The Coordination of Mental Health Services at the Neighborhood Level

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The neighborhood health center is becoming a major locus of mental health care delivery. Because of their strategic position at the neighborhood level, mental health care systems in the comprehensive health center locus have been able to develop linkages with both general health and community mental health systems to provide a broad continuum of coordinated health and mental health care. Four models identified in a survey of 19 neighborhood mental health programs are described. The authors suggest that persistent problems in coordination of care between neighborhood mental health and other caregiving systems would be considerably alleviated by a fiscal reimbursement scheme that rewarded integration rather than fragmentation of care.

NEIGHBORHOOD MENTAL HEALTH represents a population-focused system for delivering ambulatory mental health services in coordination with general health services from the comprehensive neighborhood health center locus (1). Emerging in the 1970s, it represents an area of intersection of the community mental health and neighborhood health movements of the sixties, as the former focuses on smaller and more realistically sized (i.e., subcatchment) ethnic- or destiny-related population areas, and the latter enlarges its scope to include services for emotional as well as physical health needs (2). The literature to date on neighborhood mental health systems is still relatively sparse, consisting primarily of case reports of single programs without an aggregate picture of the emerging field (1, 3–5). This paper, based on a study of 19 neighborhood health center (NHC) mental health programs, describes the wide variety of organizational and fiscal models under which neighborhood mental health programs operate and examines their methods of coordinating services with the larger general health and community mental health networks.

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The authors thank the Massachusetts League of Neighborhood Health Centers, whose sponsorship and sanction was indispensable in "opening the doors" of the participating health centers to investigation.

METHOD

Under the auspices of the Massachusetts League of Neighborhood Health Centers (a consumer-professional coalition of 40 centers across the state, devoted to improving the quality and availability of health care), a task force of mental health workers in the Boston area designed a semistructured interview to gain a better understanding of the organization, operation, and functioning of the 19 Boston NHCs with mental health programs. Information was collected by one of us (E.S.) in personal interviews with the mental health program directors at each of the 19 centers during the period of August through October 1973.

The structured interview included both qualitative data, designed to provide an overview of mental health programs and relationships within and without the NHCs, and quantitative data on patterns of service, patient visits, staffing, etc., based on the July 1972 through June 1973 fiscal year. The qualitative data available for analysis were verbal responses to the structured interview inquiries. At least two members of the task force independently classified each section of the verbal response data into descriptive categories and then allocated each center's responses into one of these categories. This independent work was then subjected to the scrutiny of the entire task force to minimize bias until agreement was reached on the representativeness of the categories and the appropriateness of the allocations.

RESULTS

Our findings have yielded a descriptive picture of the overall organization and functioning of this type of mental health delivery system. In a previous article (6), we described the patterns of mental health services provided by the NHC mental health programs and proposed reasons for the high level of acceptability and efficiency of this type of integrated health - mental health care, especially among nonwhite, highly ethnic, and poor Americans. This report will focus on the various organizational models used by NHC mental health programs, their internal linkages for health - mental health coordination, their ex-

ternal linkages with community mental health centers (CMHCs) and other caregiving agents in the neighborhood, and evaluation issues in this new system.

Organization of Neighborhood Mental Health Programs

It was readily apparent that neighborhood mental health programs operate under a variety of organizational models that appear to influence the services provided, the degree and type of health - mental health integration achieved, and the priorities of the program. Since neighborhood mental health lies at the interface of the neighborhood health and community mental health systems, it is strongly influenced by both. NHCs have the responsibility of serving all the health needs of their neighborhood, while CMHCs are responsible for serving all the mental health needs of a catchment area that often includes many neighborhoods. Structurally, neighborhood mental health programs and staff usually have an alliance with both of these systems because of their overlapping areas of interest and responsibility.

We differentiated four organizational models of neighborhood mental health programs on the basis of patterns of interaction and contributions of personnel and monetary resources by the intersecting systems (NHCs and CMHCs) to the neighborhood mental health program (NMHP). These models are illustrated in figure 1.

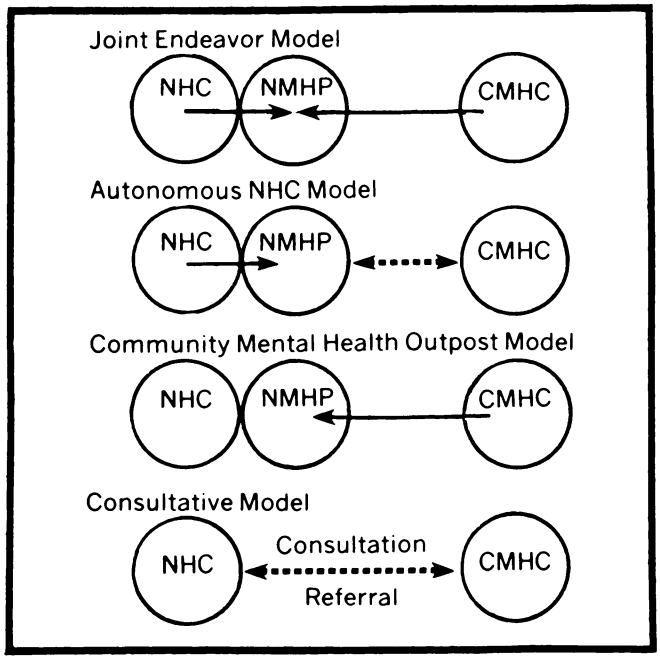
1. Joint endeavor model. The most prevalent model was one in which the NHC runs a mental health program with a mixture of employees hired by the health center (often the indigenous paraprofessional therapists and the nondoctorate mental health professionals, such as social workers and nurses) and employees hired by state, city, or university community mental health systems (often the more "expensive" doctorate level mental health professionals, such as psychiatrists, psychologists, and psychiatric residents) who are stationed at the NHCs at least part-time. This makes the neighborhood mental health program a joint endeavor of the two systems, with varying degrees of NHC program autonomy and linkage to the backup community mental health system. The dual contribution of resources often allows such joint endeavors to be "full-time" programs.

2. Autonomous NHC model. A second model is a neighborhood mental health program run by and totally funded by the NHC. There are two varieties: the first consists of a full-time neighborhood mental health staff that is well coordinated with a full-time general health program (such programs are more frequent in those health centers fortunate enough to have significant "front-end" funding, usually from a federal source). The second variety consists of part-time mental health professionals hired by the NHC to provide limited mental health sessions during each week for patients with defined emotional problems (such programs exist in centers without significant front-end funds, which can only add on mental health services to the extent that they are reimbursable.) Such programs develop nonmonetary liaison relationships with their local CMHC.

3. Community mental health outpost model. A third model has the entire neighborhood mental health staff either 1) paid for by CMHC funds and "detailed" to the NHC on a full-time basis to provide a coordinated mental health program, or 2) "loaned out" part-time to the health center to provide minimal mental health services in the neighborhood locus.

4. Consultative model. The final model is a working alliance between an NHC that does not have its own discrete mental health program and a nearby CMHC satellite. The two separately housed and controlled units serve the same population and maintain an ongoing consultative and referral relationship.

FIGURE 1
Four Organizational Models of Neighborhood Mental Health Programs



Internal Linkages to Coordinate Health and Mental Health Services

The programs we studied have developed a variety of methods for coordinating their health and mental health services and caregivers. Administratively, mental health services are either a separate department of the health center or a subdepartment of general medical services. In either case,the large majority of mental health directors reported that they were participants in the decision-making meetings of their health centers, each meeting regularly and directly with his medical director. Linkages for clinical purposes ranged from informal referral mechanisms to active, ongoing collaboration and conjoint service of multiproblem patients. In general, those centers with full-time neighborhood mental health programs interacting and housed with full-time general health programs had the opportunity, and usually a higher priority, for offering integrated health - mental health services. Centers forced to rely on part-time staffs had less opportunity for offering integrated services and often provided

parallel but separate health and mental health services at different times in the same location.

In 8 of the 19 NHCs, interdisciplinary health care teams of health, mental health, and social service staff were used to coordinate care. Such teams met on a regular basis (at least weekly) to coordinate planning and service delivery to jointly served patients, facilitate interdepartmental referrals within the health center when needed, and pool expertise to promote a multidimensional (health, mental health, and social service) perspective to the treatment of patients best treated in a single department. The 11 centers that did not have interdisciplinary health care teams coordinated health and mental health services in a variety of ways related to their size and organization. Some of the neighborhood mental health programs designated specific staff as coordinators, primary caregivers, or ombudsmen, who were expected to keep all relevant caregivers informed about jointly served patients. Health center staff meetings and conjoint case conferences were also used as contact points between health and mental health caregivers, while the common health - mental health record system served as another communication network.

Size, part-time staffing, and fiscal infeasibility were the reasons respondents gave for not having interdisciplinary health care teams. The very smallness of some centers allowed for a great degree of informal contact between health and mental health staff, with much patient service coordination occurring during lunch or coffee breaks. Dependence on part-time staff, who only come to the center for a limited number of hours each week, posed problems for scheduling regular interdisciplinary meetings and forming working alliances between caregivers. Fiscal considerations also inhibited some of the NHCs from integrating their services; direct services are, at least to a limited extent, reimbursable by fees or third-party payers, while time-consuming interdisciplinary teamwork is not. Many neighborhood health centers that work desperately to keep their heads above the fiscal tide unfortunately find the costs of such teamwork prohibitive.

Internal Coordination: Advantages and Problems

There was general consensus that mental health should be considered part of comprehensive general health care and should not be separated from it either programmatically or geographically. Centers contacted cited the following specific advantages of the neighborhood health - mental health system in providing coordinated and comprehensive health care:

1. Referrals are easier and quicker in both directions, with fewer patients likely to be "lost" between referring and referred caregivers if the caregivers are in the same location.

2. Communications about patient care for referral, consultation, or collaborative efforts are facilitated by the advantages of ready (across the hall) access to allied caregivers, a common record system, and a common administrative hierarchy to decrease red tape.

3. Since many health care delivery problems hinge on the patient-provider relationship, mental health staff can often assist health staff in learning how to deal with behaviorally difficult patients. In turn, health staff can use their ongoing relationship with patients to facilitate acceptance of mental health services when needed.

4. The appreciation of emotional problems by general health staff and their use of consultation is facilitated by the frequent informal contacts between the health and mental health caregivers located under the same roof.

The most commonly reported problem in integrating care within the health center was frustration in attempting to coordinate patient care when full-time health and mental health staffs were not available. The part-time status of caregivers, dictated by fiscal limitations, often led to their being unavailable when needed for communication, consultation, collaboration, or referral. It was seen as almost impossible to schedule regular interdisciplinary meetings to include all part-time care providers. Also, there was still a lack of basic understanding of mental health problems and treatment among some NHC staff. This was manifested in either an excessively broad definition by the general health staff of mental health problems, which fostered a "dumping" of difficult cases onto mental health staff and unrealistic expectations on the part of the patients, or an excessively narrow definition of mental health problems, in which patients with serious mental illnesses were not referred for specific mental health treatment.

External Linkages to Coordinate the Network of Mental Health Services

The mental health programs in NHCs also have multiple external linkages to community agencies and caregivers. The centers surveyed provide extensive mental health consultation to and collaboration with a variety of neighborhood caregivers, including public agencies and support systems, schools and child care facilities, recreational activities, psychiatric and social service agencies, and other medical caregivers. Because of the health center's health, mental health, and social service capabilities, the neighborhood mental health program was frequently found to have assumed the role of the focal coordinator of the neighborhood's caregiving agencies.

However, the primary external linkage of neighborhood mental health programs was to the CMHC responsible for the catchment area in which the NHC operated. On the whole, we found that neighborhood mental health and community mental health programs complement rather than compete with each other to together provide a broad spectrum of effective mental health care. In general, the care spectrum has been divided in the following manner. The neighborhood health center programs provide frontline ambulatory mental health care within the neighborhood that is geographically, culturally, and psychologically accessible to their patients. The association with general health increases opportunities for early detection, early therapeutic remediation, and preventive intervention. Most NHC mental health programs emphasize prevention, short-term therapy, hospitalization-preventive linkage with neighborhood resources and sup-

port systems, and long-term supportive aftercare. On the other hand, the CMHC programs provide those services which are best centralized and most specialized and expensive, such as inpatient and day hospital treatment, specialty diagnostic procedures, much of the long-term intensive dynamic therapies, and addiction services. Programmatically, the CMHCs also assist in such centralized services as training, supervision, and program planning and evaluation. It is important to note that neither the NHCs nor the CMHCs offer their services to the other solely out of the goodness of their hearts. Rather, a quid pro quo has been negotiated in which the neighborhood center receives needed access to expensive backup and support services in return for its help in meeting the community mental health center's catchment area responsibilities.

Linkage between the two systems was facilitated by the frequent overlap of personnel working in both systems. Such personnel gain an understanding of the differential context and capabilities of the neighborhood and community systems and can help to keep staff in each apprised of the other's activities. In some centers, specific liaison workers were designated to help patients cross the boundaries between the two systems to receive the appropriate type and level of care. Occasional conjoint staff meetings or teaching conferences facilitate the development of face-to-face professional relationships directed toward collaborative work with jointly served patients. In addition, some neighborhood programs share a common record system with their CMHC backup facility, while others have decreased barriers to rapid communication and access to records of commonly served patients through courtesy staff appointments of neighborhood staff to the CMHC and vice versa.

External Coordination: Advantages and Problems

The collaborative arrangements of NHC mental health components and CMHC programs have produced a delivery network that can provide a broad range of treatment services with linkage mechanisms to promote continuity of care. It is a network that offers the potential patient multiple portals of entry into the mental health care system. It therefore provides the all too rare opportunity for the nonrich patient to select his locus of treatment, either in his neighborhood by ethnically or racially familiar caregivers or at the less familiar but more anonymous community mental health system outside his immediate neighborhood. In addition, the frequent congruence of language, culture, and realm of experience of neighborhood mental health staff and their patients allows such staff to serve an important bridging function in helping neighborhood patients cross back and forth between the neighborhood and community systems when necessary to receive needed services (7).

Two major problems that arise in the linkages between the neighborhood programs and their community mental health partners are dual allegiances of staff and coordination of services within the two separately organized systems. Dual allegiances arise because many of the staff in neighborhood mental health programs get financial and/or academic-professional remuneration from the backup community mental health system, and the divided loyalties which result from this often cause personal and professional identity conflicts. To which system does the staff member owe his allegiance when the two systems compete for limited resources? Should he write or support a grant request for trainees for the NHC or the CMHC when he knows that few will be granted? Should he do it for both systems and therefore compete with himself? To which system is the staff member accountable for what time and activities, and how does he respond to often unintegrated pressures from the dual lines of authority? If he is assigned on a part-time basis in both systems, how can he become an "insider" and feel truly integrated into either?

At this stage in the development of the field, it is not surprising that difficulties also exist in coordination and clarification of responsibilities between the two systems in working with jointly served patients. A network with the strengths of multiple portals of entry and a sharing of responsibility for patient care also presents the possibility of duplication and fragmentation of care. Real or perceived patient dumping from one system to the other is a problem for some NHCs, especially those which have not carefully delineated in conjunction with their community mental health facility which types of patient problems are best treated in which system and what ongoing liaison mechanism will be necessary to facilitate this division of the shared labor and responsibility.

Fiscal restrictions pose an additional linkage problem that affects the ability of neighborhood programs to meet requests for coordination, consultation, and collaborative services with both their community mental health partners and other neighborhood caregiving agencies. Such vital indirect services are currently not reimbursable by third-party payments, and community caregivers are often unable to pay directly for such services through contracts or fees. It is to be hoped that public and private health insurers will rectify this regrettable gap in the near future.

EVALUATION OF NEIGHBORHOOD MENTAL HEALTH PROGRAMS

As a relatively new mental health delivery system competing for scarce resources, neighborhood mental health is challenged with the scientific and fiscal necessities of evaluating its precepts and programs as it develops. It has been proposed that evaluation efforts should utilize the collaborative expertise of neighborhood citizen-consumers and nonneighborhood professionals to examine the areas of delivery, coordination, and costs of services, and ultimately the impact of the delivery system on the total neighborhood (8, 9). Our study identified several issues and obstacles relevant to the evaluation of the neighborhood delivery system.

A major obstacle to evaluation of services in such decentralized delivery systems is the lack of a common data base for comparing programs. In the 19 centers studied,

basic quantifiable parameters of service, such as number of patients, patient encounters, and costs per patient, were recorded in different ways by different centers and often were based on different concepts and definitions. Therefore the development of a rudimentary common data base is the essential first step toward answering basic questions about the efficiency and cost effectiveness of neighborhood systems. The task force is currently planning such a data base for its Boston centers to allow us to quantitatively examine relationships between specific organizational models and the types and coordination of care provided.

In costing out this system of care, the efficiency of the total health care system must be considered. It would not be surprising to find that coordinated health - mental health care will initially increase the mental health service provision costs above those of fragmented care (in which some needed services are never received and the long-range costs of disability, medical and/or psychiatric, are never accounted for). It is also quite likely that many patients unwilling or unable to go to free-standing psychiatric facilities may be "discovered" by the excellent case finding of the general health caregivers and referred to their mental health colleagues in the health center, thereby increasing the number of mental health patients and the attributable mental health costs. If one goes beyond initial mental health costs, however, studies have demonstrated total health care cost savings through the decreased need for the use of general health services when mental health needs are met early in a conjoint health - mental health setting (10, 11).

In addition, recent studies in our Boston area health centers have described the decreased cost of treating chronic schizophrenic patients in the NHC as compared with the state hospital (12) and the acceptability and appropriateness of less expensive indigenous personnel as clinical therapists in the neighborhood setting (7). The interesting questions concerning the ultimate impact of a neighborhood-run health and mental health delivery system on the organization and cohesion of the neighborhood itself will require longitudinal collaborative studies with basic social science professionals.

REFERENCES

1. Morrill RG: A new mental health services model for the comprehensive neighborhood health center. Am J Public Health 62:1108-1111, 1972
2. Macht LB: Neighborhood psychiatry. Psychiatric Annals 4:43-58, 1974
3. Lowenkopf EL, Zwerling I: Psychiatric services in a neighborhood health center. Am J Psychiatry 127:916-920, 1971
4. Kluger JM: The uninsulated caseload in a neighborhood mental health center. Am J Psychiatry 126:1430-1436, 1970
5. Massie HN: Neighborhood psychiatry in a mobile health unit. Hosp Community Psychiatry 22:233-236, 1971
6. Borus JF, Janowitch LA, Kieffer F, et al: Neighborhood health centers: the mental health delivery system of the future? Presented at the 102nd annual meeting of the American Public Health Association, New Orleans, La, Oct 20-24, 1974
7. Borus JF, Anastasi M, Casoni R, et al: Psychotherapy in the goldfish bowl: the role of the indigenous therapist (unpublished paper)
8. Borus JF, Klerman GL: Consumer-professional collaboration for evaluative research in neighborhood mental health systems. Hosp Community Psychiatry (in press)
9. Klerman GL, Borus JF: Research and evaluation in neighborhood mental health. Presented at the Conference on Mental Health Services for the 70's: Neighborhood Psychiatry, Cambridge, Mass, June 7-9, 1973
10. Follette W, Cummings NA: Psychiatric services and medical utilization in a prepaid health setting. Med Care 5:25-35, 1967
11. Goldberg ID, Krantz G, Locke BZ: Effect of a short-term outpatient psychiatric therapy benefit on the utilization of medical services in a prepaid group practice medical program. Med Care 8:419-428, 1970
12. Sharfstein SS: Institutional or community care: costs and benefits. Presented at the 127th annual meeting of the American Psychiatric Association, Detroit, Mich, May 6-10, 1974