International Journal of Applied Psychoanalytic Studies
Int. J. Appl. Psychoanal. Studies 11(2): 172–183 (2014)
Published online in Wiley Online Library
(wileyonlinelibrary.com) **DOI:** 10.1002/aps.1407

Behavioral Health Homes: A Model for Implementation of the Affordable Care Act

FRANK C. SACCO AND STUART W. TWEMLOW

ABSTRACT

This paper outlines a model of designing a service delivery system for a targeted population of high-risk Medicaid families. The Affordable Care Act (ACA) has created a new focus on a population that has high behavioral health and medical needs. Medicaid families are segmented into categories based on the criteria outlined in the ACA and a service delivery system is suggested. The model calls for the creation of specialty services in the community that reach out to high-risk families and provide ongoing integrated care that strives for improved health outcomes. The psychoanalytic principles used in attachment theory and power dynamics are offered as a method of creating new responses to complicated health and behavioral health problems in Medicaid families.

Key words: behavioral health homes, medicaid, family, high-risk, affordable care act, psychoanalysis

The Affordable Care Act (ACA) calls for the creation of a new delivery system for segments of the population with chronic health and behavioral conditions. The goal is to improve well-being through prevention and a reduction of the mindless and unnecessary use of specialty care, emergency services, and high-end diagnostic investigations. The ACA is promoting a collaborative challenge to providers to create family-centered models of care that manage chronic conditions early and build prevention and healthy lifestyles. This is an initiative to boost the power of primary care into prevention rather than the current reactive, specialty emergency care approach to providing a safety net. This extra protection stems from the existence of a behavioral health disorder whether a chronic child or adult mental disorder or a substance use disorder throughout the lifecycle. These conditions often are over represented in the poorest but they occur in most families throughout the life cycle.

This paper argues for building a system of care using an open and reflective process known as mentalization (Fonagy, 2008). Applied in this social planning

DOI: 10.1002/aps

context, mentalization is used as a model for a role for applied psychoanalysis in helping states to follow the changes outlined in the ACA. The development of a care delivery system in behavioral health can be developed using the principles used by applied psychoanalysts. Volkan (1997, 2006) applies psychoanalytic principles to ethnic rivalries. In this case the two rivals are the provider and the payer of Medicaid health services. Complicated problems with centuries of history can be conceptualized using Volkan's model of large group identity formation. We suggest such an approach be used in developing medical service delivery systems. The approach would combine Volkan's approach (1999) with that of mentalization and Power Dynamics in a social context, (Twemlow, Fonagy, and Sacco, 2005a, 2005b).

The approaches to service delivery proposed in the ACA call for a shift in paradigm within every state. This will impact how service delivery is implemented in all states within the United States. Policy planners and practitioners need to stay in open contact to promote the maintenance of a safety net for high-risk and vulnerable populations. This psychoanalytic idea of mentalization fosters open dialogue and promotes honest experimentation with outcomes delivered in the form of long-term cost containment and improved daily living, health, and lifestyle behaviors.

MASSACHUSETTS: A STATE IN ACA TRANSITION

This paper focuses on Massachusetts's current attempt to implement the ACA. Massachusetts is a state that has mandated coverage with 90% of its citizens covered prior to any ACA implementation. This state has been a pioneer in many movements such as the closing of state-run large institutions for the seriously mentally ill. This state has been moving toward community alternatives for behavioral health conditions since the early 1970s. The public sector Medicaid has been managed by private Managed Care Entities (MCEs) and Managed Care Organizations (MCOs) for 15 years with great success (Dickey *et al.*, 1998; Dickey, Normand, Norton, Rupp, and Azeni, 2001; Frank and McGuire, 1997; Stroup, 1997). Massachusetts has evolved an experienced network of community providers because of an early commitment to community versus institutional care.

Massachusetts is facing another evolution in a state-wide service model as it prepares to implement ACA. The entire system of primary care will be shaken up and new models created to accomplish the goals of the ACA in the next three years. This is a delicate ordeal with thousands of vulnerable citizens involved. This challenge will face every state in the next four years as elements of the ACA are applied across the United States. The constant in all states is the hazards of disrupting what works with the most seriously ill, especially chronic conditions common in behavioral health conditions. The use of a Behavioral Health Home (BHH) we suggest is a way to preserve the safety net for those now being served as well as the anticipated influx guaranteed by environmentally-induced conditions such as child abuse, neglect, and domestic violence.

The goal of ACA is to segment high-risk populations with chronic medical conditions. This is a type of health maintenance organization (HMO) approach

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but not with the healthiest of populations within a private market, but for the hard-to-reach populations suffering from many behavioral health and physical conditions. The HMOs began some 15 years ago by cherry picking private populations through insurances offered by employers. Medicaid became the payer of last resort. BHH are the exact opposite of this process. Decades after the first HMOs and after a decade of managed care within Medicaid, the need for the integration of physical and behavioral health has become the focus of care coordination. The disease management principle is being used in the ACA to identify diseases known to be co-morbid and chronic. The ACA calls for a quadrant segmentation of services: (1) High Behavioral Health/High Physical Health; (2) High Behavioral Health/Low Physical Health; (3) High Physical Health/Low Behavioral Health; (4) Low Behavioral Health/Low Physical Health. The early HMOs competed for category (4) Low/Low and now BHHs as outlined in the ACA target categories (1) and (2). This is where the dialogue must be client and family focused and maximizes benefits that help families become healthier and costs are contained and used to prevent rather than react to disease.

THE PROCESS OF POPULATION SEGMENTATION AND CARE COORDINATION

Dividing a population is rife with the possibility of prejudice based on any number of factors ranging from ethnic, gender, income, racial, disease or other related broad misconceptions. There is a definite existing set of lines in the type of medical services that are available and open to everyone through the Medicaid program. This is an income differential that is broadening under the ACA. One clear distinction needs to be drawn involving the critical difference between poverty and dysfunction. When any person of any age suffers a behavioral disorder *and* is poor there is an increased risk of trouble. Children and elders have most likely existed in a toxic environment for most of his or her life beginning from birth, experienced homelessness, financial and living instability, and exposure to violence and crime, ravages of chronic/untreated addiction of some family member, system involvement through the Courts or Special Education (SPED), educational failure or disruption.

Most of the "poor" are *not* dysfunctional. Poverty does not cause dysfunction or automatically indicate serious emotional disturbance (Pelton, 1989), but it often inflames a behavioral disorder that can easily spill over into the community and begin the cycle of engaging in needless medically costly behaviors. When untreated, the mind of the behaviorally disorder individual is not thinking clearly, using good judgment, taking reflective thought before action, and is often surrounded by high-stress aggression and or exploitation. This is where the BHH can use the help of an outside expert in social process and understanding the meaning of human behavior. Underlying cause and motivations need to be examined and policies developed that reflect medical understanding and human behavior; this is the specialty of psychoanalysis and a way to apply psychoanalytic ideas in health care.

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Segmenting a population involves policies that impact vulnerable groups that receive weekly services from a network of providers that currently supports the daily life for vulnerable populations in the community. This includes genetic disorders, neurodevelopmental disorders, and environmental-stress disorders. This "vulnerable status" needs to guide segmentation efforts and is definitely going to have many implementation lessons that vary from area to area and population to population. Establishing a current base line of existing service networks is essential before any creative shifting in service delivery models is attempted while implementing the ACA.

The care coordination process is a social process involving care givers, consumers, care managers, care coordinators, and accountability/quality monitors. This is a social system that impacts the delivery of care. The quality of the output in this system of care can be a subject of analysis and should strive to be an open, reflective, and flexible system. The psychoanalytic perspective suggests that this process be referred to as mentalization (Fonagy, Gyorgy, Jurist, and Target, 2002), a form of special reflectiveness or mind-mindedness used in large group processes. When a system mentalizes, it welcomes open communications, clear boundaries, and quality focus. This is the heartbeat of the creation of a BHH. The physical health equivalent is the Practice Based Research programs in primary care (Fagnon, Handley, Rollins, and Mold, 2010; Green and Hickner, 2006). Best practices were shared in real time among primary care providers. This type of approach requires that the service delivery structure be an open social system that is client-centered and quality driven.

Who is Best served in the BHH Segment

The first distinction in this segmentation process can be seen in the current using capitated payments footprints of service delivery in behavioral health. This segment of the population has regular contact with a behavioral health provider. They are in psychotherapy, require frequent assessment and advocacy, and many have involvement in receiving voluntary and involuntary service from the State through child welfare, juvenile justice, corrections, state agencies such as the Department of Public Health, Department of Mental Health, Department of Developmental Disabilities, Special Education and the Courts. This population has been referred to in a number of ways, all of which have their share of stereotypes, but do indicate a series of predictable patterns. Sacco, Twemlow, and Fonagy (2007) referred to this population as Multiple Problem, Clark, Zalis, and Sacco (1982) refer to this family structure as Low Income Culturally Deprived (LICD); Madsen (1999) refers to this pattern as "multi-stressed."

This segment of the population has behavioral health conditions that impact how their family approaches health and accessing health care. The family dynamics are impacted by a behavioral health condition that interferes with normal parental executive functions. Many of the key parenting functions that become impaired involve well-being activities such as well child visits, regular primary care for chronic conditions, maintaining a relationship with a primary

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care agency or practitioner, daily diet and exercise, access to socialization, and protection from abuse and neglect. Children in these families begin to experience problems in school and spiral from there into a health and human service system designed to react rather than prevent. This most glaring example of this phenomenon is the use of Emergency Departments for childhood illnesses handled easily at the primary care level of care.

> Daniel was a child who spent his first year of life as an inpatient because of a dangerous loss of weight and feeding disturbances. As an infant, the feeding problems led to weight loss and resulted in over one million in health care expenditures. When Daniel was five, he was living with a surgically-implant feeding tube. He was referred for psychotherapy as part of a Factitious Disorder by Proxy concern raised by the child welfare agency. Six months of home-based therapy focused on the mother's anxiety about her child. She displayed very high ability in medical knowledge and seemed to revel in the application of medical procedures with Daniel. The next six months focused on Daniel's mother's trauma as a high school cheerleader who was gang raped. She was divorced and pre-occupied with guilt because she experienced an orgasm during the rape. The psychotherapy helped her shed the guilt and become angry at her attackers. Eventually, she began to offer Daniel whatever he would eat (hot wings, Doritos, etc.) and he began to eat other foods. After 14 months of therapy, Daniel was off the tube, eating, and his mother entered nursing school. Daniel's care costs upwards of ten thousand per month in specialized feeding. The psychotherapy was weekly for 50 sessions. Ironically, the insurance covered the entire medical costs but refused to reimburse the last 15 sessions of psychotherapy!

Regular use of primary care requires a responsible parent who is mobile and motivated to keep appointments. Also, the parent needs child care or be able to juggle a sick child with other children in a waiting room. Many of these tasks require case management from a state agency. The child welfare cases in this segment are supervised to maintain a safe home and get the child to school. There is no state that can claim that no child will fall into a crack and not receive the basics to keep the child safe. This segment also contains children living in substitute care or in kinship foster care. These are children who are removed for safety reasons and by definition have been exposed to a young lifetime of trauma resulting from lack of caretaking.

This segment also contains the serious and chronically mentally ill and intellectually disabled living in the community. Some may live in residential homes while others live at home or independently with support. This is a specialty segment within this population best served in BHH. Again, within this population there is a spectrum of natural community supports. Some may have strong kinship networks that handle the disability while others rely solely on the state to maintain daily living. There is strong evidence that this segment of the population can become much sicker than the general population.

This segment also consists of the substance use disorders that again may exist at any level of socio-economic status (SES) and the disease will do the same damage regardless of any body's economic status. Treatment of this condition requires a sophisticated network of services ranging from prevention to drug detoxification, outpatient, and residential treatment. Private coverage is often lost when the disorder takes charge and the net result is that everyone with a

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serious substance use condition may require public assistance. This population is not best served in a primary care setting unprepared for the intensity of the drug seeking and feigned illness that is part of this behavioral health condition.

Building an ACA model in Massachusetts has the benefit of a head start in the community delivery of services to adult and child behavioral health populations. Massachusetts represents well-seasoned collaborations of State Agency (Medicaid), MCO/MCE, and provider networks. Western Massachusetts was propelled into action in the 1970s by the consent decree that forced the Northampton State hospital to close and release into the community those with serious and persistent mental health disorders. Recently, Massachusetts has benefited from the Children's Behavioral Health Initiative program as a remedy in another consent decree process (Rosie, D. v Romney). The dual demonstration projects are starting in Massachusetts. The State is open to provider input, and ongoing discussions have flourished. Independent Care Organizations (ICOs) have been chosen. This is an excellent time to use a psychoanalytic consultant to assist in conceptualizing implementation policy.

Population Segmentation: A Tricky Process

The ACA needs to embrace segmentation as a way of creating medical homes with the sophistication necessary to achieve the goals of the ACA without disrupting a very vulnerable set of networks that provide a vital safety net for safe living of a high-risk segment of the population within the community. The anchors of the current service delivery system are the Emergency Service Providers for adults and children; this is where the rubber meets the road in service delivery. These agencies are usually quite large and comprehensive and have experience delivering these emergency services. They often are the remnants of the original brick and mortar of the Community Mental Act. Every region has one that is active with some that are also Child Service Agency's which already work to coordinate Children's Behavioral Health Initiative services. Many of the Multiple Problem Families are already connected to the system by agents who mostly work for the State in mandated activities such as education, public safety, and public health.

At the risk of stereotyping and being biased, it has been our experience in working with Multiple Problem Families for over 30 years that they are not the typical patient sitting in a private insurance waiting room. Their behavioral health needs often interfere with participating in available community resources. Primary care practices, even those successfully dealing with behavioral health providers in the community, are not equipped for the daily needs of this very vulnerable population. The health habits in the high behavioral health quadrants are negatively impacted by the mental impairment and may need a case manager to effectively interface with a primary health facility. They miss appointments, seek drugs for illegal purposes, and can be aggressive and demanding. There are two quadrants that have poverty but low behavioral health and medical needs. These are the functioning and healthy people living under poverty and receiving Medicaid. This population

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is likely to only need minimal behavioral health at different times in life, not for two to four years continually which is the rule and not the exception in the Multiple Problem Family. The families in these two quadrants can be treated in a primary care setting and referred out for behavioral health occasionally.

Regional BHHs could build on the existing system offering rewards for agencies that create successful projects in coping with the never-ending challenges for families with chronic behavioral health and medical conditions. This is the modern battle of mind and body that can be set free of distracting rules. The best approaches need to be defined from a family satisfaction and medical expenditure savings perspective. No one model will fit all regions in any state. This requires the use of an approach that is based on open and reflective dialogue and evaluation criteria that always include cost containment and wellness. The early work in practice based research in primary care offers a good model. The missing component is the attention paid to managing the process of delivering care, setting policy, and creating pools of targeted consumers. This is a human process with many levels of power dynamics, special interests, and cronyism. Dodge (2011) highlights the importance of considering contexts when developing child and family policies. Cultural and regional variations change context and policy should follow. This requires a commitment to a process that promotes open dialogue and shared goals of quality and cost containment. To keep the process flexible, it is necessary to develop a way to insure that the service systems are flexible and that there is an open dialogue between bureaucracy and provider rather than the "us and them" that currently defines the interface between care management and provider. We call this process mentalization in a social group (Twemlow *et al*., 2005a, 2005b). This is a guided group process that offers outside guidance in open dialogue, managing power dynamics, and creating clear boundaries and expectations that all benefit the wellness of the clients. The reduction in medical and other state costs will result from the following factors:

1. The use of well-experienced networks of professionals unshackled from the paperwork and over medicalized documentation.
2. Use of psychotherapy, least costly and restrictive option, to empower family leadership in the health and social-emotional welfare of all family members. Regular efforts to promote healthy lifestyles and management of conditions such as diabetes, asthma, obesity, hypertension, cardiac disease, serious emotional disability (SED), and chronic mental illnesses and developmental disabilities. Home-based support is essential.
3. Creating alternatives to drug seeking behaviors using physical therapy, pharmacotherapy, alternative therapies, neurofeedback.
4. Detoxification and transitional support for all client's after detoxification which should be "on demand" with the same urgency as arrest and detainment is "as needed."
5. Methadone treatment on demand; harm reduction strategies for chronic substance abusers. Methadone programs pioneers the integration of

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physical health and behavioral health by monitoring Hepatitis C, HIV, AIDS, tuberculosis in opiate addicts being dosed at the clinic.
6. Institutional diversion and primary care workforce development. There is no substitute for the current experienced practitioner. No license is a substitute for sustained, supervised experience. Workforce enhancement needs to be stimulated and cultivated, not burdened with credentialing inflexibility.
7. Use of wellness prevention including after-school activities, alternative stress management (yoga, tai-chi, massage, exercise, etc.)
8. Quick mobile Emergency Services Programs for all ages to screen inpatient, short-term respite, and secure diagnostic centers in the community.
9. Early intervention into known troubled child populations such as chronically ill (all incomes), early aggressive and attention deficit hyperactivity disorder (ADHD), childhood diabetes and other life-long conditions combined with SED or behavioral disorder in a caretaker.
10. Diagnostic and treatment services for families referred from the state child welfare or juvenile justice system, state mental health programs, elder care, and addiction services.

MEDICAL WASTE FROM UNMANAGED BEHAVIORAL HEALTH

The behavioral conditions that weave through this population segment often leave people of all ages feeling psychological pain as medical pain. Some only experience relief with the ingestion of a substance usually an opiate or benzodiazepine; they will sit in a crowded and noisy emergency room for eight hours for 12 pills. This is a substance use condition and mental health impairment often combined with other chronic medical complications best treated in regular primary care. The behavioral health interventions can be of two major types. The first and the gold standard is recovery. No question exists in this goal. The second is a population of clients that will abuse certain drugs no matter what. Harm reduction techniques such as methadone treatment provide access to the desired compound in exchange for treatment as opposed to the extremely dangerous and very unhealthy drug seeking behavior pattern known to spread infection, violence, and life destruction throughout a life span.

The medical use of emergency room departments for primary care forces high use of diagnostic precautionary measures due to the fact that the child or adult presents at a hospital emergency room. The emergency room doctors are flooded with physical emergencies such as gun shots, vehicle accidents, and heart attacks; they often resent the presentation of drug seeking, routine primary care patients. The emergency protocols call for extensive testing to rule out serious conditions. A young child presenting with a cough might require multiple other tests to rule out more serious conditions found in emergency rooms. Regular primary care is the key to avoiding this waste of medical emergency room time and expense. For many families, the regular use of primary care requires some flexible community supports such as case management; the family is driven to appointments

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and helped to schedule medical and educational appointments. In a BHH a family's behavior in seeking the needed wellness and preventative health and behavioral health care is addressed in psychotherapy with all family members or at least the caretaker and the therapist.

The danger is to tear down good structures to build a look-alike. In Massachusetts, combining the Child Service Agency and Care Coordination in place regionally could be done easily by tuning up existing structures now being used in the state. This can create a collaborative imperative for smaller providers to define and enter contracts with their colleagues that maintains a healthy competition for quality of care. State agents are the current major referral sources for many BHH clients, and we would argue, will make the best indicators of which providers are quality and deserving of a referral. Providers are now improving and sharing their skills under managed care, especially in Children's Behavioral Health Initiative.

IMPLEMENTATION PILOT: TESTING WITHOUT CAUSING HARM

The goal of the ACA is to create family-centered streams of service that can be used to achieve certain population and disease group goal. The spirit of the ACA requires developing an approach that will offer change, increased access to primary care, and a push to wellness to test the best ways to build a BHH. This process could be streamlined with the help of an outside psychoanalytic consultant who works from a neutral vantage point and helps identify blocks in communications, power struggles, and boundary blurring. New models can be developed regionally and open dialogue created to promote the replication of successful models of care throughout the state and eventually nationally. Every new model for a BHH is driven by the ACA principles of wellness, cost containment, and family engagement.

ENTRY POINTS OF A BEHAVIORAL HEALTH HOME (BHH)

The presumption in this approach is that the BHH is the primary platform for coordination of both behavioral health and primary medical services. Primary care will be coordinated by nurses initially. Since current Federal Financial Participation (FFP) for coordination under ACA is 90% for two years, all teams will be immediately challenged to reduce their cost by 40% by year two of any project. This would bring nurse coordinated care to 50% of FFP, the current level of FFP to states under Medicaid. It is more efficient and less disruptive to add medical support (primary care nursing and advanced nursing) to behavioral health care than to transfer populations whose behavioral health needs already stress primary care centers. The BHH would serve those clients whose problems or the problems of their family would interfere with the expected compliance most ordinary primary care settings and protocols require. Local nursing schools could collaborate

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with area behavioral and physical health providers and develop training programs to build a workforce in an area already depleted of qualified workers.

Typical managed care targets utilization and creates gates and enforces compliance through medical record reviews. Networks are carefully managed and limited. Providers are managed by care managers and gatekeepers. Service is chopped into units and given numbers and regulations; providers and care managers interact about authorizations. This system functions well and should only be replaced after alternatives are studied through pilots over time. ACA calls for new approaches with broader strokes for definitive populations. The BHH is an excellent area to begin studying these populations and how service manipulation impacts medical expenditures within a family-centered approach to both behavioral and primary health care. The proof should be in the actual outcome of increased functioning and savings from primary care management of chronic conditions.

The focus of the future in ACA is to establish alternatives to current practices. Segmentation begins and ends with actual numbers as well as predicting segmentation by system history or current involvement. Limiting panels forces all the service into large mega agencies and interferes with the current diversity of small and larger agencies that have built alliances and areas of specialty over the past three decades.

THEORY OF SERVICE COORDINATION

The creation of new systems of care can place many vulnerable populations at risk if the process is not reflective and does not openly discuss and collaborate in slow, measured steps. Bevington and Fuggle (2012) describe a mentalization system for working with high risk youth. This project outlines how care coordination can be addressed using the delivery system as a target of study and monitoring. They focus on key principles in managing a system of care including:

1. Individual key worker relationships
2. Well-connected team
3. Intervening in multiple domains
4. Taking responsibility for integration
5. Scaffolding existing relationships
6. Clinical governance
7. Respect for local expertise
8. Respect for evidence. (Bevington and Fuggle, 2012, p. 169)

These principles are a useful guideline to building BHH. They emphasize the need to build on existing, local expert experience in creating integrated health and behavioral health strategies through the Care Coordination process. Designing creative responses in a Behavioral Health Home also requires an openness to the "unseen" or unconscious power dynamics that generate needless waste of medical resource and contribute to violence (Twemlow, 2000).

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In Massachusetts Medicaid's report (MassHealth, 2014) the guiding principles share many of the points outlined earlier. The key principles in service delivery include: "simplicity and continuity of coverage, efficient administrative functions, building off lessons learned, and continued coverage, access, and cost containment" (p. 8). These goals suggest that BHH become the main way to address primary health care needs by first stabilizing this high-risk population and then structuring high intensity wellness and primary care for the co-morbid conditions that characterize this segment of the population.

One example of a pilot project for western Massachusetts is offered:

1. The creation of a Coordination Team to make flexible community treatment strategies for the Child and Adult BHH. The team would be structured around Emergency Service Provider and include a collaboration of Child Service Agency and Intensive Care Coordination (Children's Behavioral Health Initiative) activity, new Care Management affiliation with MCOs using nurses to help with health coordination, Information Technology and Electronic Health Records, HIPPA compliance and clinic Multidisciplinary Team Record Reviews/Utilization Management processes.
2. Establishment of waste reduction measurements from as many state spending points beginning with medical. This could be an MCO/ICO function.
3. Review and approve pilot approaches to managing chronic populations from at least the child welfare, juvenile justice, Special Education, 17–21 correctional inmates, homeless and Intellectual Disabilities. Contract with a wide spectrum of providers offering services approved by the team and the MCO/ICO.
4. Specialized assessments for high-risk child and adult populations: competencies, risk, diagnosis, and placement planning diagnostics. These are the needed tools of the state agents that manage the ever-growing state population of children, aging, and the chronic adult behavioral health populations.
5. Expanded control of pharmacy for behavioral health disorders including immunizations and vaccinations. Avoid poly-pharmacy and brand-name overuse and Prior Approval drain on the MCO/ICO.

There can be a gradual introduction of well-studied alternative risk and reward scenarios in high risk populations. This is where the majority of savings can be predicted to lie. We suggest that this process of designing policy be the subject of ongoing consultation and reflection to maximize outcomes for family health and cost containment.

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Frank C. Sacco
Community Services Institute, Boston and Springfield, 1695 Main Street, Springfield, 01103, MA, 01001, USA
fcsacco11@gmail.com

Stuart W. Twemlow, MD
Visiting Professor, University College London (Health Sciences), Retired Professor, Psychiatry, Baylor College of Medicine, 8585 Woodway Drive, Apt. 813, Houston, Texas, 77603, USA
stuart.twemlow@gmail.com

Int. J. Appl. Psychoanal. Studies 11: 172–183 (2014)

DOI: 10.1002/aps