

Over-all planning and development takes place in a weekly meeting attended by the coordinators, the service chiefs, the chief of community service, the center director, the director of research and evaluation, and a representative of the department of psychiatry, who serves as a consultant and provides liaison with the department's committee on community services. Community representatives, allied professionals, and consumers may also participate in the meeting if they are involved in topics for review and approval. The community services planning group is analogous to the peer review committees for direct clinical services.

In California, community services have for the most part been financed through Short-Doyle funds, seldom through purchase-of-service contracts with institutions or agencies that use mental health professionals as consultants or as resource people in staff education or service programs. We list as community services, under mental health education, switchboards and information centers as well as our drop-in centers for youth and parents. The latter include elements of education, information, and orientation, as well as socialization experiences, guidance, and referral. They are usually financed by a combination of private and public funds.

We list under a separate heading family-focused community services, or programs in which families may participate without there necessarily being an identified, labeled patient with a diagnosis. It is these services, some developed in collaboration with schools and other community agencies, that we envision as becoming part of basic services that can be purchased by consumer groups. They may serve as way stations or bridges in the pathway to direct clinical services for a number of individuals or families. Theoretically, they have the potential of reducing the incidence of serious disorders (and the need for traditional clinical intervention) and thus may be truly preventive. Collaboration with all family support systems in the communities where consumer group members live is a *sine qua non* of that concept. Schools, physicians, the clergy, and law enforcement, social, and recreational agencies—all should be involved in some measure. That requires continuing community organization efforts.

In summary, four kinds of community service programs are being developed by the community coordinators. They are traditional mental health consultation services, collaborative and educational programs with allied professionals; mental health information, orientation, and education programs for adults (especially parents), and youth and children; collaboration with nursery schools and elementary and high schools in counseling and educational programs for families and children with special needs; and assessment and educational-therapeutic programs for preschool children and their parents. There follows a brief description of five community service programs with a family focus.

FAMILY-FOCUSED PROGRAMS

The Teen-age Drop-in Center. The Teen-age Drop-in Center opened in November 1971 in our family, youth, and children's service building, which is next to the main hospital. It is open one night a week for social activities, arts and crafts, rap sessions, games, and special events. A committee of interested parents helped establish it and attend sessions regularly as volunteers. Several thousand dollars have been spontaneously donated to the youth center by interested community groups.

The drop-in center is staffed by student trainees and two salaried staff members who are responsible for the program and the care of the building. Some of the youth in the day treatment program have told their friends about the center, and some high school counselors, teachers, and therapists have recommended it to specific individuals. From 30 to 40 youths visit the center each week. Information about and orientation to the mental health center and its programs are provided on request, and some youths have decided to seek direct care.

From the mental health center's point of view, the drop-in center is a community service rather than a clinical service. Those who attend are not patients, but simply community youths seeking additional outlets and receiving information, orientation, and education, the last including the development of social skills.

The Parent Drop-in Center. During 1971-72, one of us (MB) organized a series of lecture-discussion groups for parents. A moderate fee was charged and some 150 people participated. It became apparent that patients felt the need to listen to and talk with other parents and professionals about child-rearing and parent-child relations.

A planning committee of parents collaborated with youth services staff to develop a parent drop-in center, which opened in the winter of 1972-73 under the name

of Parent Communication Center. Located on the second floor of the hospital, it is open one evening a week. Two center staff members, one each from the children's and the youth services, plus seven volunteers take responsibility for seeing that each evening is well organized. Notices have been placed in the hospital, libraries, supermarkets, churches, and newspapers. A member of the mental health center staff is invited as a guest speaker for each session. Discussion focuses on such areas as positive parenting, the single parent, intimacy, and communication. From 30 to 40 people are now attending, some regularly.

The center staff and the planning committee have developed small study groups or workshops on particular aspects of parent-child relations for which there is a set fee. These small groups usually meet for four to five weeks during the hour following the large group meeting.

A handful of participating couples or single parents who have attended the PCC have decided to seek individual clinical care and treatment. For those individuals, the program has provided needed information and orientation, helping them to arrive at an important personal decision. There are no designated patients in the PCC; it is clearly an indirect or community service.

The Developmental Nursery. The developmental nursery, which opened in October 1973, is designed to provide parents, teachers, physicians, and others concerned with preschool children information and insights related to the children with whom they are working. The nursery serves families with children between the ages of two and five; it is a learning center where parents observe and discuss how children play and grow and thereby gain a further understanding of developmental issues in young children within a family context. The nursery is open from 9:30 to 11:30 a.m. four days a week. It is staffed by a head teacher, a teaching assistant, a social worker, a psychologist, and volunteer aides.

A child must be admitted to the program by a member of the professional staff of the hospital, frequently a pediatrician or a family physician. Most children attend the nursery one or two days a week and remain in the program three to six months.

Broad-scale psychosocial assessments of child and family functioning and appropriate treatment are carried out in the nursery setting. Parents are involved in the sessions along with their children and observe the interactions through a one-way mirror. Parents are guided in their learning by sharing anxieties and concerns with other parents and with professional staff and by observing and discussing how the teacher interacts with the children and the children with each other. They are also involved in discussion sessions with the social worker, both in groups and individually.

The staff of the nursery gain an understanding of the child's and the family's behavior, attitudes, strengths, and weaknesses. They use that understanding to help alter the negative processes expressed in the child's behavior and in the family interaction.

For those children already in another program, such as nursery school, day care, or Head Start, every attempt is made to maintain the child in that group. The staff of the developmental nursery collaborate with the teacher and parents in developing the most appropriate methods of maximizing the child's emotional and intellectual potentials.

The developmental nursery thus operates as a mixed clinical and community service, inasmuch as each child is admitted as an outpatient and generates a hospital chart with a diagnostic label as well as a bill. In some instances a referral may be made to a mental health professional so that the child and parents may also receive individual clinical care and treatment when it is apparent that it is needed.

Mental Health Work With Law Enforcement Agencies. The center is collaborating with the police departments in a new program in which, among other things, a mental health professional from the center assists the police with community crises involving family disturbances. The program has developed out of three years of monthly meetings with the four police departments in our catchment area.

A youth and family counselor is engaged in the study of family quarrels and police responses to them. He accompanies police officers on calls and is available for special emergency consultations. He provides information to family members about resources at the center and elsewhere that may be helpful to them. He makes home visits to consult with families. He may refer some to the teen or parent drop-in center, or to the center's referral service for clinical services.

The youth and family counselor is also becoming familiar with special services in the schools and with the work of probation officers so that he can help increase their effectiveness. Thus he provides a bridge of collaboration between mental health professionals and the many other professionals who are often involved with impulse-ridden multiproblem families. The effectiveness of the mental health professional as a consultant to police and probation officers, and as a resource person in police training programs, is being enhanced by the family-focused activities in which he participates with the police.

Collaboration With Schools and Other Agencies. We identify collaboration as a mental health activity in addition to traditional mental health consultation and education for allied professionals. Under this rubric we include programs in which mental health center staff join with school or other personnel in activities that bring them into direct contact with students and parents, as well as teachers, school administrators, and special service personnel. Such activities usually take place in a community setting, such as a school or recreation center, but may take place at the mental health center. For several years, center staff, including trainees, have participated as resource persons in discussion group programs in schools. The programs have been held in both classroom and group counseling sessions

in public and parochial high schools and in intermediate schools. Mental health personnel have occasionally lectured in health education, safety, and family life education classes in high school.

A six-session training program in child care was held in the spring of 1974 and repeated again this year for young people in grades eight through ten. The program has been very well received by 30 to 40 young babysitters, who were given a certificate of attendance at the end of the sessions. We hope to expand the program to include older persons and to focus on the care of handicapped children or children with special needs. Such training will give us a cadre of people who can provide respite care for parents of children with special problems.

Mental health professionals from the center have also had direct contact with students and parents in the school nurses' offices and in conferences with guidance and other school personnel. The children involved are often identified as having special problems, such as learning and behavior disorders or drug use and abuse. Increasingly, however, the schools are interested in involving the mental health center in their general considerations of growth and development of children and youth, and in making sure of the effectiveness of their programs in reaching children and youth and in meeting their needs. We have found that the schools are eager to use outside resources whenever they are available.

We view these family-oriented information, orientation, and education services to be our key programs of mental health promotion and specific prevention. Parents, youths, and children are referred to them by school, police, and probation personnel, by friends and neighbors, family physicians, pediatricians, and others. They serve as a bridge between individuals and families in the community and direct clinical services.

WHAT ABOUT THE PACKAGE?

We raised two fundamental questions at the outset: how can we include comprehensive mental health services in health-care packages for consumer groups, and how can we conceptualize our primary prevention services in such packages? We have presented a partial answer to the second question as we redefine indirect services to include all services to consumers in which there is not an identified patient. From that redefinition has ensued a number of new service programs that clearly have as their goals mental health promotion and specific prevention, not clinical care and treatment of mental illness or emotional disorders as such.

Now we return to the first question, how can we include such programs in mental health packages for consumer groups? We have looked to the HMO concept, with a prepayment mechanism and a contract with an organization whose mission it is to deliver comprehensive health services. HMOs such as Kaiser-Permanente, Group Health, and the Health Cooperative of Puget Sound, as well as some foundations for medical care, can develop for themselves family-focused programs of mental health services for subscriber families, or can develop them in cooperation with community mental health centers. University student health services, as well as CHAMPUS (the Civilian Health and Medical Program of the Uniformed Services), may also provide models for health-care delivery systems that can develop prepaid mental health services to consumer groups.

In our thinking about financing mental health services we have considered another model, derived from automobile insurance, which we call the AAA model. Basic membership in AAA brings information and education about automobile maintenance; orientation, suggestions, guidance, and reservation services for travel; and crisis intervention in the form of tow-truck and bail-bond services. In addition, accident, collision, and liability insurance are also available to members for a cost determined by the circumstances and needs of the individual subscriber.

In like fashion, the basic services of family mental health maintenance, including (a) family-focused consultation and education services based on the public health model, and (b) crisis intervention services in emergency room, inpatient, and outpatient settings, can be viewed as the basic core of mental health services to consumer families. The usual psychiatric treatment and rehabilitation services in inpatient, outpatient, and partial-care settings can be viewed as "add-ons" to the basic core services. Utilization of as well as access to those expensive services can be monitored and controlled by means of a system of peer review.

Costs of inpatient care, outpatient services, and chronic care to any consumer group depend on many factors, including characteristics of both the consumer group and the provider group and the economics of mental health care in the particular community. But a word should be said here about catastrophic coverage. No one consumer group can develop the financial base to underwrite the costs for catastrophic coverage in the mental health field. What constitutes a catastrophe is determined by several factors, such as degree and duration of disability and cost of treatment and rehabilitation. Any comprehensive mental health plan for consumers must have provisions for catastrophic coverage, but it seems most likely that a public insurance or underwriting program for care of catastrophic mental illness, defect, or handicap is going to be needed.

It seems clear that mental health programs are so complex in themselves, and so interwoven into other areas of human affairs, that there will always be a need for multiple sources of funding. Mental health service needs exist in schools; courts; corrections, welfare, and vocational rehabilitation agencies; and business and industry. The interfaces, however, are unclear. There is much role confusion between areas of human services as well as within the mental health field itself.

Ideological struggle seems to ensue from constructive questioning of traditional conceptualizations and ap-

proaches to the organization and delivery of mental health services; one such struggle centers on the medical model. In our approach, we suggest the use of an over-all public health–mental health frame of reference, within which the illness model, the growth and development model, the education model, and the social service model can each be used when appropriate. Such a broad conceptualization seems imperative when developing comprehensive mental health services for consumer groups living in catchment areas.

QUESTIONS TO BE ANSWERED

A brief discussion of the AAA model raises more questions than it answers. Where are the demographic and incidence and prevalence data needed to determine the cost of such a program to a consumer group, or to individual subscribers? How do you pull together the idea of consumer groups, which is basic to prepaid health plans and health maintenance organizations, and the idea of catchment area, which is basic to community mental health centers?

How many people can be expected to utilize each of the program elements during any given year? Are deductibles and co-insurance feasible and desirable for direct services? How do the practitioners view peer review, and how does it affect the type and quality of care provided? Do they feel it interferes with delivery of high-quality care and treatment? How do cost-of-living, salary, and other increases affect the annual expense of such programs?

Who, if anyone, picks up the deficit? How can mental health planners work effectively with health-care providers, representatives from the health insurance industry and fiscal intermediaries, public finance experts, biostatisticians, epidemiologists, economists, sociologists, and others to develop the feasibility studies, technical papers, and monographs related to the establishment of family mental health maintenance programs that can be sold to consumer groups? Can a family mental health maintenance program successfully activate the comprehensive approach to child mental health that has been advocated by Prugh, Noshpitz, and others who worked on the report of the Joint Commission on Mental Health of Children? [5,6]

At our center we have worked for several years on a proposal calling for the formation of an independent center for study of delivery and financing of mental health services to bring together experts from the fields mentioned earlier to develop joint study and research projects in the delivery and financing of mental health services. Bringing together all the parties concerned in the study and planning phase of program design should result in sounder programs that can be incorporated into broad health plans stressing pluralism for providers and multiple-source funding for consumers.

Our work on this project culminated this past spring in the incorporation in California of a nonprofit organization, the Center for Collaborative Studies in Mental Health Delivery and Financing. The focus of its efforts will be on developing studies by collaborating institutions and agencies, with representation from consumers and funders as well as providers.

Prevention programs have traditionally been paid for with public funds, and insurance plans, including prepayment plans, have traditionally offered indemnity against illness. Accordingly, we may be able to measurably influence indemnifiable factors. Therefore, we feel that it should be possible to include some payment for family-focused community services in health insurance programs. The burden of proof, of course, is on us.

We welcome the interest of other centers in joining in studies—through the newly established Center for Collaborative Studies—that can move some of these ideas forward. It is unthinkable that mental health services not be included in any national plan for meeting the costs of health care. However, we believe that reconceptualizations are urgently needed to accomplish that effectively.

We believe the concept of family mental health maintenance can be used not only to design comprehensive programs for consumer groups, but also to help pull together the disparate groups of mental health practitioners, both in the public and private sector, who now seem to be pulled apart in internecine struggles, both ideological and territorial. Very real threats to mental health practice exist. We would rather see us all joined together in the challenge of developing a modern mental health delivery system for our country.■

[5] Joint Commission on Mental Health of Children, *Crisis in Child Mental Health: Challenge for the 1970s*, Harper & Row, New York City, 1969.

[6] Group for the Advancement of Psychiatry, *Crisis in Child Mental Health: A Critical Assessment*, Report No. 82, New York City, 1972.