Integrating Primary Health Care and Mental Health Services —a Successful Rural Linkage

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SYNOPSIS

The local delivery of human services is currently receiving national emphasis. The expectation is that community-based services shall be provided with a minimum of duplication and with maximum efficiency, achieved partly by interdisciplinary and interorganizational cooperation. This emphasis was appropriately facilitated in the mid-1970s through the availability of the Mental Health Initiative grants. The grants, initiated by the Bureau of Community Health Services in conjunction with the National Institute of Mental Health, Public Health Service, promoted the increased availability of mental health services through formal linkages between community mental health centers and primary health care programs.

One such successful linkage was between a small primary health care center and a nonfederally funded, multicounty, mental health center in northwest Illinois. Initiated in September 1980, the services of the linkage project included direct clinical mental health services delivered at the primary health care center site, consultation and education activities, and the coordination of interagency services.

The project patients differed from the general clients of the mental health center in demographic characteristics, source of referral, and diagnoses. The key elements in successful linkages and the achievement of goals are analyzed.

The experience of the linkage project is relevant to the 1980s. The project was prematurely ended after 14 months. Reduction in Federal funds severely cut support for the primary health care center, and the depressed local economy could not match the withdrawn Federal funds.

MUCH HAS BEEN WRITTEN concerning the pervasive fragmentation of services so characteristic of the pluralistic U.S. health care system. The problem is rarely better exemplified than in the areas of traditional medical care and mental health services. It has been consistently shown in special studies that approximately 15 percent of the patients served in primary medical care settings have related mental disorders (*1*), yet the coordination and cooperation between community medical and mental health providers typically have been minimal at best.

Growing recognition of this gap between providers, coupled with the almost universal dilemma of meeting increased service needs with limited resources, has led many officials and program administrators to espouse major efforts aimed at greater integration of services and increased cooperation among organizations (*2*). Nationally, one such major effort was initiated in 1978 by the Bureau of Community Health Services (BCHS) in conjunction with the National Institute of Mental Health, Public Health Service. Known as the Mental Health Initiative, this Program offered supplemental grants to eligible (currently BCHS funded) primary health care centers to increase the availability of mental health centers and to establish formal linkages with existing federally funded mental health centers within the same service area. In 1979, the Federal initiative was expanded to enable linkages with State, local, or privately funded not-for-profit community mental health centers (*3*).

Goldman and co-workers have discussed both general problems and the prospects for Federal linkage efforts from a theoretical perspective previously in this journal (*4*). Our purpose is to (*a*) describe the experience of a small rural primary health care center and a multicounty mental health center with a Mental Health Initiative grant, (*b*) analyze the program's effectiveness in terms of goal attainment, and (*c*) discuss the elements essential to successful linkages.

Background

Initiated in September 1980, the linkage program we describe was designed to serve the residents of the town of Savanna and surrounding rural Carroll County in northwestern Illinois. Savanna, the county's largest town with a population of 5,000 is the site of the sponsoring primary health care center that also served as the base for most of the mental health programing. The county's population of 20,000 relies on an economy of agriculture and small manufacturing plants. Both median family and per capita income levels are below that of the region and the United States. About 10 percent of the population have incomes below the Federal proverty level guidelines, and 14 percent are age 65 or older.

Savanna/Carroll County Health Services, the primary health care center, began operations in late fall, 1977, with assistance from a Health Underserved Rural Areas (HURA) grant. Funding support was subsequently changed to the Rural Health Initiative (RHI) grant program, enabling the center to develop a complete base of primary family health care services, including the services of a primary care physician, a wide array of special preventive and health education services, and home health services.

Sinnissippi Mental Health Center, the cooperating mental health agency, is a multicounty, private, not-for-profit, State and locally funded community mental health center. Its services include (*a*) emergency and diagnostic services, (*b*) outpatient services for individuals and families, (*c*) substance abuse services, (*d*) sustaining care programing for the chronically mentally ill, and (*e*) community consultation and education-prevention activities. The center's main offices are located in Dixon, Ill., approximately 50 miles from Savanna/Carroll County Health Services. The two agencies are referred to subsequently as the Savanna center and the Dixon center.

Program Design and Implementation

The linkage project had two explicit, interrelated goals. The first was to increase accessibility of mental health services by providing them at a primary health care center. The second stated goal was to reduce the fragmentation of services, thus promoting the evolution of a more comprehensive health care model for the residents of this designated underserved area. The linkage project was designed collaboratively by the administrators of the two agencies. After they established program goals, they directed efforts to blending two discrete service systems and implementing direct clinical and consultation-education services. Several key elements of the structural design will be discussed.

Staffing needs for the linkage project were met by a full-time, master's degree-level clinician who was hired and supervised by the administrator of the mental health center. The linkage worker was at the Savanna center 4 days a week, with the fifth day spent at the Dixon center. All patient appointments were scheduled through the Savanna center to identify it as the main site where services were delivered in this project.

The issue of confidentiality in record keeping was reviewed carefully during the implementation process. Although most patients were seen exclusively at the Savanna center, it was agreed that the primary responsibility for maintaining and safeguarding records rested with the Dixon center. Separate mental health records were set up and kept in a locked file at the Savanna facility. Upon completion of clinical services to a patient, the records were housed permanently at the main office in Dixon.

Several forms were devised to promote communication about patients' needs between the primary care providers and the mental health clinician. Among these was a separate linkage project exchange-of-information form. With the written consent of the patient, portions of the mental health clinician's records—an initial assessment report, periodic progress reports, and a case closing summary —were provided to the appropriate staff member of the Savanna facility. These reports became part of the health care center's medical records.

Because the linkage worker was at the site, numerous in-person referrals and collaborative case consultations occurred. These actions facilitated the planning for comprehensive case management and improved the delivery of services.

The services given through the linkage project were (*a*) direct clinical mental health services delivered at the Savanna center, (*b*) consultation and education activities, and (*c*) coordination of interagency services. Direct clinical mental health services included outpatient diagnostic evaluation and comprehensive treatment planning carried out through individual, conjoint, and family therapy. If after careful assessment, more specialized services were indicated, the linkage worker facilitated referral of the patient to other programs of the Dixon center or to community resources. The provision of direct clinical services to patients and their families was the primary focus of the linkage project.

Consultation and education were offered to the staff of the Savanna center's home health program. They provide nursing care to homebound patients, many of whom suffer from chronic debilitating diseases. Such serious health problems cause major emotional stresses for the patients and their families. Requests for direct clinical services for home health service patients and their families often resulted in a team approach; the nurse and the linkage worker together took their skills into the patients' homes.

The linkage worker also offered a broad range of consultation and education activities in the general community. These included contact with schools, the court system, law enforcement personnel, child welfare agencies, clergy, the elderly, and various civic groups. To promote public awareness of the increase in local services, a printed brochure that described the linkage project was distributed in the community.

Coordination of services between the two participating agencies was essential to the monitoring and maintenance of the linkage project. Information sharing and enhancement of communication regarding both organizational and clinical service issues occurred among the various physical and mental health care providers. The two administrators communicated regularly with each other, their respective staffs, and the linkage worker about the development of the project, assessment of operations, and patient service needs. Orientation meetings, board presentations, planning sessions, and periodic inservice training presentations were held at the Savanna center.

Program Results

The demographic data on the 104 project patients that follow reveal some similarities with and differences from the Dixon center's general client population.

Patients' age and sex categories	*Linkage program*		*Mental health center (percent)*
	Number	*Percent*	
Newborn–12 years	14	13.5	6.5
13–17 years	14	13.5	16.6
18–64 years	70	67.2	70.6
65 years ald older	6	5.8	6.3
Total	104	100.0	100.0
Female	72	69.2	50.4
Male	32	30.8	49.6
Total	104	100.0	100.0

The age distribution of the two groups of patients was generally similar, except that the linkage project had twice the percentage of patients aged 12 years and younger. The other significant difference was in the numbers of males and females served. The mental health center's clients were approximately equally divided between male and female, while the project's patient population showed a 7 to 3 (69.2 percent) ratio of females to males.

The referral sources of the two groups of patients follow.

Source of patient	*Linkage program*		*Mental health center (percent)*
	Number	*Percent*	
Referred by medical personnel	32	30.8	9.3
RHI physicians	27	26.0	...
Home health care staff	5	4.8	...
Referred by community sources[1]	72	69.2	90.7
Total	104	100.0	100.0
Patient was not previously served by mental health system	86	82.7	69.7
Patient was previously served by mental health system	18	17.3	30.3

[1] Self, agencies, clergy, schools, and so forth.

The onsite linkage with the primary health care center's physicians and the home health nursing personnel resulted in 30.8 percent of the project's referrals coming from the onsite medical personnel. This proportion compares with 9.3 percent of the mental health center's referrals coming from medical personnel. The total number of intake cases to the Dixon center from Carroll County for a comparable period before the start of the linkage project amounted to 63. During the project, 104 cases were opened, a 65 percent increase in intake cases.

Only 17.3 percent of the project patients had previously been served by the available mental health service system. This proportion compares with the Dixon center's data indicating that 30.3 percent of the annual intake cases were of clients who had previous contact with the same mental health service system. The data showing that nearly 83 percent of the project patients had not previously received services substantiates that accessible services in outlying rural areas will be used.

The primary problems in the 104 project cases and the modality of service used to address these problems follow.

Problem and mode of delivery of services	Linkage program		Mental health center (percent)
	Number	Percent	
Presenting problem:			
Depression, anxiety	47	45.2	30.3
Family relationship problem	40	38.5	18.0
Acute or chronic psychosis	8	7.6	25.5
Substance abuse	9	8.7	26.2
Total	104	100.0	100.0
Mode of service delivery:			
Individual	13	12.5	71.6
Individual with others	38	36.5	18.7
Family therapy	53	51.0	9.7
Total	104	100.0	100.0

The problem occurring most frequently was depression or anxiety or both (45.2 percent). Family and other relationship problems accounted for another 4 in 10 (38.5 percent) of the cases, with a substantial portion of the relationship problems experienced by adolescents. Family relationship problems, associated with parent-child stress and conflict, are understandable for this rural area. High unemployment rates for children and adults, the traditionally heavy consumption of alcohol, premarital pregnancy and early marriage, and the relative paucity of entertainment or recreational opportunities result in multiproblem family and community situations which are counter to positive adolescent adjustment.

During the 14 months of the linkage project, the total numbers of chronically mentally ill and chronic substance abusers served by the Dixon center increased slightly. These patients, however, were served primarily within the previous programs at the Dixon center. This circumstance explains the relatively small percentage of project patients who had a presenting diagnosis of psychosis (7.6 percent) and substance abuse problems (8.7 percent).

Specific sustaining care services for those with chronic mental illness have been a primary function of the Dixon center for 15 years. The center's outreach nursing personnel provide ongoing services to the chronically mentally ill population that account for one-quarter of the agency's caseload. The Dixon center also has an outpatient day program for the rehabilitation of substance abusers. The day rehabilitation program at the center's main facility has a transportation component that helps to assure that clients in need of such service will be able to come to the main center from all parts of the four-county catchment area. The linkage worker was able to rely on colleagues and resources of the mental health center to give needed services to these special patients. The linkage worker was therefore available at the Savanna center to respond to those with less chronic presenting mental health problems.

The mode of services delivery reflects both the realities of the linkage project and the professional preferences of the linkage worker. Family-focused intervention was chosen for 51 percent of the patients. Because nearly 4 in 10 of the presenting problems were relationship dysfunctions, this method of intervention was appropriately case specific. Also, the caseload demand on the single linkage worker dictated an efficient model of service delivery. Time-limited, family focused intervention, averaging 10 interviews per project case, was necessary. Additionally, the linkage worker was experienced in family-oriented intervention, and therefore, understandably selected this method of service delivery whenever it was appropriate.

The data provide an interesting and substantiating assessment of the linkage. Persons in need of mental health services who had not previously used them responded to the availability and accessibility of such services through the linkage project. The functional linkage between primary health care and mental health services was realized through an increase in onsite referrals. Also, the problems of the project patients were consistent with the individual, family, and community dynamics of this rural area. Finally, the family-focused delivery of services by the linkage worker was consistent with the family-oriented, primary health care practice of the physicians and the home health care nurses. This similarity in professional orientation among the physical health care and mental health service staffs facilitated a close interdisciplinary working relationship and enhanced comprehensive service delivery to the patients.

Discussion

Two interrelated factors contributed to the overall success of the project: organizational strategies and competence of personnel. Both were essential to the achievement of goals, and both are the basic ingredients of any successful single or interorganizational venture.

Organizational strategies. Our assessment of the linkage pinpointed key strategies that contributed to interorganizational success. These included (*a*) mutual felt need and philosophical compatibility, (*b*) opportunity, and (*c*) effective communication. Individually, these components have relevance, but in

combination they transformed a conceptual model into an operational reality.

The governing boards, administration, and professional personnel of both organizations actively recognized the interrelatedness of physical and mental health needs for services. This recognition had to precede the cooperative effort. Interdisciplinary jealousies would have stifled the conceptual openness necessary for joint development of a program. The staff of the primary health care center recognized their patients' need for mental health services. Similarly, the staff of the community mental health center recognized the physical health complications of many clients of the Dixon center. This mutually perceived need and philosophical compatibility provided the conceptual basis for the project, and these qualities reinforced it throughout its existence.

The Federal Mental Health Initiative grant gave the two organizations the opportunity to act. The limitations of local funding did not preclude conceptual cooperation, but they had previously blocked expanded mutual organizational efforts. Grant funds provided the mechanism for harnessing the enthusiasm for a cooperative service link. Although the link continues in restricted form since the withdrawal of grant funding, it was the grant option that gave the opportunity to fulfill the mutually felt need.

Putting together the grant application and the implementation of the arrangement required effective communication between the two organizations. Initially, the two administrators met with each other's board of directors to share information and perspective on their agency and the linkage program. Additionally, the administrators met routinely to share successes and discuss problems. Even the best conceived program design can run into practical obstacles when it is implemented. The willingness of managers and practitioners to adapt to changing realities kept the project alive and applicable to persons in need of services. Taking the risks of being flexible made for project viability.

Most important, however, the professional practitioners of both organizations opened channels of effective communication that made possible daily cooperation in the delivery of services. Officed together at the project site, the physicians, nurses, and the linkage worker were formally and informally accessible to one another. Even the strategic placement of the linkage worker's office near the coffee room facilitated the informal communication necessary to build relationships. Informal networking plus the formal case referrals, consultations, staff meetings, and inservice sessions made for effective collegial interchange.

Competence of personnel. We submit that professional competence is a combination of knowledge, skill, commitment, and personality. Credentials represent the knowledge base (education) and skill level (training and experience) of the practitioner. The necessary ingredients of commitment and personality, however, are not as measurable. The nearly unquantifiable human qualities of the human services professional are as essential as degrees and skill credentials.

Commitment and personality are those ingredients of the good bedside manner in medical practice that help the patient to deal with the physical ailment and follow the prescribed course of treatment. Similarly, in delivering mental health services, the caring personality touches the clients' emotions and enables the essential rebuilding of interpersonal relationships. The acceptance that such commitment and personality are necessary ingredients to successful solo practice is generally understood. The significance of the same factors to the success of a linkage program should be acknowledged as essential.

The Dixon center-Savanna center linkage was graced with several strong personalities who, in coming together, reinforced each other. The key persons shared their respective commitments in the best interests of collaborative service delivery rather than clashing over interdisciplinary concerns. The physician, the nurse, and the linkage worker functioned in a cooperative spirit, without sacrificing professional autonomy. The essence of this competence is the human touch in professional practice.

Conclusions

Integrating primary health care and mental health services through the linkage grant was successful. The major goals—an increase in the availability and effective use of community mental health services and a reduction in the fragmentation of health and social service systems by integrating and coordinating scarce resources—were accomplished during the project's 14 months.

Rural Carroll County, with its traditional value system steeped in midwest agricultural practicality and human genuineness, offered an environment within which this well conceived interdisciplinary program model became operational. Although some

forces in this rural environment contributed to the medical and mental health problems of the people, we believe that the dynamics of this rural system also contributed to the successful implementation of the linkage. The strong value accorded cooperation in this rural area affected systems collaboration positively. Additionally, the basic competence of professional and lay persons, a competence laced with a healthy pragmatism, promoted the interpersonal relationships that strengthened the cooperative effort.

The Mental Health Initiative concept was designed in the mid-1970s, but it has great relevance to the political and service realities of the 1980s. National emphasis is now being placed on the local delivery of services. The appropriate expectation is that community-based services shall be provided with a minimum of duplication and with maximum efficiency, achieved partly by interdisciplinary and interorganizational cooperation. Local health workers attuned to such a philosophy can comprehensively intervene with the family and the community systems where the patient lives and works.

The linkage project we describe is relevant to the 1980s. It was formally ended with a commendable record after 14 months. Reduced Federal support for community programming has prematurely terminated this linking of primary health care and mental health services.

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Self-Inflicted Gunshot Wounds Among Alaska Natives

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SYNOPSIS

Deaths by violence (accidents, homicide, suicide) have increased significantly among Alaska Natives who have a suicide rate three times that of the general U.S. population. Self-inflicted gunshot wounds comprised 75 percent of the suicides among Alaska Natives from 1976 through 1980. A review of psychiatric consultations concerning 34 Alaska Natives who had survived a self-inflicted gunshot wound indicated some common characteristics.

Of the group, 28 were male, and 20 had been using alcohol at the time of the shooting. Interpersonal conflicts were cited by most persons as partial motivation for the shooting, and most shootings were impulsive rather than premeditated. Few patients had a psychiatric history or appeared impaired at the time of the consultation.

Cultural and intrapsychic factors that might contribute to this high rate of self-destructive behavior were examined. These include a proscription against verbal expression of negative affect and an increase of non-Native influences with subsequent social disorganization and cultural conflict.

FOR SEVERAL DECADES, DEATH BY VIOLENCE has increased significantly among Alaska Natives. In the period from 1950 to 1974, mortality by violence (accidents, homicide, suicide, alcohol) in this population grew from less than 20 percent to greater than 40 percent of all deaths. During the same pe-