Integrating Primary Health Care and Mental Health Services: a Preliminary Report

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INTEGRATING SERVICES and coordinating existing resources have become major goals in the development of current health and social welfare policy. In the 1970s and thus far in the 1980s recession and inflation have combined with prevailing attitudes of social and fiscal conservatism to produce a social policy characterized by austerity and consolidation. Few large social programs and new service initiatives have been funded. Instead, relatively modest programs have been created to coordinate the activities of existing service units. Designed to reduce fragmentation in the health and social welfare systems, these programs make limited demands on scarce resources. As a result, service integration and coordination of existing resources have become important strategies for a new social policy for the 1980s.

In this paper we (*a*) outline a theoretical perspective on interorganizational relationships for service integration, based on a framework presented in an earlier paper (*1*), (*b*) describe a new service grant program designed to stimulate coordination between primary health care projects (PHCPs) and community mental health centers (CMHCs), and (*c*) pinpoint the problems and prospects of PHCP-CMHC linkage grants in the context of this theoretical perspective on interorganizational relationships.

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Interorganizational Relationships

Social scientists and policy analysts interested in interorganizational relationships have studied the service integration strategy to gain an understanding of the basic ingredients essential for organizational coordination and cooperation. Some see great promise in services integration (*2–4*), while others warn of the limitations of such a strategy (*5,6*).

Organizations cooperate as a self-interested alternative to competition for limited resources (*6*). This assertion, which derives from social theory (*7,8*), has been corroborated by social research (*9*). In their studies of social welfare organizations, Aiken and Hage concluded: "It is scarcity of resources that forces organizations to enter into more cooperative activities with other organizations, thus creating more integration . . ." (*9*). Resource limitations initiate interorganizational relationships, but other conditions are necessary to sustain them.

According to a number of reports on the sociology of interorganizational relationships (*9–16*), several key elements are essential if a services integration strategy is

to succeed. Interdependence and mutual benefit are fundamental characteristics of organizational cooperation (*6,7,9,11*). Further organizational cooperation requires complementary, if not similar, goals (*8,9*) and technology (*17,18*). In addition, interorganizational cooperation is facilitated by common modes of communication and interaction (*4,9,16,19–21*) rooted in a mutually accepted set of theories, values, and ideologies (*10,21–23*).

Health-Mental Health Service Coordination

In the area of mental health policy, many Federal, State, and local programs are adopting a service strategy for coordinating existing resources. Community mental health service programs continue to emphasize the collaboration and affiliation of existing service opportunities. Community mental health centers, community support programs, and the recent Most-in-Need Program (all sponsored by the National Institute of Mental Health) are predicated on coordinating social, educational, health, and mental health services.

Further endorsing this strategy, the President's Commission on Mental Health (*24*) and recent legislation (*25*) have mandated the coordination of health and mental health services. Such coordination holds different promises for the organizations and individuals involved. For the general health care system, coordination increases the comprehensiveness of patient care and may lead to easier access to much needed, but relatively scarce, mental health resources. For the specialty mental health care sector, coordination provides access to the more ample resources of the health care sector, including increased third-party insurance benefits. Most important for the public, the hope is for more accessible and appropriate services, which make more effective and efficient use of health resources in a time of rising medical care costs.

Coordination of health and mental health services also has taken many forms. In some cases coordination means the integration of mental health professionals into the health care team and the health care setting to provide comprehensive services to patients. In other cases it means the affiliation of autonomous professionals and providers who enter into a cooperative agreement, increasing referral and consultation between them. Two reports (*26,27*) describe numerous models of coordination, including the expansion of general hospital and consultation-liaison psychiatry, the provision of mental health services in primary medical care settings (such as HMOs and neighborhood health centers), and most recently the development of linkage grants between primary health care projects and community mental health centers.

PHCP-CMHC Linkage Grants

In 1977, the Bureau of Community Health Services (BCHS) in conjunction with the National Institute of Mental Health (NIMH) developed a plan to increase the availability of mental health services to patients of BCHS-supported primary health care projects. Initially, BCHS and NIMH project staff in Washington and in the regional offices participated jointly in planning the grant program. Such cooperation and coordination at the central office and regional office levels have been viewed as essential preconditions for linkage at the service delivery level. In 1978, grant funds were made available to link BCHS projects with established federally funded community mental health centers located in the same geographic area. Eligibility was limited to PHCPs that were not providing adequate mental health services, either directly or through an existing relationship with a mental health center. Included in the grant program were BCHS projects funded under the rural and urban health initiatives and all migrant health care projects. A total of 57 sites (two-thirds in rural projects) in all 10 Federal regions were selected for funding in July 1978. All but two of the grants were actually awarded and implemented during 1978 and 1979.

These linkage grants were based on a negotiated agreement between a PHCP and a CMHC. The funds (up to a maximum of $30,000 per site) were used primarily to pay the salary and benefits of a mental health liaison professional affiliated with the CMHC and the BCHS project. The mental health professional, called a "linkage worker," was expected to perform the liaison functions of triage, referral, and consultation. In addition, direct mental health services for PHCP patients were to be provided by the linkage worker or other staff, either at the CMHC or at the PHCP. Resources to support administrative and secretarial services were to be allocated by the BCHS project. The details of the plan for service delivery were not specified by the Government. Individual project directors were encouraged to establish linkages that would best meet the needs of their target populations and would augment the scope and spectrum of the services being provided.

The formal written agreement between the PHCP and the CMHC includes a minimum of 12 terms required for linkage. These terms outline the interdependence, mutual benefit, and common modes of interaction between the parties to the agreement. Interdependence is reflected in the identification of the interrelated needs of the PHCP and the CMHC. Mutual benefit is addressed by an assurance that the PHCP will provide funds for a mental health liaison professional and that the CMHC will provide backup mental health services

and supervision for the linkage worker. Furthermore, in the interest of mutual benefit, the agreement includes terms specifying the remuneration of the mental health liaison professional and billing procedures for patient services. Common modes of interaction are detailed in terms relating to patient transportation, referral procedures, clinical records exchange, program planning and operation, joint decision making, and other "planned interaction . . . between administrative staff . . . and professional staff."

A project is expected to meet the established goal of increased mental health services for PHCP patients by satisfying the terms of this formal linkage agreement. The terms of this agreement contain the basic ingredients or conditions necessary for interorganizational cooperation. Some projects are better able to satisfy these conditions than others. Some projects have encountered few problems in meeting their objectives, while others have experienced difficulty in implementing the linkage initiative.

Implementation—Prospects and Pitfalls

The formal evaluation of the linkage initiative is currently underway. As a first step in the evaluation process, staff from the NIMH and the BCHS jointly obtained some preliminary descriptive information about the early stages of project implementation through a combination of site visits, a regional conference, and a telephone survey conducted during the past year. The initial linkage experience reveals exciting prospects as well as problems.

In the early stages of implementation, the linkage worker—crucial to the development of the linkage project—was the focus of activity. The mental health professionals who have been hired in this capacity have been drawn from several disciplines. Social workers with master's degrees have been recruited most frequently, followed in frequency by several types of professionals with master of education or master of arts degrees. A number of the sites have hired full-time workers with master's degrees, as well as part-time psychologists or psychiatrists.

Overall, in the early months of these grants, linkage workers saw a large number of patients on a short-term basis (for example, for several visits), although at some sites linkage workers were reported to have accumulated a long-term caseload. For the most part, it seems that patient contacts have been limited primarily to brief evaluation or triage for referral to appropriate sources of care. The clinical problems of patients include all of the major clinical syndromes, except psychotic disorders. Linkage workers have referred patients to CMHCs, to other community resources, and to other staff at the PHCP. A small number of referrals have been made from the CMHC to the PHCP. Although not specifically stated as a grant objective, health care for mental health center patients is an unanticipated benefit of the linkage projects.

Prospects. Many of the linkage projects have met the basic objectives of triage, consultation, and referral. It appears that PHCP patients are receiving mental health services that were unavailable or inaccessible before the initiation of the linkage grants. In addition to fulfilling the basic clinical objectives, some projects have created interagency programs resulting in clinical collaboration and consultation training. Examples of collaboration include obesity and hypertension programs for adults and special developmental screening programs for children. To facilitate and support the development of clinical linkages, projects have tried a variety of administrative mechanisms to promote interagency cooperation. One project created an Oversight Committee with representation from the board of directors of both participating agencies. In the training area, several sites have reported joint inservice training for CMHC and PHCP staff on a monthly basis. In addition, an unexpected outcome of the closer relationship between health and mental health centers has been increased access to other community agencies. In one community, the PHCP had provided ongoing health services to a nursing home, but the CMHC had not been able to gain access to the home to provide either services or consultation. As a result of the CMHC's affiliation with the PHCP, the CMHC staff was able to gain entry to the nursing home.

As might be expected, the more easily implemented linkage projects are those based on earlier cooperation between the CMHC and the PHCP. In these linkage projects, there is a clear understanding of common goals and an agreed-upon division of labor and responsibility, essentially satisfying the basic conditions of interorganizational cooperation. Both parties have recognized their interdependence, and they benefit mutually from the relationship. They have learned to work toward complementary clinical goals and have accepted a common form of interaction for the planning, administration, and implementation of linkage objectives. In short, the PHCP and the CMHC have learned to share information, patients, staff, and resources.

Pitfalls. In contrast, some projects have encountered barriers to linkage development. Where significant problems have been reported, it appears that the linkage project has experienced difficulty in satisfying one or more of the conditions for interorganizational cooperation.

Although most projects have agreed to the overarch-

ing project objective of providing mental health services to patients in BCHS primary health care clinics, not all have agreed on the approach to linkage. (Disagreement over linkage strategies appeared to reflect different perceptions of project objectives among staff within and between NIMH, BCHS, and the regional offices.) Some projects have favored a linkage arrangement that encourages the referral of primary health care patients to the CMHC for treatment. Others have endorsed a strategy that integrates the mental health professional into the primary health care team as a service provider. Some diversity in linkage strategies is acceptable. However, at times, differences in the perception of goals and strategies have created conflict within a single linkage project and affected other spheres of interagency cooperation.

Delineation of responsibility and authority for the linkage program, in some instances, also has been a source of tension and conflict. The ambiguity associated with personnel who work both within and between health care systems has reinforced the need to clarify supervisory responsibility. This issue is critical to recognizing the interdependence between the PHCP and the CMHC. Although accountable for the fiscal resources, the PHCP administering the program is not likely to have mental health experts on its staff. Each center must depend on the other to achieve the common goals of the linkage project. From the perspective of the linkage worker, it is important to be affiliated with the CMHC (to obtain clinical supervision and peer support) and to be perceived as an integral part of the PHCP (to gain referrals and fiscal support). By clarifying the lines of clinical and administrative supervision and responsibility, linkage workers have been able to identify with both the health and mental health care systems and to work between them more effectively.

In addition to these administrative issues, several fiscal barriers to linkage have been identified. These barriers disturb the perception of mutual benefit between the PHCP and the CMHC. Competing claims for revenues collected for direct clinical services have caused some friction between the agencies. Generally, fees are paid to the center where the service is actually provided. In many States, PHCPs cannot collect fees for mental health services because they are not licensed to provide them. Therefore, fees are collected by the CMHC. However, in States requiring that mental health services be delivered at the CMHC, more patients may be referred to CMHCs than to PHCPs. This result of fiscal pressure runs counter to the linkage strategy of increasing the provision of mental health services in primary health care settings. It is, however, consistent with a strategy of increased mental health referral.

Another funding problem is related to the nature of the fiscal agreement between the PHCP and the CMHC. Because the grants were made to PHCPs, in many cases no portion of the funds was allocated to the CMHCs. The lack of reimbursement to the mental health center could reduce the incentive to provide necessary supervision for the linkage worker, making it difficult for the CMHC to provide consultation, education, or direct services to the PHCP.

In addition, a lack of common modes of interaction between the PHCP and the CMHC has led to conflict and an inability to fulfill some objectives of the linkage project. In this context, many of the tensions associated with implementing the linkage function derive from the complexity of the various types of clinical interfaces that need to be negotiated. Professionals in PHCPs and CMHCs do not always speak the same language. To develop effective communication and referral practices between the PHCP and the CMHC, professionals in each setting must agree on the clinical needs of special populations (for example, children, the elderly, the developmentally disabled, and members of various ethnic groups). They must also share common expectations concerning specialized clinical services available to help patients (for example, inpatient psychotherapy). To achieve this understanding, the linkage worker must learn sophisticated skills for negotiating inter-agency agreements. Recently trained clinicians, serving as linkage workers and lacking experience in consultation and interorganizational relationships, run the risk of accumulating a large caseload if they are unable to marshal the clinical resources of the CMHC and the PHCP.

In addition to having a high level of skills and knowledge for carrying out diverse functions, the linkage worker must achieve credibility in both the PHCP and the CMHC. To attain this credibility, the linkage worker must approach each job slowly and sequentially. Establishing clinical credibility is necessary before consultations with health care providers are initiated; this credibility could be facilitated if the linkage worker conducted an orientation session for the providers on the art and practice of mental health referral and consultation. Moreover, to become established at the CMHC, the linkage worker might attend regular case conferences to gain acceptance as well as an understanding of the CMHC's resources. By interacting with both agencies, the linkage worker is an intermediary between them. In this capacity, he or she attempts to bridge the difference between agencies in what has been termed a "boundary-spanning role" (*12*).

In summary, projects lacking a perception of inter-

dependence and mutual benefit seem to have encountered difficulties in creating linkages between PHCPs and CMHCs. Unable to satisfy some of the conditions necessary for interorganizational cooperation, agencies have learned to devise mechanisms for reducing tensions and conflict and for promoting linkage. These mechanisms have focused on the role of the linkage worker and on structural changes in the relationship between the PHCP and the CMHC. In all instances, the success of the linkage project appears to be predicated on achieving the conditions of interorganizational cooperation outlined in our theoretical introduction.

Conclusion and Prospects

Although data are limited, the experience gained during the first year of the PHCP-CMHC linkage program points up the problems and the potential of establishing cooperation between mental health and primary care agencies. We have examined the implementation of the linkage program in the context of a theoretical framework based on previous research on integrating and coordinating services. This framework provides a conceptual basis for evaluating the developing linkages. Within this context, under conditions of resource scarcity, interdependence and mutual benefit are key ingredients for successful interorganizational relationships. Furthermore, common modes of interaction seem to facilitate interagency cooperation.

In the future, this conceptual framework will guide the continued evaluation of the PHCP-CMHC linkage program and the search for linkage models that work in a variety of circumstances. Exploratory work is underway to characterize the interagency linkages and to model a variety of approaches to linkage development. This preliminary analysis is a necessary first step in the evaluation of the impact of interorganizational cooperation on the quality of patient care.

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