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SECURE ATTACHMENT TO FAMILY AND COMMUNITY:

**A PROPOSAL FOR COST CONTAINMENT WITHIN HIGH USER
POPULATIONS OF MULTIPLE PROBLEM FAMILIES**

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ABSTRACT

The Multiple Problem Family (MPF) is described as the social context for the evolution of high risk populations of high users of Medicaid and Health and Human Services. The clients from these families are involved in domestic violence, addiction, child abuse and neglect and are often on the caseloads of state protective service agencies. This approach, based on social attachment theory models, stresses the use of long-term, home-based therapy and community support agencies to maintain safe secure attachment for these fragile families. The goal of the therapy is to foster an attachment that leads to increased mentalisation within these families and decreases the crisis-driven behavior that often results in high utilization of State resources. A placement prevention model is outlined as an alternative “mentalising social system” approach to disruptive MPF children instead of more costly inpatient psychiatric admission and follow up residential care.

KEY WORDS: COST-EFFECTIVE; HOME & COMMUNITY SERVICES;
MULTIPLE PROBLEM FAMILY; MEDICAID; PSYCHODYNAMIC THERAPY

“...I lost my childhood,” it was stolen from me”, “I became an adult early...” Observers of children persecuted during the Holocaust frequently refer to their adult ‘looks.’ We therefore speculate that not only adults but also children can undergo an ‘aging’ process under the influence of massive physical and psychic trauma”

From: *The Last Witness: Child Survivor of the Holocaust*
Kesentberger & Brenner, 1996, American Psychiatric Press, p.132

Introduction

This paper argues that the child protective and juvenile justice-involved children and adolescents who live in multiple problem families (MPF) need to be aggressively treated with a special approach to services delivered in the families’ homes and community or they will quickly become a tangled, escalating, and untraceable expense across a state’s health and human services accounts, especially Medicaid. Clark, Zalis, and Sacco (1982) described these families as low-income-culturally deprived (LICD) living in rural, industrial or urban areas. Minuchin, et al (1999) refer to the MPF as “multi crisis” families. The Department of Health and Human Services released a survey estimating that child abuse and neglect in the United States nearly doubled during the seven years between 1986 and 1993.¹ Younger parents have more problems and fewer supports. Disruptive children from MPF flood the public schools. Parents suffer from Axis II disorders and substance abuse and often are incarcerated, homeless, on probation, or regularly using state services including Medicaid. This is a distinct population requiring a specialized therapeutic approach that stresses psychotherapy with multi-agency support. The therapy addresses the trauma as well as the psychiatric symptoms and social deviance that stem, in great part, from the MPF’s having to live within oppressive social contexts ripe with exploitation, prejudice, shrinking resources, poverty, and unstable family and community life. The therapy works to connect the MPF to the

¹ <http://www.prevent-abuse-now.com/stats.htm#Increase>

necessary community, state, and federal supports they need to feel safe and secure, a type of holding environment without having crisis behavior propel family members out of their families and into state funded, higher cost residential and educational services.

These families could be called second tier, in the sense that 1st tier families exhibit Major mental illness like Schizophrenia, Bipolar Disorder etc, and for whom case management and medication are critical for a successful outcome. This second tier group consists of those with severe personality disorders, developmental disorders, substance abuse and PTSD secondary to physical and sexual abuse, all problems for which psychological approaches are more important to successful outcome.

This approach to therapy emphasizes cognitive and social skills acquisition, understanding, parenting effectiveness and other preventive interventions. Families are helped to begin mentalising and supported in developing skills to cope with “the system.” This is hypothesized to foster a family’s self agency, impulse control, and the ability to create boundaries. The approach to therapy stresses helping families to mentalise. Mentalizing is a form of imaginative mental activity, namely, perceiving and interpreting human behavior in terms of intentional mental states (e.g. needs, desires, feelings, beliefs, goals, purposes, and reasons (Fonagy, P., Gergely, G., Jurist, E., & Target, M., 2002).

There is evidence that psychotherapy is more effective than medication or even medication and psychotherapy when there is significant trauma impacting psychiatric symptoms, like clinical depression (Nemeroff, CB, et. al., 2003). Links, PS, Heslegrave, R., and van Reekum, R. (1998) found that Borderline Personality Disorder is a persistent disorder that did not remit after discharge from an inpatient setting. Stevenson, J.,

Meares, R. and D'Agello, R. (2005) studied 30 Borderline Personality Disordered (BPD) patients in Australia and found that psychotherapy was an effective intervention for this population and that the impact of therapy was maintained for four years. In this same study in Australia (Stevenson, J & Meares, R, 1999) the costs of treating the BPD patient with psychotherapy represented over \$8,000 savings (hospital costs) per patient over the year before psychotherapy. Perry, JC Banon, E. and Ianni, F. (1999) reviewed fifteen studies on the effectiveness of psychotherapy with BPD. Results indicate that all studies showed improvements in personality disorders with psychotherapy. In a larger study with 362 inpatients Zanarini, MC, et. al. (2004) found that a majority of BPD patients continue to use outpatient treatment through six years of follow up.

Abused children use more mental health services than non-abused Medicaid children. Combs-Orme (2002) compared 956 Medicaid eligible children with and without serious mental health problems. Children with emotional disorders were significantly more likely to also have chronic health problems. Cuellar (2001) examined Colorado's Medicaid carve-out. The study convincingly documents that youth involved in either juvenile justice or child protection use more services and are often the hardest hit by traditional managed care plans. Glied (2001) estimates that 6.2 % of children in the United States meet the criteria for depression. This study found that children with manic or depressive diagnosis have higher levels of expenditures, higher rates of inpatient use, and higher rates of Medicaid payment than other children with mental health illnesses. Ezzell (1999) studied Medicaid-eligible children and reports that physically abused

children were disproportionate users of health and human services resources. Duckworth² reports that approximately 80% of Medicaid-funded child and adolescent beds in Massachusetts are DSS child protection or (state custody) children and adolescents. This population is especially suited for psychotherapy delivered in their home and community. Interventions stress family empowerment and build long-term attachments to positive elements in the social system.

This population is growing in every state. Child Protection and Juvenile justice caseloads are peopled by damaged personalities that live in and create increasing numbers of MPF. The child victims become parents after being traumatized during childhood and the pattern of disconnection and destabilization continues. Volkan, et al (2001) studied children of Holocaust survivors and theorize that there is an unconscious trans generational transmission of trauma. Overwhelmed and oppressed single mothers in the MPF are forced to go it alone; oppression quickly causes trauma, which then becomes compressed down through generations of families. Living in a dysfunctional, violent, and neglectful homes create patterns of violent, dependent, anti-authority, self-defeating attitudes often hardened into Personality Disorders. These “bad attitudes” become transmitted unconsciously to generations of children and parents living in MPF. The net result is a fast-growing population of highly dysfunctional individuals/recipients many of whom form the engine for the growth in spending for Medicaid in behavioral health and preventable high cost medical care. These victims in MPF become blamed by society for the social deviance that grows from their oppression and trauma.

Approach to these Families :

² Based on a pre-published study reported on by Dr. Duckworth, Assistant Commissioner of the Massachusetts Department of Mental Health, at an Massachusetts Behavioral Health Partnership Forum in Worcester, Massachusetts, 2002.

This therapeutic approach differs from case management and brief interventions by working to empower families through the internalization of mentalising strategies. Therapy is used to model and teach ways to solve problems, manage stress, and maintain social connectedness. The therapeutic relationship creates a safety net or an auxiliary ego to help organize, contain, and arrange impulses that can lead to social deviance. The therapist also tries to alter the pathological self-other object relationships developed during toxic attachment experiences. Medication helps the therapy keep family members functioning at school and in the community. Twemlow, SW, Fonagy, P, Sacco, FC (In Press) define the healing process as, “...the ongoing experience of otherness in the present, where the power dynamics are balanced, and conducive to a full intellectual experience of self and other.” Such dynamic definitions of self emphasize how the mind is working to experience an object relationship rather than the content or what the mind works on (the thoughts). Such an approach characterizes mentalisation based social systems approaches.

Penetrating high-risk families in their homes requires a special attitude. Simply prescribing the right medicine or offering services at an office will not work with this population³. Resistant, multiple problem families (MPF) need to be met on their own terms and in their own homes and schools. Once the therapist is inside the home, these families can be stabilized and empowered to stay at home or in the community rather than in more expensive institutional or residential settings. This model describes an intensive, long-term service delivered from a private mental health clinic. Masters levels clinicians, backed by a multidisciplinary team including a psychiatrist, psychologist, and

³ Many clinics report as much as an 80% “no show” rate for MPF cases referred from State Child Protective agencies.

senior social worker, deliver weekly therapy to the family. The family can call the clinic for support twenty four hours a day, seven days a week. Clinicians enter families and begin shifting the family dynamics from crisis prone, non-mentalising (symptomatic) behaviors, to more shared reflective strategies for living safer and more productive lives in the community.

This approach is presented as a cost effective treatment approach specifically targeting this high-risk population of families most of whom are well known to the state child protective services. The secure attachment of the family to the clinic is built through long-term mentalisation based psychotherapy which works to increase the family member's self control and decrease the need for higher cost state resources. When the family goes into crisis, they turn to the therapist who has earned their trust weekly. The families receive strategies designed to solve problems through reflection rather than reaction and crisis-driven behavior that often results in police involvement, emergency room visits, residential placements, school expulsion and expanded special education, and incarceration. All of these crisis responses are state resources being drained by these families' lack of attachment to a stabilizing force in the community. The State benefits by having these families secured at home rather than using escalating public resources. The families benefit by learning how to live more productively in the community with less State interference.

It is the long-term trust that evolves over time in psychotherapy with these families that can be used to shift risky behavior away from being acted out in the community and toward the family's containing its member's behavior. The clinician uses the therapy relationship, transference equity, and back-up services to help the children

attend community school, live at home or in the community, and have positive after school social-recreational activities. The therapy actively reaches out to foster positive relationships between the family and the school, court, state agencies, and community resources. Children and adolescents attending and staying at school are the key measures of success. When the child can attend school, living at home is possible.

In the absence of secure attachment experiences, violent, anxious, and disorganized patterns of child personality evolve (Fonagy, P. 2002). These damaged children develop for generations in disconnected, mobile, and dysfunctional families. The abused child develops into a victim or perpetrator. Axis II disorders develop in response to environmental trauma and low social support. Trauma is transmitted intergenerationally in these families through unconscious process similar to those of Holocaust survivors and their families, for example identification with the aggressor. (Kesentberger & Brenner, 1996). The net result is an exponentially growing number of high users of public resources such as Medicaid, Special Education, Corrections, and State Child Welfare services. This paper suggests that this MPF population responds to human contact sustained over time with some use of medication. Psychiatrists work to assist the therapist in maintaining control in community settings as part of their mentalisation therapy plan.

Child and Family Mental Health Spending: An Elusive Measurement

Being securely attached to one's own family is the surest way to avoid shifting responsibility and costs away from individual family members to the larger society as a whole. When families mentalise, they solve problems and stick together despite problems and risk. Mentalising families generate power to deal with their social contexts which are

often oppressive, lack support, and are rich with temptation for self destruction. One problem in most social systems is the lack of the ability to truly track the cost of “not responding” to an MPF. Simply looking at the length of stay in psychotherapy does not take into account the interrelationships of family behavior and resource allocation. If an MPF can stay together, keep their children in community schools, and avoid placement, then, psychotherapy has prevented the escalation of cost in the larger system of state resources. This can become the standard to measure the effectiveness of this approach to therapy within this population of MPF. Simply counting the number of sessions of psychotherapy does not capture the impact of the care. The following case illustrates the cost benefits from long-term, outreach therapy.

The S Family

The following case has existed in the pre and post managed care systems. It illustrates the most typical type of MPF who require multi-generational, long-term psychotherapy. Therapy began when the oldest son Bob and his sister Tara were both in residential and secure treatment facilities. This pattern continued for both with Bob being incarcerated for 12 years. None of the family members involved in the therapy ever required removal from this family.

The S family is a three generation family living in an east coast urban housing complex. The family consisted of a grandmother, an absent Native American, US veteran, alcoholic grandfather, and 4 children. At the time of the clinic’s intervention 18 years ago, the youngest male child Sammy was 10 years old and the oldest male Bob was 18 and well on the way to a criminal career. The younger sister Angela remains at home to this day with grandma raising 2 sons of the absent sister (Tara) who abandoned the boys and remarried. She had a daughter with this man whom she recently separated from due to reported domestic violence. Tara and her child moved into the grandma’s already overtaxed project apartment and then to a shelter where she is now. Bob has recently been released from prison.

This family was referred by the state’s protective services agency for the behavior of the 10 year old boy Sammy. He was aggressive, displayed regular school behavior problems, engaged in fire setting, street fights, and vandalism. He was at very high risk of being placed and remaining in residential care for 2-4 years and being placed (in pre-managed care) in an inpatient facility.

The treatment involved a combination of individual therapy for grandmother, grandson, and remaining sister. Regular contact was established with the school, court, social services and health providers. The therapeutic alliance was built using one therapist, a psychiatrist, and rotating outpatient therapists who alternately provided individual and family therapy over the 18 years. 10 years ago, the 2 boys of the absent sister went to live with grandmother. At this time, both boys (ages 3 and 5) were traumatized by living with a very unstable mother who lived in chaotic and abusive relationships with men. Both boys suffered from psychiatric disorders and immediately needed special education services.

The therapeutic efforts focused on using the therapeutic alliance with grandmother and children to foster independent living without placement of any of the family in psychiatric inpatient or residential placements. All family members received weekly therapy and were prescribed psychotropic medication. The therapy focused primarily on securing the family to the clinic who advocated on a number of system fronts for the family including special education, courts, social services, after school programs, health centers, corrections and probation. The family was often fighting with the schools or in the courts. The grandmother used the services of the clinic to advocate for her children and grandchildren. All family members were at risk for psychiatric placements from early ages.

The therapeutic alliance offered grandmother a chance to reflect and plan (mentalise) rather than to react. The children were in therapy early and developed social skills rehearsed and reinforced in the weekly therapy. Family therapy focused on crisis resolution of intense envy and jealousy. The grandmother was the central figure. She suffered serious bipolar disorder and borderline personality disorder. Both grandchildren suffered from pervasive developmental disorders. The psychiatrist and therapist made field visits every 3 weeks to check on the family's medical responses to psychotropic medications.

Since the introduction of therapy through a home-based outpatient mental health clinic, none of the 5 family members needed a psychiatric placement or removal from grandmother's care for any reason. All the children involved in therapy finished school. None of the children involved in the therapy ever were incarcerated. Sammy completed school in Special Education and left the home to live with a woman and have a child. Sammy works and has never been involved in the criminal justice system, his extreme behaviors diminished over the course of 7 years in treatment.

This case required an average of 3 hours of therapy a week delivered in the public housing projects apartment. Grandmother lived her entire life in these housing projects as did all of her children. Therapy worked to build the alliance with the family members and help them mentalise rather than simply react and force the system to remove children and place them in state programs. All family members required psychotropic medication. The prevention orientation resulted in the family staying together without creating life-long dependents on the states human service resources.

Effectiveness in this case can be measured by what did not occur and what resources were saved by investing in this aggressive style of outreach family therapy. A Massachusetts DSS Quarterly Report for Fiscal 2005 found that more than 50% of children in placement have been there from between 2 to 4 years. A quarter of the children in continuous care have been so for 4 years or longer. If any of the 3 younger children in this family needed placement there is a 50% chance that they would have been in DSS care for up to 4 years. Incarceration costs reach \$30,000 per annum. Bob cost the State hundreds of thousands of dollars in correction, court, and law enforcement resources. Tara's multiple hospitalizations cost tens of thousands. These costs never occurred in any of the family members involved in the intensive therapy effort.

Table One outlines six basic "cost engines" which are clusters of services often used in dealing with the MPF over the life cycle. The six areas represent societal functions that are engaged when the MPF is not securely attached to a helping agency. These cost areas can all begin rising, especially in fragmented service delivery systems. The use of a re-created attachment process (therapeutic alliance in a mental health center) to secure families to a positive community resource, we argue, is a cost-effective investment when planning interventions for the MPF.

(Insert Table One)

The effectiveness of this approach could be measured by randomly assigning high risk families to this approach and compare the costs of psychotherapy and other services used for this group. A formula could be designed to attribute costs for both groups for the services they use during the study period and for several years after treatment. For example, the "therapy" group would be hypothesized to require far less of the services outlined in Table One. An extrapolation formula could be created to test this hypothesis. Once the MPF population is identified as "high risk", the approach needs to intensify to reduce longer term outputs of resources by the State as well as needless stress for the families themselves.

Table Two offers an analysis by the managed care provider⁴ of Community Services Institute, a licensed private mental health center, offered as the pilot study for this paper. The therapy is aggressive with few patients dropping out because of the penetrating impact of the outreach psychotherapy. The inpatient use is among the lowest in the state for a population with almost half of the cases DSS wards; use of the Emergency Services or Crisis Services was also very low compared with other clinics in the state. This is only one year and refers only to one account of spending within Medicaid and does not include the many others services used in this population of Medicaid recipients. The challenge for future research is to create a project to track these costs as a way to measure the “value” or effectiveness of this psychotherapy within this distinct population. This pilot project has been operating in the most difficult urban areas in Massachusetts (Springfield and Boston) for twenty years. The clinic is primarily Medicaid funded and specialized for home based treatment of the MPF.

Managing Care in the Community rather than Hospital

Medicaid is the primary funding mechanism for a state’s most difficult, vulnerable, and potentially dangerous and disruptive recipients. Unlike private insurance pools, Medicaid populations contain (because of federal entitlement requirements) a disproportionate share of unselected recipients that have complicated health and behavioral health problems. Medicaid is the public’s medical shield against the high risk behaviors that often stem from serious mental impairments of children, adolescents, and adults. Medicaid frequently is one element in a patchwork of services purchased by the state for highly dysfunctional, high-user recipients. A state may have contracts to pay for special education, foster care, protective case management, after-school programs, residential treatment

⁴ Massachusetts Behavioral Health Partnership, a Value Options Company.

settings, and vocational programs. These clients also have Medicaid, and their entire treatment plan may contain one or all of the above-mentioned services.

There are usually three agents involved in the placement process: Medical, State, and Community Agents. Most hospital referrals are the result of the interaction of at least two of the above agents interacting with each other concerning a client's need for a hospital placement. Every area of the state will have different landscapes of service providers with different ideologies concerning who should be admitted to a hospital and why. Regional resources and affiliations with academic and teaching facilities attached to hospitals are more likely to be admission prone rather than regions with more developed, grass-root home and community programs.

Medicaid often pays for hospital placements of youth referred by state agents working in state agencies within a larger health and human service agency (state.) Often these youth are in the state's custodial care and are also receiving services from a wide spectrum of state contracts (without federal matching dollars in FFP.) The common element among prospective hospital-referred clients is that they are likely to be living in a MPF headed by a single mother or in foster care.

The MPF feeds the caseloads of the state agencies. This family often has two to four children, no productive and involved male, and is often plagued by violence, over stimulation, drugs, crime, and neglect. Children often act out through behavior disorders that create problems in the school, community or at home. The mothers lack the necessary parental skills because of poor upbringing, resentment at the absent male and social oppression to effectively lead the family through the many crisis and conflicts that occur while their children attend schools and participate in the community. The children do

poorly in school and often develop into bullies, victims or bullies or bystanders (Twemlow, et al, 1996).

We suggest that many hospital placements can happen as a result of a clinician's reactions to the fear of managing risk in natural community settings and failing to keep families together and connected to their community. Further, we posit that medical responses in the Emergency Room and for chronic psychosomatic disorders can also be managed using psychotherapy that fosters mentalising rather than somaticising and medicalizing psychosocial problems. This model views risk as an ever-present factor of treatment. A family's feeling safe becomes a top priority. Attachment to people and agencies who can convey to the clients a feeling of being safe and understood becomes a means to managing stress in the family and finding alternative routes to the over use of medical resources. The following case illustrates how a psychotherapy intervention can reduce medical costs; this case is unusual in that it only required 14 months of weekly individual therapy with the mother rather than the typical longer term interventions.

The B family was referred for an evaluation because the state's child protective service agency feared that Munchausen's by Proxy might be a risk to a 5 year old child who was connected to a mobile feeding tube twenty four hours a day, seven days a week. The child spent most of his early development hospitalized at an estimated cost of 1.5 million dollars and his monthly home health care for feeding was \$10,000. Her child's digestive problems became an obsession. She was afraid he would die if he did not eat. She had engaged in a sustained effort forcing medical providers to pursue extreme medical ends to guarantee her son's safety during the first 5 years of his life.

The referral was accepted but under the conditions that the state agency back off and allow the therapy to contain this family and protect the child. The therapy involved the child, mother, divorced father, and maternal grandparents who lived next door. The first session was very tense with the family gathered around the kitchen table. The mother had researched the

therapist and began questioning his qualifications. She asked to audio tape the session. The family mood was very defensive.

After several months of weekly family therapy at the home, the child began to become less of a focus and the mother began using most of the therapy time to talk about her problems while the child played in his room. The rest of the family dropped in on the therapy at the mother's kitchen table from time to time. The child would come down to check on what was going on and to attempt to distract the mother into doing something with him. The therapist always visited the child in his room for 5-10 minutes each week and never mentioned the tube in his belly, the food knapsack he had to carry for the tube, or what he ate or did not eat.

Eventually, the mother began to trust the therapist and she slowly started to take some risks with the child's food intake. The therapy shifted to focus exclusively on the mother (a type of separation-individuation) and only tangentially related to the child. This shift deepened the transference which was used to encourage the mother to take some risks with lightening up about her son's digestion.

Mother always complained of being overburdened and underappreciated. The therapist assumed a supportive and reflective stance in the therapy and modeled mentalizing. Eventually, she reported with great expression of shame that she had been gang raped at a high school outing and blamed herself for 10 years. She had never told anyone. She had experienced an orgasm during the rape and assumed that she was to blame since she obviously had enjoyed it. The therapist emphatically reinforced her position as purely that of a victim and that the orgasm was incidental to the criminal sadism of her peers.

Remarkably quickly the child began to respond to the mother by eating junk food that she left out without demands. As the mother relaxed, the child began to eat more regularly. The mother was referred to a local job training center for nursing education. She graduated and eventually worked for the hospital that had reported her for child abuse. Her fascination with the medical was re-directed, the child's tube was removed, and no further services were required after 14 months of weekly therapy.

Long term coaching in the form of consistent contact with the case provides the forum for development of healthy mentalizing habits. Many of these severely impaired patients and families have developmental impairments that have evolved over several generations and are likely to be permanent. Such cases are not necessarily in need of

intensive costly psychiatric care. This approach to therapy also works well for “therapeutic lifers” or chronic users of medical services. These clients can be managed with periodic phone calls and brief interventions by consistent caregivers such as therapists and case managers whom they trust. Continued intensive work is not necessary to help them feel safe. The families can be slowly released into the rough waters of their oppressive social contexts. The families remain on “maintenance” programs in therapy requiring fewer services to maintain their stabilizing function for the family. In one case a chronically psychotic woman had formed a close relationship with a psychiatrist over a 25 year period. she maintained an excellent adjustment in a nursing home as long as she said hullo to the psychiatrist once a month, a contact that did not need to be billed to Medicaid. She would catch a bus to his office and sit in the waiting room for the contact, and leave quite happily afterwards..

Analyzing how children are placed in psychiatric hospitals can shed some light onto the underlying process and dynamics of a spending pattern and how psychotherapy can contain needless use of high cost state resources. The therapy creates an attachment to a relationship in therapy that increases the family’s sense of being safe and secure in the face of an abrasive and oppressive social context. Placement in hospitals is often a means to secure a safe environment during crisis. The following represents a list of 5 possible reasons for hospital placement and the fundamental vocabulary for the language of placement gleaned over twenty years of outreach therapy experience with MPF:

(1) Escalating Risk and No Structure: Many psychiatric hospital placements result from the accurate assessment of mounting risk to a child or adolescent from the toxicity of living in a disorganized, low-structure, multiple-problem family. The child's maladaptive behavior increases in intensity, frequency, and risk mounts exponentially. Parents are generally passive observers and powerless actors in the escalating crisis evolution. Hospital admission creates a much needed pause in the high risk

behaviors in low structured community settings and offers immediate safety.

Community Alternative: Relies on the use of a therapeutic relationship in partnership with community and state agencies that offers 24 hour/ 7 day a week access to support for families when they are experiencing the early stages of crisis. Therapy and short respites are used to manage risk and create a sense of safety within the family.

(2) Liability for Non Placement: Mental health clinicians may be encouraged to refer to psychiatric hospitals as a way of managing their employer's exposure to malpractice or negligence litigation. Supervisors and administrators follow suit and endorse policies that call for the use of hospitals when there is a question of suicide or violent behavior. Hospital admissions buy time and provide paper protection against future litigation.

Community Alternative: Safety contracting and Emergency Services Screening with respite back up are used to manage risk. Clinical documentation of due diligence in risk management is used to minimize litigation risks. Cooperative relationships with public managed care companies⁵ allow community clinics to extend services over time into these MPF.

(3) Suicide, Violence, and Firesetting: Most anyone becomes afraid at the thought that a child may die by his or her own hand or at the end of a knife held by a patient. Hospitals rely on the use of a very highly structured milieu featuring full programming, 24-hour monitoring, and medical oversight. This is very effective in maintaining safety and security for high risk clients. Hospitals are becoming the safety zones when there is suspected danger to self or others. This is especially true if "core services" are not available or accessible in community-based program alternatives

Community Alternative: Safe zones can be created by emergency interventions in client's homes, brief respites, specialized foster care, short-term residential assessment centers. Suicide is always taken seriously and therapists connected by a mental health center's emergency 24 hour, 7 day a week phone back up can work with clients early in the escalation of a destructive pattern of behavior. The main tool is the therapeutic

⁵ Value Options through Massachusetts Behavioral Health Partnership is the managed care provider currently working with Massachusetts Medicaid to serve MPF.

alliance that stabilizes these crises in the home and community to the extent safely possible.

(4) Eroding Families Involved with Crime and Violence: Many hospital placements result directly from the State's intervention into families with traumatized children of active or passive criminals. The children's behavior becomes explosive and aggressive. The parents are collusive with their children's anti-authority positions within school and the community at large. Hospitals become the short-term holding environment for youth being moved away from criminal homes.

Community Alternative: Long-term individual and family therapy in MPF homes to strengthen mothers and help empower families to stay away from victimization and exploitation. Work closely with community corrections, substance abuse providers, state agencies, and human service agencies to create service plans to reunify families.

(5) Unsupported Foster Care: Many state youth placed in foster care (\$15-20/day) are very disturbed. Foster parents routinely work very hard at low cost to cope with these children before and after they are placed in hospitals. Often, the foster home and state agency don't have access to flexible community support, recreation, and crisis intervention. The overworked and under-compensated foster care system strains to care for these children. Traditional office therapy is impractical for use in supporting the many needs of foster families. Little flexible money is available to offer community programming to foster children during placement. Eventually the intensity of a child's behavior results in the termination of the foster home placement. The child may then start bouncing from foster home to foster home. Hospital placement is a common way to stabilize a foster child who becomes unmanageable, but the attachment network necessary to keep the process going is not in place.

Community Alternative: Long-term in home therapeutic support and community psychiatric services to children in foster care combined with after school programming are used to help children stabilize in foster care without needing inpatient stays to manage crisis.

The purpose of outpatient therapy in this model is to, wherever possible, repair the damage to basic attachments in children living in MFP. The price of non-mentalising is that

children fail to learn how to: (1) regulate their emotions and establish boundaries (2) read emotional states of themselves and others (3) mediate conflict and feel in charge of their own recovery (self agency). Home-based, outpatient therapy targets these key functions in members of MPF and aggressively reaches out to them with a secure therapeutic alliance that can help the families learn how to mentalise and solve problems despite the damage sustained from trauma.

Table 3 summarizes and compares the traditional approach to problems regularly seen in the MPF with those derived from this model based on attachment theory, practice and research

Concluding Comments

This paper argues for the economic and clinical value of using the human relationship developed over time as the primary therapeutic tool. A MPF's capacity to mentalise is fostered through directive and reflective therapy techniques in this model and can serve as a cost-effective way of keeping these families together. Identifying the high utilizing family is easy; they are mostly on the caseloads of child protection and juvenile justice caseloads of state agencies funded through tax revenue. This allows for the creation of segmented high user pools of recipients. This segmentation allows for the development of specialized community interventions that rely on human relationships that are able to contain the crises occurring in the MPF before the escalation of the exponential cost formula. No one in the community benefits when this population goes unserved; they show up quickly in high cost care delivery systems such as emergency rooms, inpatient psychiatric hospitals, and corrections. Untreated, this population also poses a direct risk to the citizenry. The effectiveness of this approach is calculated by

comparing the utilization of a wide spectrum of services ranging from short inpatient treatment, longer-term residential care and community alternatives. Outreach therapy with the MPF exists as one of a variety of community options that also include specialized foster care, intensive outpatient programs, day treatment, and emergency services.

Table One
6 Cost Engines for Non- Attached, Non-Mentalising MPF

Health Care

- ER Services
- Ambulance
- Pharmacy
- Specialists
- NICU
- Hospital Detoxification

Education/Vocational

- Special Education
- Court
- State Case Management
- Police
- Health & Human Service

Correction & Court

- Housing
- Juvenile
- Criminal
- Court Security/Lock Up
- Attorney's Fees

Attachment Substitutes

- State Foster Care
- Specialized Foster Care
- 90 day Residential
- 6 month Residential
- Long Term Residential (yrs)
- Inpatient Psychiatric Hospital

Infection & Crime

- Acquisitive Crime
- HIV Pharmacy
- AIDS Health Costs
- Incarceration
- Court

Basic Entitlements

- ❖ Cash (state welfare, SSI)
- ❖ Food Stamps
- ❖ Housing
- ❖ Medical Coverage

Table Two

Outpatient Provider Analysis: Community Services Institute (CSI)
 July, 2003 to December 31, 2003
 (300 patients)

Measured Area	CSI	Comparison with other state wide clinic averages		
		25 th Percentile	50 th Percentile	75 th Percentile
Members NOT receiving treatment within 30 days of diagnosis	2.6(S)	14.4	21.6	37.8
	10.8 (B)			
Inpatient Admissions	1.4 (S)	2.7	4.4	6.3
	3.7 (B)			
Accessed Emergency Services	6.9 (S)	6.4	9.6	11.5
	7.4 (B)			

S-Springfield
 B-Boston

Table Three

Comparison of Traditional and Attachment Approaches to Social Deviance

Social Problem	Traditional	Attachment
Domestic Violence	Rescue and Place Child; Punish and Separate Parents	Court Containment (Probation & Diversionary Service and Intensive Family Therapy
Violent Adolescents and Delinquency	Institutional Restriction, Residential Placement	Family Therapy & Psychopharmacology, Crisis Respite, Social- Recreational Activity and Community Monitoring
Addict Parents	Child Rescue, Foster Care and Residential Placement of Children. Incarceration for Parents	Methadone, Community Detoxification, Drug Courts, Supervised Urine Screening and Probation with Family Therapy stressing Family Preservation
At Risk Elders	Nursing Homes	Community Senior Protective Case Management, in home psychotherapy bridging generations

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