RURAL MODELS FOR INTEGRATING PRIMARY CARE, MENTAL HEALTH, AND SUBSTANCE ABUSE TREATMENT SERVICES

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RURAL MODELS FOR INTEGRATING PRIMARY CARE, MENTAL HEALTH, AND SUBSTANCE ABUSE TREATMENT SERVICES

Donna C. Bird, MS, MA
David Lambert, PhD
David Hartley, PhD

Maine Rural Health Research Center
Edmund S. Muskie Institute of Public Affairs
University of Southern Maine
96 Falmouth Street
Portland, Maine 04104-9300

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EXECUTIVE SUMMARY

Policymakers have long championed the integration of mental health and substance abuse treatment services into primary care as a means to improve access, quality, and cost of care. Service integration is an especially important strategy in rural areas, where mental health and substance abuse treatment services are often in short supply and many residents hesitate to seek specialty care due to concerns about stigma and lack of confidentiality. Although various public and private funders have supported numerous service integration initiatives over the years, empirical studies examining the structural factors shaping integration, the organizational characteristics of integrated service providers, and the effects of integration remain quite limited in number, scope, and generalizability. This paper presents findings from a study designed to identify and describe models for integrating these services in rural communities. Our specific objectives were to:

- identify organized rural primary care providers that have undertaken specific initiatives to link or integrate mental health and/or substance abuse treatment services;
- determine structural factors which appear to facilitate or inhibit integration based on the experience of these providers;
- describe the organizational characteristics of these initiatives; and
- propose a typology of integration models to inform future research, including studies of their effects on access, quality and cost of care.

We obtained data by conducting telephone interviews with staff at rural primary care sites around the country. We solicited the names of these sites through a nomination process. Criteria for inclusion were that the nominee:

- be located in a rural area, or provide services to a significant rural population;
- be an organized provider of primary care services, e.g., a community health center, rural health clinic, hospital-sponsored primary care satellite or outpatient clinic, public health department, group practice or health maintenance organization; and
- have undertaken specific program initiatives to establish linkages with mental health

and/or substance abuse treatment services or to integrate these services into the existing primary care program.

Our findings are based on the responses of 53 primary care organizations in 22 states. Information was obtained during the first six months of 1 994, and organized within the framework shown in Figure 1. In our sample, community health centers were the dominant organizational type engaged in integration activities, representing 55 percent of respondent organizations. This finding is consistent with the comprehensive definition of primary care that has been core to the mission of the community health center program since its inception. It also reflects continued federal emphasis on community health centers in integration initiatives.

We identify four integration models, which we call diversification, linkage, referral and enhancement. These appear to exist in combination, rather than as pure types. While not exhaustive, our inventory of integrated programs suggests the range of possible approaches to linking mental health and substance abuse treatment services to rural primary care. Our taxonomy of models provides a relatively straightforward way to organize this complexity. Our analytical framework outlines aspects of integration that are readily amenable to study, and suggests that access might be measured in terms of availability, utilization, and comprehensiveness; quality in terms of clinical outcomes and patient satisfaction; and cost in terms of efficiency and cost-effectiveness.

INTRODUCTION

Policymakers have long championed the integration[1] of mental health and substance abuse treatment services into primary care as a means to improve access, quality, and cost of care. In the last thirty years, for example, the federal government has fostered numerous efforts to accomplish this type of service integration. Legislation establishing community and migrant health centers (1965) and federally qualified HMOs (1973) included provisions that these organizations would offer basic mental health services as a supplement to comprehensive primary health care (Geiger 1 984; U.S. Congress, Office of Technology Assessment 1990). Rural Health Initiative and Health Underserved Rural Area grants (1977-1980) required recipients to coordinate with area mental health services providers (Ozarin et al 1978). The Linkage Initiative program (1978-1980) provided funds for community and migrant health centers to hire staff to assess patients, provide basic counseling and/or refer them to needed services at nearby community mental health centers (Broskowski 1980). Provisions of the Omnibus Budget Reconciliation Acts of 1 987 and 1 989 broadened Medicare and Medicaid reimbursement to cover the services of clinical psychologists and masters' level social workers practicing in rural health clinics (Travers and Ellis 1992). In response to the growing AIDS epidemic, the National Institute on Drug Abuse and the Bureau of Health Care Delivery and Assistance collaborated in the late 1 980s in sponsoring demonstration projects linking primary care and substance abuse treatment programs.

[1] Integration refers to any of a range of inter- and intra-organizational strategies aimed at increasing functional coordination with the intent of improving performance measures such as access, comprehensiveness, continuity, and/or cost-effectiveness.

Service integration is an especially important strategy in rural areas, where the limited availability and accessibility of mental health and substance abuse treatment services is a longstanding problem (Beeson 1990; Flax et al 1979; Wagenfeld and Buffum 1983). Many rural areas lack specialty mental health professionals (Keller et al 1980; Knesper et al 1984; Stuve et al 1989). Physical distance, adverse weather, and lack of public transportation present barriers to care even when resources are available (Adams and Benjamin 1988; Jones et al 1976; Prue et al 1979). Many residents of rural areas are unwilling to use specialty mental health or substance abuse treatment services because of the stigma associated with mental illness and substance abuse and concerns about confidentiality (Berry and Davis 1978; Fehr and Tyler 1987; Wagenfeld et al 1994). In many rural areas, some form of service integration may be the only option for assuring access to these services at all.

Despite persistent policy interest in service integration, empirical studies examining the structural factors shaping integration, the organizational characteristics of integrated service providers and the effects of integration remain quite limited in number, scope, and generalizability. This paper presents findings from a study designed to identify and describe models for integrating mental health and substance abuse treatment services with primary care in rural communities in the United States[2]. Our objectives were to:

- identify organized rural primary care providers that have undertaken specific initiatives to link or integrate mental health and/or substance abuse treatment services;

2 For the sake of clarity, we focus on provision of these services to patients of primary care providers. Although we also recognize the importance of assuring that primary health care is available to patients originating in the specialty mental health and substance abuse treatment sector, consideration of integration from this direction is beyond the scope of this study.

- determine structural factors which appear to facilitate or inhibit integration based on the experience of these providers;
- describe organizational characteristics of these initiatives; and
- propose a typology of integration models to inform future research, including studies of their effects on access, quality and cost of care.

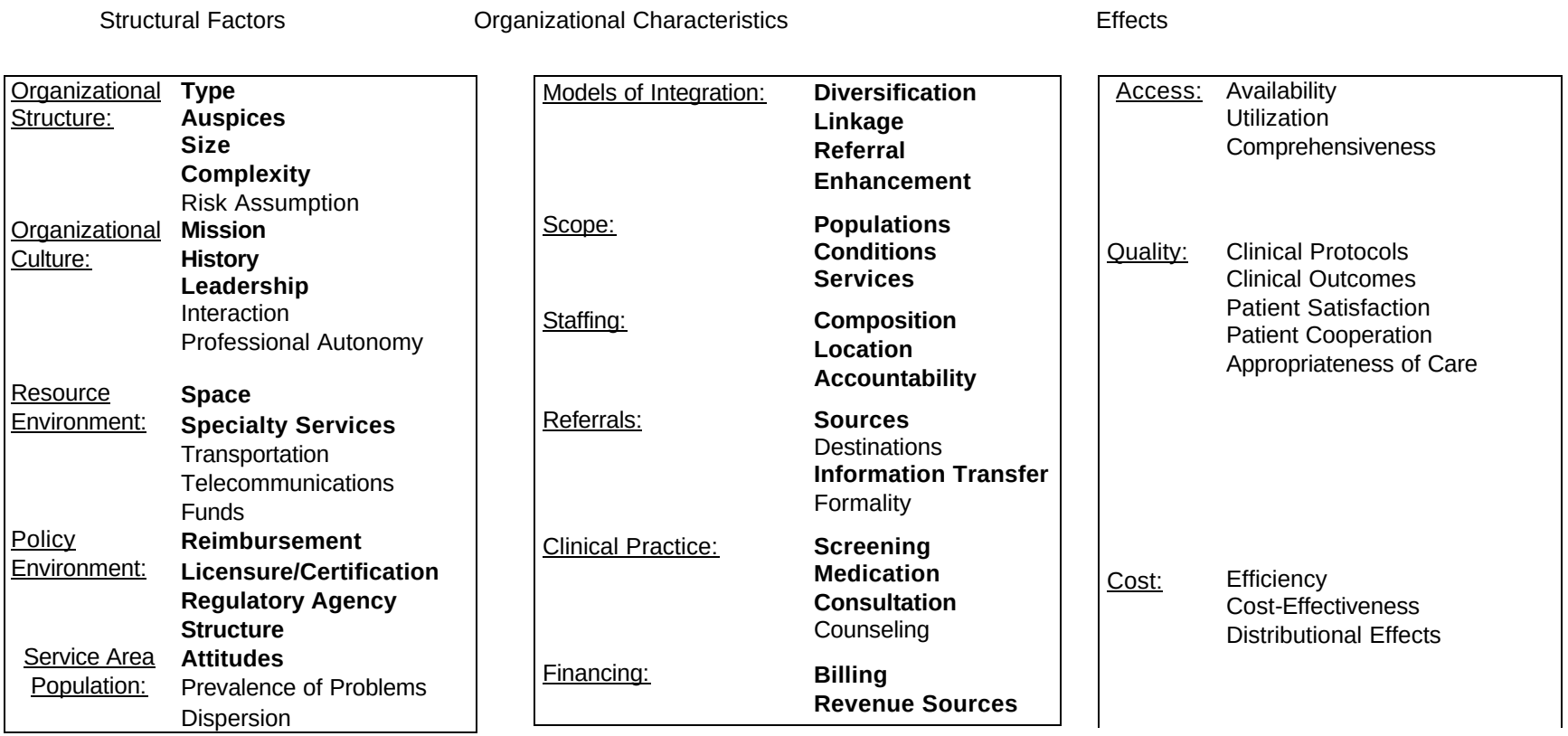
We have organized our analysis around the conceptual framework shown in Figure 1. This framework, described in greater detail elsewhere, draws on both the interorganizational literature and on prior studies of integrated mental health, substance abuse treatment, and primary health care service delivery initiatives (Bird et al 1 995). This framework is comprised of three sections encompassing the structural factors shaping integration, the organizational characteristics of integrated service programs, and the effects of integration. Particular elements of the framework included in our analysis are highlighted in bold face type in the Figure 1.

BACKGROUND

Overview

While the concept of service integration initially entered the policy literature in the early 1 960s, articles specifically addressing the integration of mental health and substance abuse treatment services with primary care did not begin to appear for another ten years (Borus et al 1975; Borus 1976; Morrill 1972). For the next ten years, until the mid-1980s, studies based on the federal Linkage Initiative dominated the literature (see, for example, Burns et al 1983; Celenza and Fenton 1981; Goldman et al 1980; Parlour et al 1985; and Prindaville et al 1 983). In the most recent ten years, this literature has expanded its focus, as the accelerating emergence of health services networks and managed care generated

Figure 1: Conceptual Framework for Studying Integrated Primary Care and Mental Health Services



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renewed interest in integration (e.g., Arons et al 1994; Christianson and Moscovice 1993; Zimmerman and Wienckowski 1991).

Structural Factors

Studies of the Linkage Initiative and other integrated programs have identified a number of **structural factors** which might facilitate or inhibit integration. By structural factors, we mean attributes of the environment external to the integrated program or preceding it in time. Among the key dimensions of *organizational structure* for integrated rural health networks, Moscovice et al (1994) include complexity and risk assumption. In their scheme, complexity refers to characteristics of member organizations (e.g., number, type, size) and types of services offered; and assumption of risk refers to whether or not a network shares financial risk for services provided. Thought by some to limit access to mental health services, risk assumption appears to be a necessary condition of integration in some settings (Moscovice et al 1995; Schlesinger 1986).

Several aspects of *organizational culture* have been found to affect integration. Positive cultural effects are associated with mutually accepted values, active support from staff and board members of participating organizations, and open exchange of information (Goldman et al 1980; Prindaville et al 1983; Van Hook & Ford 1993). However, because primary care and mental health practitioners rely on different healing paradigms and may use different terminology to describe the same conditions, professional autonomy can impede service integration unless a real effort is made to overcome these barriers (Barrett 1991; Light 1981; Parlour et al 1985; Strauss et al 1981).

Particularly in rural areas where resources of many kinds are scarce, elements of the *resource environment* have a considerable impact on integration. Since many rural programs have reported difficulty recruiting or retaining specialty mental health staff or

maintaining referral relationships with specialty mental health providers (Burns et al 1 983), a lack of human resources may pose a barrier to integration initiatives. Lack of private space in which to conduct counseling sessions appears to inhibit integration (Broskowski 1980). Transportation is an essential resource where the distances between service providers are great, although some have found telecommunications to be a partial substitute for adequate transportation (Preston et al 1992). While few would argue that funds are a sufficient condition for the occurrence of integration, many integration programs came into existence largely as a consequence of available federal funds, and did not survive in the same form after those funds ended (Prindaville et al 1983).

The influence of the *policy environment* on integration has not to date been widely studied; however, related work on the effect of government and professional standards on the formation of community support networks suggests the fruitfulness of this area for research (Provan and Milward 1991). With regard to the *service area population,* several studies have concluded that geographic dispersion affects both awareness of service availability and service use (Fehr and Tyler 1987; Prue 1979; Sommers 1989).

Organizational Characteristics

By **organizational characteristics**, we refer to administrative and clinical aspects of the integrated program itself. Within the constraints imposed by the structural factors, these characteristics are amenable to change through the decisions and actions of staff and board members of the program or its parent organization. *Models of integration* are particular arrangements used to provide mental health services to primary care patients. The literature to date continues to reflect the dominance of the model favored by the

federal Linkage Initiative, i.e., a mental health worker placed at the primary care site to provide basic services and referral to off-site specialty care. However, a number of empirical studies and

conceptual works have suggested the existence and feasibility of other arrangements. A study predating the Linkage Initiative identified four integration models depicting a range of relationships between primary care centers and community mental health centers based on patterns of interaction and the relative contributions of personnel and monetary resources by participating organizations (Borus et al 1975). Another early study described three models: 1) the primary care practitioner receives limited specialty mental health training; 2) specialty mental health practitioners consult with primary care practitioners on a case-specific basis; and 3) mental health practitioners serve as members of the primary care team (Coleman and Patrick 1976). In his review of the Linkage Initiative projects, Broskowski (1982) distinguished variations in the balance between organizational partners with respect to contribution and control of resources and in the intensity, frequency, and levels of exchange fostered by the coordination. Pincus (1980) conceptualized integration in terms of contractual, functional, and educational elements and described six models in terms of their relative reliance on these elements. The more recent literature on health care networks has added to this discussion the concept of levels of integration. We prefer the term “dimensions,” which avoids the implication of an ordinal relationship among the elements. Rosenberg (1993) depicted four dimensions along which organizations might integrate: 1) governance structure; 2) decision making and policy; 3) administrative and service delivery; and 4) goal identification and assessment. Moscovice and colleagues (1994) identified three dimensions of integration among rural health networks: level, complexity, and assumption of risk. In their scheme,

level of integration refers to the degree of shared decision-making, contribution of resources and sacrifice of autonomy by member organizations. We have already discussed their measures of complexity and risk assumption in our structural factors section.

Beyond these discussions and debates about models of integration, the literature on organizational characteristics remains quite limited. A number of Linkage Initiative case studies described *scope of services* but lacked the ability to examine them comparatively (see, for example, Celenza and Fenton 1981; Parlour et al 1985; Prindaville et aI 1983). With regard to *staffing,* previous studies suggest that integration efforts were more successful when linkage workers spent comparable time in the primary care and mental health settings, when their accountability was clearly defined, and when sufficient resources were available to enable them to work full-time (Borus et al 1975; Borus 1976; Broskowski 1980). Particularly in rural areas, staff credentials may be less important than energy, flexibility, and good communication skills (Burns et al 1983). These skills come into play during the *referral* process. The completeness and interactivity of information transfer appears to be related to the degree of satisfaction with the referral relationship experienced by the primary care practitioner (Rosenthal et al 1991). Informal contact of the sort that occurs naturally when services are co-located also seems to enhance the referral process (Boydston 1983; Borus et al 1975). Regardless of the strength of this relationship, however, some patients refuse to follow through with referrals to specialty mental health care (Olfson 1991).

Much of the work accomplished to date in the area of *clinical practice* debates the efficacy of training primary care practitioners to provide mental health services to their patients. Because of its focus on outcomes, we discuss that work in the next section of

this review. When primary care practitioners screen patients for mental disorders, they may improve their ability to recognize and diagnose these conditions, although there are concerns about the specificity and sensitivity of some of the instruments (Campbell 1987; Kamerow 1987). Federal guidelines for treatment of depression in primary care recommend that primary care physicians use medication and counseling, alone or in combination, to treat patients with symptoms of depression (Depression Guideline Panel 1993). While primary care physicians are major prescribers ~of minor tranquilizers and antidepressants, they may not have time to counsel patients with mental health problems (Gonzalez et al 1994; Hohmann et al 1991; Rost et al 1994).

While studies of integrated programs have not given much attention to the issue of *financing,* it is likely that billing practices and diversified revenue sources have had an effect on establishing and sustaining integrated programs. For example, a community health center may be able to use Section 330 grant funds to cover the overhead associated with mental health services, while using its status as a Federally Qualified Health Center to bill Medicaid and Medicare on a cost basis.

Effects

By effects, we mean the outcomes of integrating primary care and mental health services on *access, quality* and *cost* of mental health care. By creating a more rational system of health and mental health services, integration has the potential to increase access to health care for those who need it, improve quality of care overall, and result in more cost-effective use of services (Mechanic 1994; Morrissey et al 1982).

People with mental disorders tend to use health care services at higher rates than the general population (Goplerud 1981; Hankin and Oktay 1979). By making needed mental health services more readily *accessible,* integration should lead to reductions in the use of general health care services. Offset research, a method of evaluating the impact of mental health services on utilization of general medical care, has generally found this to be the case, although the focus on managed care settings in many of these studies may confound this finding (Jones and Vischi 1979; Mumford et al 1984; Wertlieb and Budman 1982).

Integration is also expected to increase the *quality* of mental health care in terms of patient satisfaction and cooperation, clinical outcomes and appropriateness of care. This effect seems to vary with the model of integration employed and the severity of the mental disorder. For example, there is considerable uncertainty about the ability of primary care practitioners to recognize, diagnose, and treat mental disorders effectively. One perspective argues that even when these practitioners receive specialized mental health training and use screening instruments, their skills may be inadequate to meet the needs of persons with chronic or severe mental health problems (Jones et al 1987; Kessler et al 1985; Mechanic 1990). Another point of view contends that primary care practitioners wi~th recent specialized mental health training, especially if that training focuses on a specific condition, are effective in recognizing, diagnosing, and treating that condition (Andersen and Harthorn 1990; Magruder-Habib et al 1990). To date, findings from studies of integration arrangements that involve consultation or linking between primary care practitioners and mental health specialists have been inconclusive and difficult to generalize (Gonzalez and Norquist 1994).

Overall *cost* and cost-effectiveness of health and mental health care have been dominant themes in health policy discussions for many years. While evaluations of linkage initiatives during the late 1 970s suggested that integration would lead to reductions in the cost of care and

improvements in its cost-effectiveness, such effects have not been documented (Broskowski 1 980). Providing needed specialty care to patients with mental disorders may reduce utilization and costs associated with general health care, but lead to higher overall costs due to increased utilization of mental health services (Borus et al 1985). In managed care programs, where even those patients with severe mental disorders are likely to receive care in the general health setting, costs are kept under control but clinical outcomes seem to worsen (Norquist and Wells 1991; Sturm and Wells 1995).

APPROACH

Overview

Our approach to this study reflected our four objectives. Initially, we had to *identify* those organized rural primary care providers that had undertaken specific initiatives to link or integrate mental health and/or substance abuse treatment services. This step was necessary because no inventory of these providers was available at the time[3]. Next, we sought to determine what *structural factors* facilitated or inhibited our respondents' ability to accomplish integration. Our survey included questions concerning aspects of organizational structure and history as well as policy environment and service area population. We also wanted to describe the *organizational characteristics* of these

[3] We were not able to obtain a list of Linkage Initiative grantees from the successors to the federal agencies which funded the program.

initiatives. Of particular interest to us were variations in scope of services, staffing, referral patterns, financing, and clinical practice. Finally, we used data from our survey to create a *typology of integration models* as the basis for future comparative research.

Identification of Subjects

We solicited nominations of eligible organizations from state and regional primary care associations, state hospital and rural health associations, other rural health research centers and primary care cooperative agreement grantees, as well as from the American Hospital Association, the American Psychological Association, the Office of Rural Health Policy, the National Association of Community Health Centers, the National Rural Health Association, the National Association for Rural Mental Health, the National Association of County Health Officials, and Group Health Association of America. Our intent was to generate a comprehensive list of organizations, broadly representative of geographic areas, organizational types, and integration models. Criteria for inclusion were that the nominee:

- be located in a rural area, or provide services to a significant[4] rural population;
- be an organized provider of primary care services, e.g., a community health center, rural health clinic, hospital-sponsored primary care satellite or outpatient clinic, public health department, group practice or health maintenance organization; and
- have undertaken specific program initiatives to establish linkages with mental health and/or substance abuse services or to integrate these services into the existing primary care program.

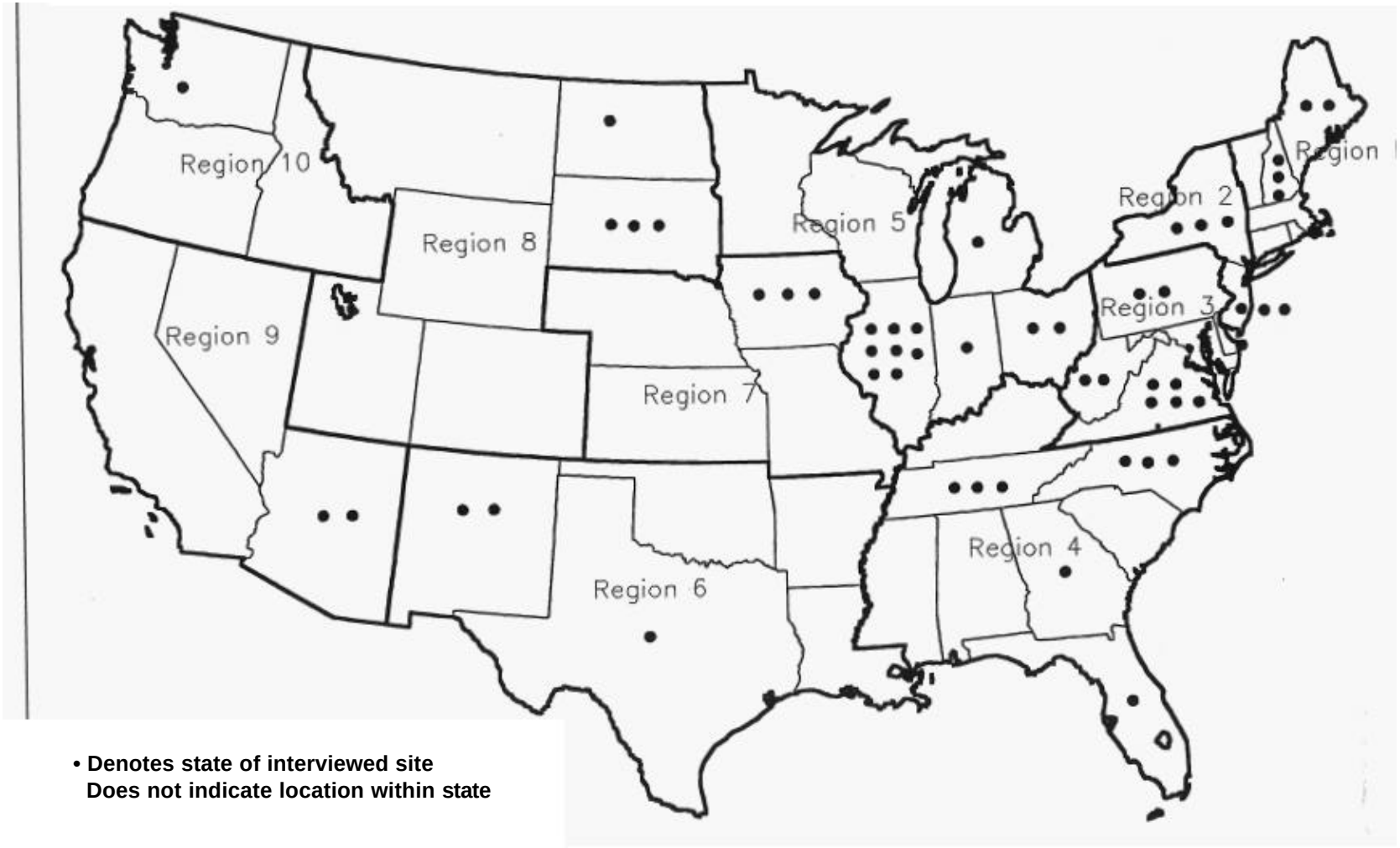
[4] We chose to allow our nominees to define the term significant. Generally, we took it to mean that at least half of the organization's patients resided in non-metropolitan areas.

We mailed requests for nominations in the summer of 1993 and followed up with telephone calls in an effort to increase responses. A number of nominators referred our requests to colleagues familiar with rural primary care providers; we accepted nominations from them, as well. We obtained a total of 11 4 unduplicated nominations from this process, including six primary care physicians in solo practice. Although we did not include solo practitioners in our selection criteria, we decided to include them in the study.

In the fall of 1993, we sent letters to the nominated organizations informing them of the study and inviting their participation. We followed this letter with a telephone prescreen survey, confirming each organization's eligibility and willingness to participate. Based on the pre-screen, 28 organizations did not meet our selection criteria, i.e. they provided no primary care services or did not serve a rural population. An additional six could not be reached despite persistent calls, and were dropped from the sample. Six eligible organizations refused to participate in the survey at the time of the prescreening call for an interview sample of 79.

We asked our initial contacts to provide us with the names of two persons, one most familiar with administrative and one with clinical aspects of the integrated program. In some instances, one individual with an adequate knowledge of both aspects was named. During the process of scheduling and conducting the interviews, we screened out an additional eight ineligible organizations for a final sample of 71. Another two decided not to participate and ten could not be reached or provided insufficient information. Ultimately, we completed telephone interviews with staff at 53 organizations in 22 states representing all ten DHHS regions (Figure 2). Their names and a brief description of their programs are listed in Appendix 2.

Figure 2: Integrated Models of Primary Care, Mental Health and Substance Abuse Treatment Services, Interviewed Sites by State and by USDHHS Region



• Denotes state of interviewed site
Does not indicate location within state

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Interview Instrument and Process

Our interview instrument included questions or elicited responses addressing all the elements shown in bold-face type in Figure 1. We relied primarily on closed-ended questions for ease of administering and coding. Questions were sufficiently general to accommodate the variety of possible models we expected to encounter. We conducted a pretest with one program administrator and two clinicians, using their feedback to make final revisions to the instrument. We asked the same questions of the clinical and administrative respondent at each participating organization, recognizing that the scope of responsibility for these roles might differ from site to site.

Copies of the instrument were mailed to respondents before the interview. A few respondents filled out the instrument and mailed it back to us. We conducted the rest of the interviews by telephone. In some instances, both respondents participated in the interview at the same time. In most cases, we spoke to them at different times, and completed separate instruments for each. We entered the responses from these pairs onto a single instrument prior to coding them for data analysis. When we observed differences in the two responses to a question, we used the response of that individual whose job responsibilities indicated the highest likelihood of accuracy. We assigned organizations, rather than individual respondents, to interviewers to assure reliability in recording information.

We encouraged interviewers to elicit and record responses that might elaborate or clarify replies to questions on the instrument. When necessary, we made follow-up telephone calls to respondents or individuals referred by them to obtain complete

information. Depending on the level of interaction between interviewer and respondent, interviews took 45 to 90 minutes to complete.

FINDINGS

Structural Factors

Organizational Structure

With regard to *organizational type,* over half of our respondents were community health centers (Table 1). These include multi-site organizations like Southern Ohio Health Services Network (Cincinnati, OH) and Presbyterian Medical Services (Santa Fe, NM), a consortium of three family medical practices (Robeson Health Care Corporation, Pembroke, NC), and a community health center linked with a migrant health center (Tri-County Community Health Center and Migrant Benevolent Association, Newton Grove, NC). This finding is consistent with the comprehensive definition of primary care that has been core to the mission of the community health center program since its inception. It also reflects continued federal emphasis on community health centers in integration initiatives. Thirteen percent were rural hospitals like Caylor-Nickel Medical Center (Bluffton, IN), which oversees five affiliated primary care satellites and an outpatient counseling center. Another 1 3 percent were public health departments, such as Lawrence County Health Department (Lawrenceville, IL), which is also a licensed mental health facility. The remaining participants included private physician practices, HMOs, and networks. For example, Drs. Robert and Richard Elghammer (Danville, IL) are a father and son practice providing pediatric medical care and child psychology services in east central

Illinois. The Johnson Clinic (Rugby, ND) operates the smallest HMO in the country, serving about 3500 enrollees from the town and surrounding areas.

Two-thirds of respondent organizations operated under private, non-profit *auspices,* while another 1 7 percent were state or local government entities, including public health departments and municipal hospitals (Table 1). Only three respondents were for-profit organizations. This mix may reflect the auspices typical of rural primary care providers.

We measured organizational *size* in terms of number of annual primary care visits, total full-time equivalent staff, and annual operating budget (Table 2). Respondents varied widely in number of visits reported. Over half experienced 20,000 or fewer visits in the most recent year; nearly twenty percent had fewer than 5,000 visits. At the same time, eight organizations had over 50,000 visits that year. We observed comparable variations in size when we examined total staff and total annual budgets. For the most part, organizations fell into the same size groupings across all measures; for example, Isabel Community Clinic (Isabel, SD), a community health center with a relatively small number of annual visits, had a correspondingly small staff and budget. Similarly Presbyterian Medical Services, with ten rural primary care sites, relied on a relatively large staff and budget to support its large overall annual visit load. Organizations using diversification as one approach to integration tended to be larger in terms of total staff and annual budget. That diversified organizations did not differ noticeably from others in terms of the number of primary care visits per year indicates that direct employment of mental health practitioners is not necessarily associated with volume of primary care.

Regarding organizational *complexity,* over a quarter of respondents (28 percent) told us they currently belong to a formal, legally constituted network, consortium, or other multi-organizational structure. Laurel Health Systems (Wellsboro, PA), for example, is a corporate affiliation of health and social service providers serving residents of five rural Pennsylvania counties. Union-Grainger Primary Care (Morristown, TN) participates in a network with Cherokee Health Systems, a mental health services provider. Because some respondents may have used a broader definition of network than ours, the actual number of formal networks represented in our study sample may be overstated. For example, one community health center spokesperson considered his state primary care association to be a network. On the other hand, some respondents who answered "no" to this question were joining or forming networks. Shenandoah Community Health Center (Martinsburg, WV) was actively engaged in consortium development at the time we spoke with staff there, while Central Virginia Community Health Center (New Canton, VA) has taken the lead in forming a network of community health centers. A number of other respondents indicated that they participate in informal networks.

Organizational Culture

Forty-eight respondents (over 70 percent) indicated that their organizational *mission* facilitated their decision to provide mental health or substance abuse treatment services. In this study, we used program duration as a measure of organizational *history.* Responding organizations had a mean age of 25 years. They had been providing primary care services for an average of 23 years, suggesting that primary care has historically been integral to their mission. Their current arrangements for providing mental health and substance abuse treatment services had been in place an average of nearly ten years,

indicating a considerable degree of stability in many programs. The nurse practitioner at Hall County Primary Health Care Clinic (Gainesville, GA) told us that the mental health clinic had been part of the county health department for as long as she could remember, and actually predated the primary care clinic. Southern Ohio Regional Health Services Network (Cincinnati, OH) has offered mental health services since 1 980, when the facility received a Linkage Initiative grant. Coos County Family Health Services (Berlin, NH) began providing substance abuse counseling to patients at its prenatal clinic in April 1994.

Leadership is another key aspect of organizational culture. Although we did not specifically ask about leadership, several respondents provided examples of individuals who played key roles in making integrated programs happen. The director at Johnson Clinic (Rugby, ND) recognized the need for mental health services and initiated the program by making telephone calls to recruit staff and establish referral arrangements. For the past eighteen years, Monroe Health Center (Union, WV) has been located in the same multi-purpose building as the local community mental health center satellite, greatly facilitating an informal relationship between the two organizations. A physician and the counselor who currently directs the community mental health center satellite in Monroe provided the leadership that prompted the necessary building renovations. The wife of the administrator at Decatur County Hospital (Leon, IA) led the movement to start the hospital's adolescent behavioral medicine unit when declining acute care occupancy motivated the hospital board to consider diversifying. Although many noted that some education was necessary to win over the skeptics, thirty-four respondents (64 percent) indicated that board members also provided leadership to bring about integration.

Resource Environment

Twenty respondent organizations (38 percent) noted significant problems finding adequate *space* for provision of services that require considerable privacy. The Saltville Medical Center (Saltville, VA), for example, stopped providing mental health services on site due to space limitations. The center director noted that patients were more likely to keep appointments when these services were provided at the center. Another eighteen respondents (35 percent) indicated that space availability facilitated their ability to provide mental health or substance abuse treatment services on site. Clinics affiliated with Stone Mountain Health Services (St. Charles, VA) provided private consultation rooms for workers from the area community mental health center in communities where such space is difficult to obtain.

We also measured resource environment in terms of availability of *specialty staff and services*. Given the well-documented shortage of specialty mental health professionals in mast rural areas, we expected that many rural primary care providers would have difficulty recruiting these staff. Although twenty respondents (38 percent) indicated that staff availability inhibited their efforts to provide mental health or substance abuse treatment services, another fifteen (28 percent) told us they had no problems finding qualified staff. Several respondent organizations were approached by mental health providers interested in placing staff at their sites. This happened at the Warrensburg Health Center of Hudson Headwaters Health Network (Warrensburg, NY), which was contacted by Catholic Charities in Glens Falls and now provides part-time clinic space for counselors from the mental health agency. Some respondents, like Marana Health Services (Marana, AZ) and Family Medicine Center (Amarillo, TX) address the

problem of staff availability by using family practice residents and externs from clinical psychology training programs.

Policy Environment

Responses to our questions about the effect of *reimbursement* on service integration were mixed. While sixteen respondents (30 percent) told us that Medicaid reimbursement inhibited their efforts to provide mental health or substance abuse treatment services, seventeen (32 percent) said it facilitated those efforts, and another ten (19 percent) said its effect was neutral. Medicare seemed to have a more negative than positive effect, with seventeen respondents (32 percent) calling it an inhibiting factor and only nine (17 percent) calling it a facilitating factor. These findings may reflect variations in Medicaid benefits for mental health and substance abuse treatment services among states and in the number of Medicare beneficiaries served by different responding organizations. A number of respondents noted that Medicaid and Medicare do not reimburse the masters' level counselors who often staff these programs. Organizations serving populations in multiple states observed that cross-state variations in reimbursement policies often affected staffing decisions. For example, Decatur County Hospital (Leon, IA), near the Iowa-Missouri border, uses a psychiatrist for patient assessments to satisfy Iowa Medicaid rules, but is required to use a psychologist for the same service if the reimbursement is from Missouri Medicaid. Over half of our respondents (55 percent) reported that their state did not have an insurance mandate requiring inclusion of mental health or substance abuse treatment services in the benefit package. Another 21 percent told us that the effect of the mandate was neutral, because most of their patients didn't have private insurance.

We asked about the effects of professional *ilcensure* on service integration, having read of problems experienced by rural clinicians traveling long distances in order to obtain continuing education credits necessary for certification (Clayton 1977). Only nine respondents (1 7 percent) noted negative effects from this factor, while sixteen (30 percent) indicated that these requirements actually facilitated their ability to provide mental health and substance abuse treatment services because of the link between licensing and reimbursement.

We also wondered if facility *certification* requirements might deter some primary care providers from offering on-site mental health or substance abuse treatment services. While twelve of our respondents (23 percent) were licensed mental health facilities, only three (6 percent) reported any negative effects related to this factor. Staff at Shenandoah Community Health Center (Martinsburg, WV) considered applying for certification as a behavioral health center, which would have made the facility eligible for reimbursement for case management services. They chose not to apply because of concerns about excessive paperwork and the required shift to a more "medical model" approach to psychotherapy. Another seventeen respondents (32 percent) told us the effect of licensing was neutral. This finding may reflect the high proportion of respondents (66 percent) that are Federally Qualified Health Centers eligible for cost-based Medicaid and Medicare reimbursement for the services of clinical psychologists and clinical social workers.

Another aspect of the policy environment that may affect service integration is *regulatory agency structure.* Coordination between the state agencies administering general health, mental health, and substance abuse treatment services may facilitate integration, while lack of coordination may inhibit it. While we asked no specific questions

about regulatory agency structure, some of our respondents offered pertinent observations. The director of Coos County Family Health Services (Berlin, NH) explained that the grant her center received for substance abuse counseling services represented a cooperative effort of the state agencies administering maternal and child health and substance abuse treatment services. Our respondent from Presbyterian Medical Services (Santa Fe, NM), on the other hand, observed that lack of coordination between the state entities administering funding for health and mental health services inhibits her agency's integration efforts.

Service Area Population

Given the issue of stigma often mentioned in the literature on rural mental health services, we anticipated that many organizations providing integrated services would experience problems gaining community acceptance. Remarkably, half of our respondents reported that community *attitudes* favorably influenced their integration efforts. The administrator at Decatur County Hospital (Leon, IA) explained that, while community members were initially suspicious of the adolescent behavioral medicine unit, over time they came to accept it, and eventually helped to support it with corporate and individual donations. Another twelve (23 percent) described community attitude as neutral, often noting that they prefer to keep a low profile. The director of Coos County Family Health Services (Berlin, NH), for example, told us that, in order to offer substance abuse counseling to low-income pregnant women in a non-threatening way, the center planned to give the counselor a title like "community educator."

Organizational Characteristics

Models of Integration

We identified four models of integration, which appear to exist in combination rather than as pure types (Table 3). *Diversification* involves the primary care organization directly hiring staff to provide mental health and/or substance abuse treatment services on site. *Linkage* occurs when the primary care organization arranges to have an independent practitioner or an employee of another organization provide mental health or substance abuse treatment services on site. *Referral* entails a variety of formal and informal arrangements to assure that off-site mental health or substance abuse treatment services are available to primary care patients who need them. *Enhancement* refers to the training of primary care practitioners to improve their ability to recognize, diagnose, and treat mental health and substance abuse problems independently.

Every organization participating in our study used referral as an integration approach. Sixteen organizations (30 percent) used a combination of diversification, linkage, and referral approaches. Twenty-one (40 percent) relied on diversification and referral, while eight (15 percent) used linkage and referral. Another eight provided mental health and substance abuse treatment services through referral only[5].

Scope

With regard to scope of services, half of our respondents did not limit their mental health or substance abuse treatment services to particular *populations* (Table 4). When they existed, population restrictions were imposed by funders or reflected limitations in

[6] Our survey did not include questions about enhancement. In another research project, the Maine Rural Health Research Center is surveying primary care practitioners in one state in an effort to learn more about the enhancement of their mental health skills and knowledge in treating depression.

practitioner skills or preferences. Substance abuse treatment and prevention services at Blue Ridge Community Health Services (Hendersonville, NC) focused on the needs of pregnant and postpartum women and their children because of priorities set by the funder, the U.S. Center for Substance Abuse Prevention. Sacopee Valley Health Center (Kezar Falls, ME) had problems finding local practitioners willing to treat children, especially Medicaid eligible children.

Most respondent organizations treated a wide range of mental health and substance abuse *conditions,* whether directly, by referral, or through a combination of both strategies. They were as likely to treat patients with chronic or severe mental illness directly as they were to refer them to available specialty providers. They likewise offer a range of *services* either directly, by referral, or through a combination of both strategies. Services most likely to be offered directly included individual and family counseling and outreach and community education. Group counseling was somewhat less likely to be offered directly. The director of the community mental health center satellite affiliated with Monroe Health Center (Union, WV) noted that he avoids using group therapy in a town where everyone knows everyone else. Services most likely to be offered by referral only included self-help groups (e.g. Alcoholics Anonymous), alcohol or drug detoxification, day treatment, acute hospitalization, and residential care.

Staffing

A diverse *composition* of practitioner types were involved in providing mental health and substance abuse treatment services to patients at respondent organizations through diversification, linkage, or enhancement arrangements (Table 5). In addition to the types listed in the table, Lake Powell Medical Center (Page, AZ) and Frances Nelson Health

Center (Champaign, IL) used lay outreach workers to provide counseling services. While primary care physicians appeared to be the principal practitioner type providing these services, their actual role varied considerably from site to site and from physician to physician. The medical director for Manning Family Recovery Center (Manning, IA) provided chemical dependency services to patients as part of his primary care practice. Family practice residents staffing the Family Medicine Center (Amarillo, TX) became actively involved in treating patients with mental disorders. Primary care physicians at the Lewistown Clinic of Geisinger Health Plan (Danville, PA) assessed the mental health needs of patients before referring them to the clinic's staff counselor. At the Family Medical Clinic (Drakes Branch, VA), a primary care physician supervised the work of an unlicensed social worker. Organizations using diversification as an integration approach were more likely than others to engage the services of a psychiatrist, PhD-level psychologist, psychiatric nurse, or certified alcohol and substance abuse counselor.

With respect to *location,* half of respondents provided mental health or substance abuse treatment services on site. Another eighteen (34 percent) offered services on site and through affiliates elsewhere, while eight respondents offered services exclusively off site. The twenty-six organizations providing services off site used providers an average distance of 10-27 miles away (Table 6)6. These distances do not include service providers to which respondents might make occasional referrals. For example, the Johnson Clinic (Rugby, ND) refers patients in need of alcohol detoxification to a facility in Bismarck, nearly 200 miles away. Patients of Family Health Center of Columbia County

[6] Since most organizations used more than one integration strategy, services offered off site may represent diversification, linkage or referral relationships.

(Lake City, FL) who require psychiatric hospitalization must travel to Gainesville (45 miles away) or Jacksonville (60 miles away).

Findings regarding *accountability* of staff providing mental health and substance abuse treatment services showed that staff employed directly by primary care providers were generally supervised by other staff of the primary care organization. Those who provided on-site coverage through a linkage arrangement were supervised by staff of the mental health or substance abuse treatment provider. Occasionally, these practitioners were independent contractors. This was the case for the substance abuse treatment counselor working for Coos County Family Health Services (Berlin, NH).

Referrals

Primary care physicians were the primary *source* of inside referrals to mental health or substance abuse treatment services. Most organizations also received outside referrals from schools, law enforcement agencies, clergy and family members. Several respondent organizations explained that the relatively low frequency of outside referrals from other mental health professionals and other health care facilities was due to the lack of these services in their communities.

Most respondents favored informal methods of patient *information transfer* (Table 7). Face-to-face and telephone conversations were used most often, although thirty-nine respondents (74 percent) conducted case conferences. A number made frequent use of fax machines in forwarding chart sections or referral notes to other providers. Some respondents noted that they were prohibited by state law from using common charts for physical and mental health. Generally speaking, those organizations that used diversification as an integration approach were more likely to use a common chart. Most

respondents assured us that patient information transfer is only done with written consent of the patient.

Clinical Practice

Primary care practitioners at thirty respondent organizations (57 percent) used *screening* instruments to help them detect mental health or substance abuse problems. Some used standard instruments, such as the General Health Questionnaire or the Beck Depression Scale, although a number had developed their own or included questions related to mental health and substance abuse in their general medical history forms. In over 85 percent of responding organizations, primary care practitioners prescribed psychotropic *medications* to patients whose conditions warranted their use. Over three quarters indicated that primary care physicians did the prescribing; fourteen (26 percent) said that physicians' assistants prescribed; while only seven (13 percent) attributed that responsibility to nurse practitioners. These variations reflected staff composition of the integrated programs as well as scope of practice regulations specific to each state. Seventy percent of respondents reported that they had readily available *consultation* to assist them in prescribing psychotropic medications. Many described formal or informal agreements with psychiatrists for telephone consultation, although some experienced delays in receiving needed advice.

Financing

Most respondent organizations (68 percent) billed directly for the mental health or substance abuse treatment services they provided directly. Other *billing* arrangements were more likely to be found when the integration model was linkage. Major *revenue sources* for these services included Medicaid, self-payment on a sliding fee basis, and

private insurance (Table 8). Bucksport Regional Health Center (Bucksport, ME) used enhanced Medicaid and Medicare reimbursement resulting from FQHC certification to hire a full-time licensed clinical social worker. A number of organizations received federal, state, or local funds. Isabel Community Clinic (Isabel, SD) used a Rural Outreach Grant from the federal Office of Rural Health Policy to cover some of the costs of obtaining part-time services from a psychologist and a drug and alcohol abuse counselor who traveled from a community mental health center seventy-five miles away. In Illinois, the state provided funds to support mental health and substance abuse treatment services offered through the county health departments. Hunterdon Medical Center (Flemington, NJ) received county funds for its youth services program.

CONCLUSIONS

Interest in integrating mental health and substance abuse treatment services into rural primary care has persisted over the years, despite the lack of substantive knowledge about them. Increased emphasis on managed care and the accelerated growth of rural health networks are prompting a renewed interest in this approach. Our research confirms that various models of service integration already exist in rural America. While not exhaustive, our inventory of integrated programs suggests the range of possible approaches to linking mental health and substance abuse treatment services to rural primary care. Our taxonomy of models provides a relatively straightforward way to organize this complexity. Our analytical framework outlines aspects of integration that are readily amenable to study. Further research on integration is needed to determine how this service delivery strategy might be expanded and enhanced and whether it should be. Some possible fruitful avenues for research and policy development are described below.

In the course of conducting our study, we identified a number of structural factors likely to be responsive to policy intervention, including availability of specialty staff and services, reimbursement, licensure/certification, transportation, telecommunications, and state agency structure. The relative impact of these factors on various organizational structures and cultures, and on various service area populations, remains to be determined.

Our findings suggest that a considerable number of integrated programs are joining or forming networks. We have limited understanding, however, of why some programs choose to affiliate with networks, and why some networks include mental health and substance abuse treatment services while others do not.

We observed that primary care physicians may play a number of different roles in handling mental health and substance abuse problems. Follow-up studies could further delineate those roles and determine how such factors as availability of specialty staff and services, reimbursement, and practitioner training and attitude affect them.

This descriptive study has demonstrated that structural factors and organizational characteristics vary among integration models and among sites, and that many of these can be quantified. An analysis of the effects of integration on access, quality, and cost of care, while beyond the scope of this study, is implied by our conceptual framework. Our framework suggests that access might be measured in terms of availability, utilization, and comprehensiveness; quality in terms of clinical outcomes and patient satisfaction; and cost in terms of efficiency and cost-effectiveness. Such an analysis would help policy makers understand how and to what extent these models of integration should be encouraged by means of policy initiatives.

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APPENDIX 1

Tables

Table 1
Participating Organizations

	Number	Percent
Organizational Type		
Community Health Center	29	55
Hospital	7	13
Public Health Department	7	13
Private Physician Practice	2	4
Other (includes HMOs and Networks)	8	16
Total	53	101
Auspices		
Private Non-profit	35	66
Private For-profit	3	6
State, Local Government	9	17
DK or Missing	6	11
Total	53	100

Note: Percents do not sum to 100 due to rounding.

Table 2
Participant Size

Number of Visits per Year	Number	Percent	Diversification* Number	Diversification* Percent	No Diversification * * Number	No Diversification * * Percent
Under 5000	10	19	6	16	4	25
5,001 -20,000	19	36	12	32	7	44
20,001 -50,000	10	19	9	24	1	6
More than 50,000	8	15	5	14	3	19
DK or Missing	6	11	5	14	1	6
FTE Staff						
25 or less	19	36	8	22	11	69
26-100	21	40	17	46	4	25
More than 100	10	19	10	27	0	0
DK or Missing	3	6	2	5	1	6
Annual Operating Budget						
$1,000,000 or less	16	30	8	22	8	50
$1,000,001 - $5,000,000	20	38	14	38	6	37
$5,000,001 - $20,000,000	6	11	6	16	0	0
More than $20,000,000	3	6	3	8	0	0
DK or Missing	8	15	6	16	2	13
Total	53	100	37	100	16	100

Table 3
Models for Integrating Primary Care with Mental Health and Substance Abuse Services

Model	Practitioner Providing MH Service	Site Where MH Service is Located	Organization Billing for MH Service
Diversification	MH	PC	PC
Linkage	MH	PC	MH
Referral	MH	MH	MH
Enhancement	PC	PC	PC

Table 4

Scope of Mental Health and Substance Abuse Services Offered by Participants

Conditions Treated	Direct Only		Referral Only		Both	
	#	%	#	%	#	%
Chronic or Severe Mental Illness	20	38	21	40	10	19
Serious Family Problems, e.g. spouse or child abuse	29	55	13	25	11	21
Substance Abuse	26	49	20	38	7	13
Situational or Life Circumstances, e.g. bereavement	33	62	11	21	8	15
Organic Conditions	18	34	15	28	12	23
Service Type						
Individual Counseling	28	53	17	32	7	13
Group Counseling	26	49	19	36	4	8
Family Counseling	29	55	15	28	7	13
Self-Help Groups	9	17	35	66	4	8
Alcohol or Drug Abuse Counseling	26	49	20	38	6	11
Alcohol or Drug Detox	6	11	39	74	2	4
Day Treatment	10	19	30	57	1	2
After Care	21	40	17	32	8	15
Community Support	16	30	24	45	3	6
Acute Hospitalization	10	19	37	70	2	4
Residential Care	8	15	39	74	0	0
Emergency/Crisis Services	26	49	15	28	10	19
Outreach/Community Education	28	53	15	28	5	9
Services Limited to:	#	%				
Children 12 and Under	9	17	Percentages shown do not sum to 100% because participating organizations may treat several conditions, offer several types of service, and limit services to more than one special population.			
Adolescents Age 1 3-1 9	7	13				
Pregnant Women	6	11				
People Aged 65 +	2	4				
People with Diagnosed Mental Illness	8	15				
Substance Abusers	10	19				
Services not Limited to Specific Populations	27	51				

Table 5
Average Number of Staff FTEs Involved in Provision of Mental Health or Substance Abuse Treatment Services

Type of Staff	Average FTEs
Primary Care Physician	2.3
Physicians' Assistant	0.4
Nurse Practitioner	0.5
Psychiatrist	0.3
PhD Psychologist	0.5
Masters' Level Psychologist	0.5
Licensed Clinical Social Worker	0.7
Masters' Level Social Worker	0.8
Psychiatric Nurse	0.9
Certified Alcohol/Substance Abuse Counselor	1 .0

Note: Includes only those staff employed by or working at the site of the respondent organization.

Table 6
Off-site Locations Where Associated Mental Health And Substance Abuse Treatment Practitioners Work

LOCATION	NUMBER	PERCENT*	AVERAGE DISTANCE (Miles)
Acute Care Hospital	12	46	10
Psychiatric Hospital	6	23	27
Community Mental Health Center	16	62	10
Alcohol or Drug Abuse Treatment Program	16	62	10
Private or Public Social Service Agency	9	35	15
Private Practice	9	35	14
Satellite Office of Respondent Organization	12	46	24

Note: percentages calculated on a base of 26, the number of organizations indicating that associated staff work at off-site locations.

Table 7
Method of Patient Information Transfer

METHOD	NUMBER	PERCENT
Common Chart	16	30
Chart Transfer	34	64
Case Conference	39	74
Paper Memo or Note	35	66
Computer Memo	4	8
Face-to-Face Conversation	47	89
Telephone Conversation	45	85

Note: Percents do not add up to 1 00 because many organizations use multiple strategies.

Table 8
Major* Sources of Revenue for Mental Health and Substance Abuse Treatment Services

SOURCE	NUMBER	PERCENT
Self-Pay Full Fee	21	40
Self-Pay Sliding Fee	28	53
Private Insurance	31	59
Medicare	23	43
Medicaid	38	72
Workers' Compensation	11	21
Federal Grants	22	42
State Grants	21	40
County or Local Grants	11	21

* *Major defined as 10 percent or more of total revenues.*

Note: Percents do not add up to 100 because all organizations receive funding from mukiple sources.

APPENDIX 2

Directory of Participating Organizations

Directory of Participating Organizations

NOTE: Organizations are listed in alphabetical order first by state, then by town. In most instances, program status, contact names and telephone numbers are current as of November 1 994.

MARANA HEALTH CENTER
13644 N. Sandario Road • Marana, AZ 85238 • 602-682-4111
Administrative Contact: Ora Hahn, Executive Director
Clinical Contact: Susan Dalton, MD

Marana is a primary care clinic located approximately twenty miles northwest of Tucson. Primary care services are provided by students from the family practice residency program at Tucson General Hospital. Externs in the PhD psychology program at the University of Arizona provide mental health services on site. The clinic also provides case management services for the mentally ill, as well as a variety of social support services including low-income housing, a food bank and home-delivered meals.

LAKE POWELL MEDICAL CENTER
467 Vista Avenue P0 Box **1625 • Page, AZ 86040 • 602-645-8123**
Administrative Contact: Sarah Kramer, Executive Director
Clinical Contact: Same

Lake Powell Medical Center is a community health center that uses lay outreach workers to provide a variety of services, including basic counseling, child abuse prevention, and hea'th education, to the area's largely Navajo population. Patients with more complex mental health needs are referred to the Lake Powell Mental Health Agency, which also provides consultation on prescription of psychotropic medications to the center's primary care physicians.

NANTICOKE MEMORIAL HOSPITAL
801 Middleford Road • Seaford, DE 19973 • 302-629-2100
Administrative Contact: Fran Brolle, Program Director, Behavioral Health Unit
Clinical Contact: Same

Nanticoke Memorial Hospital is a 120-bed community hospital which operates a worksite wellness program, a prenatal care program, and a behavioral health unit with in- and outpatient mental health and substance abuse treatment services. The hospital also leases office space to several affiliated primary care physicians. The primary care physicians occasionally refer patients to the behavioral health unit$_1$ although the referral relationship is very informal. The director of the behavioral health unit is trying to convince the staff at the prenatal care program to make more regular use of the behavioral health resources available to them.

FAMILY HEALTH CENTER OF COLUMBIA COUNTY
P0 Box 249 • Lake City, FL 32056 • 904-755-5685
Administrative Contact: Edwina Dees, Executive Director
Clinical Contact: Frederick Peterson, MD, Medical Director

This is a community health center affiliated with the College of Medicine at the University of Florida. Many of the low income people served by the center experience low level depression or anxiety, or have problems with drug or alcohol abuse. The center employs no specialty mental health or substance abuse treatment practitioners; however, its primary care practitioners provide basic counseling to patients on an as-needed basis. Referrals are made to private psychiatrists in the area, as well as to the local community mental health center and substance abuse treatment program. Individuals requiring long-term hospitalizations must go to facilities in Gainesville (45 miles away) or Jacksonville (60 miles away).

HALL COUNTY PRIMARY HEALTH CARE CLINIC
P0 Box 1295, 1131 Vine Street • Gainesville, GA 30503 • 404-535-5743
Administrative Contact: Alice Martin, Family NP
Clinical Contact: Same

The state of Georgia provides funds to support a family nurse practitioner who operates this primary care clinic within a county health department. Her work is supervised by a general practice physician who spends one day a week at the clinic. The clinic is also the recipient of a Ryan White grant to provide HIV testing, counseling, and treatment. The county health department is informally linked to a state-funded mental health facility, to which the family nurse practitioner refers patients with mental health problems. The clinic's caseload is comprised of medically indigent patients, many of whom are Medicaid recipients.

DECATUR COUNTY HOSPITAL
1405 NW Church Street • Leon, IA 50144 • 515-446-4871
Administrative Contact: Neil Davenport, Administrator
Clinical Contacts: Mark Easter, DO, Medical Director
Barb Campbell, RNC, Administrative Coordinator

This county-run acute care facility established an adolescent behavioral medicine unit in 1 987. The unit provides in- and outpatient behavioral health services to children and adolescents up to age 18 from southern Iowa and northern Missouri. Referrals come from community-based primary care and mental health practitioners, schools, the state Department of Human Services, and the courts. A general practice physician from the community serves as part-time medical director of the unit. Other staff include a part-time psychiatrist and a part-time psychologist (both are necessary to satisfy varying reimbursement regulations of the two states), licensed social workers, bachelor's level behavioral associates, nurses, a recreational therapist, and teachers. The unit specializes in treating behavior and mental disorders and working with victims of child abuse or incest and their families.

MANNING FAMILY RECOVERY CENTER
410 Main Street • Manning, IA 51455 • 712-653-2072
Administrative Contact: Danny Garvis, Administrative Director
Clinical Contact: Hunter J. Hansen, DO, Medical Director

Manning Family Recovery Center is a chemical dependency unit at Manning Hospital. Its medical director provides primary care and outpatient chemical dependency services at three nearby sites. He also employs a nurse who teaches smoking cessation classes. A PhD psychologist from Des Moines spends one day a week with him, seeing patients at two sites. If he needs consultation in prescribing psychotropic medications, he calls a psychiatrist at another hospital which has a psychiatric unit.

SPENCER MUNICIPAL HOSPITAL
114 East 12th Street • Spencer, IA 51301 • 712-264-6111
Administrative Contact: Jim Striepe, Administrator
Clinical Contact: Cindy Nelson, Nurse Manager

This municipal hospital, located in northwest Iowa, provides primary care through its emergency room and operates an inpatient adult mental health unit. Persons needing outpatient mental health care may be treated at the hospital or referred to the community mental health center or alcohol and drug abuse treatment facility located in the same town.

FRANCES NELSON HEALTH CENTER
1306 N. Carver Drive • Champaign, IL 61820 • 217-356-1558
Administrative Contact: Robert Boone, MD, Medical Director
Clinical Contact: Same

Located in an urban area, this community health center serves the surrounding rural communities, as well. Two social workers on staff handle a variety of counseling services, including mental health. An outreach worker also does some informal counseling. These services are supported by a combination of Medicaid reimbursement, the health center's federal grant, and a subsidy from the Champaign County Mental Health Board. Patients with more complex mental health needs are referred to the community mental health center in town.

W. ROBERT ELGHAMMER, MD AND RICHARD W. ELGHAMMER, PHD
723 North Logan • Danville, IL 61832 • 217-446-3259
Administrative Contact: W. Robert Elghammer, MD
Clinical Contact: Richard W. Elghammer, PhD

This is a father and son team in private practice near the Indiana border. Dr. Elghammer senior is a pediatrician; his son is a clinical child psychologist who works in the office and also provides free programs to local schools and youth agencies on subjects such as parenting, child abuse, depression and coping with stress. They have submitted an application to become a rural health clinic in an effort to improve their reimbursement situation.

EGYPTIAN HEALTH DEPARTMENT
Rt. #3 Box 90-A • Eldorado, IL 62930 • 618-273-3326
Administrative Contact: Cathy Taylor, Director of Nursing
Clinical Contact: Dorothy Smith, RN

This county public health department offers comprehensive mental health services and primary care case management services for AFDC and medically indigent pregnant women and children up to age 3. These services are funded by Medicaid, state mental health grants, and local and county tax revenues.

BOND COUNTY HEALTH DEPARTMENT
503 South Prairie • Greenville, IL 62246 • 618-664-1442
Administrative Contact: Maxine Barth, Public Health Administrator
Clinical Contact: Rita Miller, Director Mental Health

This county public health department added basic mental health services in 1 975 in response to unmet community need for these services. They remain the only mental health provider in the county. Public health nurses provide limited primary care services, including immunizations and case management for pregnant women and young children. The department employs a social worker, an art therapist, and three other counselors with at least master's level training, and has contractual arrangements with a hospital 60
miles away for psychiatric coverage.

LAWRENCE COUNTY HEALTH DEPARTMENT
RR #3 Box 414 • Lawrenceviile, IL 62439 • 618-943-3302
Administrative Contact: Sylvia L. Pulleyblank, Public Health Administrator
Clinical Contact: Judy Wissel, Mental Health Department

This county health department is a licensed mental health facility, employing a master's level social worker, two psychiatric nurses, and five counselors. The state of Illinois provides some funds for the mental health services under a contractual arrangement; services are also funded by Medicaid and patient fees.

GRUNDY COUNTY HEALTH DEPARTMENT

1320 Union Street • Morris, IL 60450 • 815-941-3400

Administrative Contact: Shelly Ebbert, Public Health Administrator

Clinical Contact: Mike Costello, Division Director of Mental Health

Grundy County Health Department is a county health agency that provides a range of public health services including immunizations and influenza vaccines, home, school and correctional facility nursing, screenings and environmental health. Like other county health agencies in Illinois, Grundy County Health Department receives state funds enabling on-site provision of mental health and substance abuse treatment services.

WABASH COUNTY HEALTH DEPARTMENT

130 West Seventh Street • Mt. Carmel, IL 62863 • 618-263-3873

Administrative Contact: Michael P. Henry, Public Health Administrator

Clinical Contact: Cynthia Brown, Clinical Coordinator, Counseling Services

This is a county public health agency that provides limited primary care, along with on-site counseling and case management services to individuals with mental health and substance abuse problems.

CAYLOR-NICKEL MEDICAL CENTER

One Caylor-Nickel Square • Bluffton, IN 46714 • **219-824-3500**

Administrative Contact: Bill Brockmann

Clinical Contact: Ted Ramsey

Caylor-Nickel Medical Center is a northern Indiana hospital with five affiliated primary care satellites and an outpatient counseling center. The social worker who staffs the counseling center provides basic mental health and substance abuse counseling services to individuals, groups, and families. Patients whose needs are more complex are referred to psychiatrists also affiliated with the medical center. The hospital
previously offered more comprehensive substance abuse treatment services, but discontinued these because of problems with excessive regulation and paperwork.

BUCKSPORT REGIONAL HEALTH CENTER

P0 Box 447 • Bucksport, ME 04416 • 207-469-7371

Administrative Contact: Jack Corrigan, Executive Director

Clinical Contact: Max Goode, LCSW

This community health center serves a number of eastern Maine communities near Bangor. Recognizing a critical need for on-site mental health services, the center director utilized enhanced Medicaid and Medicare reimbursment obtained when the center obtained FQHC status to hire a full-time male social worker. Now this employee’s time is fully utilized, and the director is hoping to hire a part-time female with counseling skills.

SACOPEE VALLEY HEALTH CENTER

RR1 Box 6 • Kezar Falls, ME 04047 • 207-773-0807
Administrative Contact: Margaret Roy, Executive Director
Clinical Contact: Neil Korsen, MD, Medical Director

This community health center rents on-site space to a part time counselor who is employed by a community mental health center in a nearby town. The counselor accepts referrals from health center staff and makes her own appointments. The community mental health center bills third-party carriers for her services. The health center recognizes the need for additional counseling staff and is actively seeking to expand these arrangements.

STERLING AREA HEALTH CENTER

725 East State Street P0 Box 740 • Sterling, Ml 48659 • 517-654-2491
Administrative Contact: Roger Rushlow, Executive Director
Clinical Contact: Michael Ossian, Psychiatrist

This community health center provides comprehensive substance abuse treatment services supported by a state grant, and also employs a psychiatrist who provides mental health services. Although the psychiatrist is a full-time employee at the center, he spends part of his time doing contract work for a community mental health center in a neighboring town.

BLUE RIDGE COMMUNITY HEALTH SERVICES, INC.

P0 Box 5151 • Hendersonville, NC 28793 • 704-692-4289 Ext. 226
Administrative Contact: Leigh Stanton, Assistant Administrator
Clinical Contact: Beverly Kelly, Director, Substance Abuse Prevention Program

This community health center shifted from seasonal migrant worker services to full-time, year-round services to the community in 1988. A half-time master's level psychologist handles general counseling and makes referrals to specialty mental health providers. The center has a grant from the Center for Substance Abuse Prevention to offer substance abuse screening and treatment as well as case management to pregnant women and mothers with children up to age 5. Services are provided on site, as well as at two health center satellite locations and in the homes of patients.

TRI-COUNTY COMMUNITY HEALTH CENTER
P0 Box 237 • Newton Grove, NC 28366 • 910-567-6194
Administrative Contact: J. Michael Baker, MPH, Executive Director
Clinical Contact: Laura Aponte, MSW

This is a community and migrant health center located in eastern North Carolina, about 40 miles southeast of Raleigh. A National Health Service Corps social worker still employed by the center started its on-site mental health program ten years ago. Substance abuse treatment services were started five years ago, with state funding. The center has recently expanded substance abuse treatment to include intensive outpatient services as well as a half-way house for male farm-workers.

ROBESON HEALTH CARE CORPORATION
P0 Box 1629 • Pembroke, NC 28372 • 919-628-5200
Administrative Contact: Jennie Lowery, Executive Director
Clinical Contact: Ann Clegg, Clinic Director

Robeson Health Care Corporation is a rural community health center consortium located in southeastern North Carolina. Robeson is also licensed as an outpatient substance abuse treatment center. In the late 1980s, the consortium applied for and received funds from a number of federal and state sources to improve overall linkage with area mental health services providers and to undertake a substance abuse prevention program aimed specifically at pregnant and postpartum women. In addition to these services, the consortium offers developmental disabilities screening services for 0-3 year olds, a case coordination program for children aged 12 and under, and services for juveniles referred by the court system.

JOHNSON CLINIC, PC
POBox315 • Rugby, ND 58368 • 701-776-5235
Administrative Contact: Judy Jelsing, Administrator
Clinical Contact: none available at time of last contact

The smallest HMO in the United States, Johnson Clinic is a for-profit health center with four non-profit FQHC satellites, all located in north central North Dakota (Rugby is the geographic center of the North American continent). A full-time social worker provides mental health services at the central clinic and the remote sites. A psychiatrist from Minot, about 60 miles west of Rugby, works at the clinic twice a month and oversees medications and treatment plans. A chemical dependency counselor employed by the hospital in Rugby spends a half day a week at the clinic, which also makes referrals to him at the hospital.

COOS COUNTY FAMILY HEALTH SERVICES
54 Willow Street • Berlin, NH 03570 • 603-752-2040
Administrative Contact: Adele Woods, Executive Director
Clinical Contact: Elaine Davis, Substance Abuse Coordinator

Coos County Family Health Services formed out of the merger of a family planning program and a maternal and child health program. Until the end of 1 993, when the organization received a Section 330 community health center grant, services were limited to women's reproductive care. At about the same time, the organization received a state grant enabling arrangements to be made for a certified alcohol and drug abuse counselor to spend 1/2 day a week in the prenatal clinic. This service was scheduled to start up in April 1994. The organization also operates a domestic violence shelter, and provides counseling services related to serious family problems.

AMMONOOSUC FAMILY HEALTH SERVICES
6 Mt. Eustis Road • Littleton, NH 03561 • 603-444-2464
Administrative Contact: Norrine Williams, Executive Director
Clinical Contact: Phyllis Towle, Clinical Social Worker

Since its inception in 1975, this multi-service agency has offered mental health services to its patients through a combination of direct staffing and informal referral relationships with a community mental health center about a mile away. These services are mandated by and paid for by the state of New Hampshire. The agency became a federally-funded community health center in 1994 and includes a network of primary care centers located in Littleton, Woodsville, and Warren.

LAMPREY HEALTH CARE
207 South Main Street • Newmarket, NH 03857 • 603-659-2494
Administrative Contact: Ann Peters, Executive Director
Clinical Contact: Priscilla Shaw

Lamprey Health Care is a community health center located in southeastern New Hampshire with a satellite office in the town of Raymond, a few miles to the west of the main site. In the late 1 970s, Lamprey Health Care received a Linkage Initiative grant and had a formal relationship with Seacoast Mental Health Center. That arrangement became less formal after program funding ended. At the time the survey was conducted, an MSW from Seacoast worked as Lamprey 1 1/2 days a week, seeing mostly child and family cases. The center is in the process of working out a more formal cooperative agreement with Seacoast, which would involve full-time MSW coverage. Lamprey makes referrals to Seacoast and to a few private specialty mental health providers who accept sliding fee patients.

COMMUNITY HEALTH CARE
105 Manheim Avenue P0 **Box 597** • Bridgeton, NJ 08302 • 609-455-7844
Administrative Contact: Carol Martin, Executive Director
Clinical Contact: Lori Talbot, MD, Medical Director

Community Health Care is a community health center affiliated with a general acute care hospital and three school-based health clinics. The hospital has an inpatient unit for adults and adolescents. The school-based health clinics utilize mental health as well as primary care practitioners and are grant funded. The health center employs a social worker who provides basic mental health and counseling services to patients on-site.

HUNTERDON MEDICAL CENTER
2100 Westcott Drive • Flemington, NJ 08822 • 908-788-6151
Administrative Contact: Lawrence Grand, Chief Operating Officer
Clinical Contact: Diana Koziupa, Chair, Dept. of Psychiatry

Hunterdon Medical Center is a hospital which established a community mental health center over 20 years ago. The CMHC offers outpatient psychological services, a day hospital, crisis intervention and emergency services, substance abuse treatment services, inpatient psychiatric care, and special services for children and adolescents. Affiliated primary care physicians (who are not on the Hunterdon Medical Center payroll) regularly refer to the CMHC's various programs.

SOUTHERN JERSEY FAMILY MEDICAL CENTERS
879 Twelfth Street • Hammonton, NJ 08037 • 609-567-0200
Administrative Contact: Linda Flake, Executive Director
Clinical Contact: Nancy Merle, MD, Medical Director

Southern Jersey Family Medical Centers receives federal funding as both a community and a migrant health center. Most mental health and substance abuse treatment services are available by referral only. SJFMC has a formal arrangement with Atlantic Mental Health to provide addiction counseling on-site for pregnant women. The health center also has an LCSW on staff to provide initial assessment and on-going counseling services to patients.

HEALTH CENTERS OF NORTHERN NEW MEXICO
152 N. Railroad • Espanola, NM 87532 • 505-753-7218
Administrative Contact: Lucille Montoya, Administrative Services Director
Clinical Contact: Fred Ochsner, MD, Medical Director

This is an FQHC/CHC operating nine clinic sites in rural northern New Mexico. One of the sites is across the street from a state mental hospital, and has formal and informal relationships with that facility. Another site is in the same building as a community mental health center; staff are trying to develop more active relationships with this provider. Our respondents report problems working with mental health agencies due to the state's focus on providing services to chronically or severely mentally persons. The system employs two social workers and two health educators who provide some mental health services.

PRESBYTERIAN MEDICAL SERVICES
P0 Box 2267 • Santa Fe, NM 87501 • 505-982-5565
Administrative Contact: Judy Enright, Vice President
Clinical Contact: Bill Belzner

Presbyterian Medical Services operates a comprehensive health and human services delivery system with community health centers in ten rural sites, some of which have obtained FQHC status. Two of the satellites offer mental health services directly; one (at Farmington) has a mental health and substance abuse treatment program fully integrated with primary care services. PMS also operates two freestanding mental health centers which serve chronically mentally ill people. Our respondent noted that integration is difficult in New Mexico because the state entities administering funding for mental health and general health services function as independent divisions. Services to the mentally ill require significant resources from both the financial and manpower perspective which are currently severely limited.

GOWANDA MEDICAL CENTER
100 Memorial Drive • Gowanda, NY 14070 • 716-532-5142
Administrative Contact: Carolyn Gokey, Office Manager
Clinical Contact: Dr. Ranaan Gilboa, Medical Director

Gowanda Medical Center comprises three satellite primary care clinics of Tn-County Memorial Hospital, a 35-bed rural hospital that also provides in- and outpatient chemical dependency services. The clinical director of the chemical dependency unit is a psychologist who takes referrals from the primary care satellites for mental health counseling. Patients with chronic or severe mental health problems are referred to a psychiatric hospital in Buffalo.

SALAMANCA HEALTHCARE COMPLEX
150 Parkway Drive • Salamanca, NY 14779 • 716-945-1900
Administrative Contact: Kenneth L. Oakley, PhD, Administrator
Clinical Contact: Bill Felton, RPA

Salamanca Healthcare Complex is a corporate member of a rural health network that emerged following the closure of a small rural hospital in 1 990. At the time the survey was conducted, the network site had been providing primary care services for about two years, and included a licensed alcohol and substance abuse treatment center. The organization has developed a sensitivity in the treatment of substance abusers who are mentally ill or have been referred by the criminal justice system.

HUDSON HEADWATERS HEALTH NETWORK
Health Center Plaza • Warrensburg, NY 12885 • 518 623-2844
Administrative Contact: Harold Shippey, Administrator
Clinical Contact: Paul Bachman, MD, Medical Director

Hudson Headwaters Health Network operates a multi-site community health center in the Adirondacks. Two counselors from Catholic Charities in Glens Falls provide services at the Warrensburg Health Center two days a week, using space made available by the health center. They handle their own billing and appointments, and are supervised by a psychiatrist who also works for Catholic Charities.

SOUTHERN OHIO HEALTH SERVICES NETWORK
817-A Eastgate South Drive • Cincinnati, OH 45245 • 513-752-8500
Administrative Contact: John Stewart, Operations Director
Clinical Contact: Same

This is a community health center with sites in several small Ohio Valley towns. Our respondent came to the center in 1 980 as a linkage worker under the Linkage Initiative program. One social worker employed by the center provides basic mental health services at three sites. Another is assigned to the prenatal program, where she does some mental health work but also helps patients manage money, make arrangements for other needed services, and learn parenting skills. In addition, a staff person from a local mental health center provides services out of space at one of the clinic locations one day a week.

FAMILY MEDICAL CENTER
305 North 5th Street • Ironton, OH 45638 • 614-532-3534
Administrative Contact: Tony Crowe, Executive Director
Clinical Contact: Gail Feinberg, Medical Director

The lronton-Lawrence County Community Action Organization is grantee for three community health center satellites located along the Ohio River in southeastern Ohio. The CAP agency also operates a community mental health center, which handles most of the substance abuse and mental health service needs of the client population. Because the health centers and CMHC serve a region that covers parts of Ohio, Kentucky, and West Virginia, they experience considerable difficulty negotiating Medicaid reimbursement for mental health services.

GEISINGER HEALTH PLAN
100 North Academy • Danville, PA 17822-3020 • 717-271-6516
Administrative Contact: John Gerdes, PhD**,** Director of Behavioral Medicine
Clinical Contact: Rick Goss

Geisinger Health Plan is the HMO portion of Geisinger Medical Group, a rural health network including Geisinger Medical Center, a tertiary care facility in Danville, and a number of primary care clinics. Our survey focused on arrangements at the Lewistown Clinic, which is located in a building owned by and contiguous to Lewistown Hospital, a 250-bed facility with its own in- and outpatient behavioral medicine program. The full time master's level counselor now at the Lewistown Clinic is a former employee of the hospital, hired to replace a panel of specialty mental health practitioners. He provides basic mental health services to patients referred to him by the clinic's primary care physicians.

LAUREL HEALTH SYSTEMS
32-36 Central Avenue • Wellsboro, PA 16901 • 717-724-2675
Administrative Contact: Kathryn Brodrick, Program Director
Clinical Contact: Same

Laurel Health Systems is a corporate affiliation of health and social services providers serving five rural counties in north central Pennsylvania. Participating organizations include a general acute care hospital, six federally qualified health centers, a senior citizens' housing facility, a home health agency, several Head Start centers, a multi-site residential treatment program for youth, and a mental health provider that offers
inpatient, outpatient, and partial hospitalization services.

NORTHWEST SD RURAL HEALTH SERVICES CORP.
P0 Box 577 • Faith, SD 57626 • 605-967-2644
Administrative Contact: J.W. Baxter, Executive Director
Clinical Contact: Rod Simmons, Physicians' Assistant

A small community health center located in a very remote area, Northwest South Dakota Health Services provides space and schedules appoints for a substance abuse counselor employed by a community mental health center in Lemmon, SD, about 70 miles due north. The state of South Dakota directly underwrites the cost of providing these services. Patients with mental health needs are referred to the Lemmon facility. Some patients also go to Rapid City for mental health care.

RURAL MEDICAL CLINIC, INC.
P0 Box 900 • Freeman, SD 57029 • 605-925-4219 - 605-648-3559
Administrative Contact: Ken Kirton, MD
Clinical Contact: Same

This is a primary care physician group practice operating at four sites. One day a week, the program utilizes the services of a nurse/counselor affiliated with an Iowa-based, church-supported group called Wellspring. When patient needs surpass her capacity, the practice may call for assistance from a Sioux Falls psychiatric hospital that sometimes sends in a consulting psychologist. Practitioners refer persons in need of substance
abuse treatment services to state and private agencies.

ISABEL COMMUNITY CLINIC
P0 Box 209 • Isabel, SD 57633 • 605-466-2120
Administrative Contact: Pam Locken, Executive Director
Clinical Contact: David Rollason, Physicians' Assistant

Isabel Community Clinic is small community health center located in an isolated part of northwest South Dakota between two Indian reservations. Two years ago, the clinic received a Rural Health Outreach grant that provided funds to obtain the services of a psychologist and a drug and alcohol abuse counselor employed by a Professional Consultation Services, a community mental health center in Lemmon, SD, about 75 miles away. Each of these mental health professionals provides 1/2 day a week of clinic time at Isabel, and is available by telephone for consultation.

PERRY COUNTY MEDICAL CENTER
P0 Box 333 • Linden, TN 37096 • 615-589-2104
Administrative Contact: Barbara Heady, Director
Clinical Contact: Same

Perry County Medical Center is a small community health center that provides no direct mental health or substance abuse treatment services. Patients with these needs are referred to off-site specialty providers. Many years ago, the center handled medical assessments for patients at Buffalo Valley Substance Abuse Treatment Center. This arrangement has ceased, although the center still refers patients to the organization on an as-needed basis. The community supports both a substance abuse treatment center and a community mental health center.

UNION-GRAINGER PRIMARY CARE
815 West Fifth North • Morristown, TN 37814 • 615-586-5031
Administrative Contact: Dennis Freeman, PhD, Executive Director
Clinical Contact: Hal Moncier, Medical Director

Union Grainger Primary Care is a multi-site community health center that shares clinic space with a satellite office of Cherokee Health Systems, a community mental health center. This arrangement enables provision of comprehensive primary care and mental health services at the same location. The executive director of the community health center is a PhD psychologist who is also affiliated with Cherokee Health Systems.

MOORE COUNTY HEALTH FACILITY
P0 Box 196 Majors Avenue • Lynchburg, TN 37352-0196 • 615-759-4251
Administrative Contact: Donna Tucker, Administrative Assistant
Clinical Contact: Donna Seely, Nurse Clinician

This county public health agency employs a full time nurse clinician who provides primary care services and refers patients with mental health needs to a specialty mental health provider. The mental health provider is very expensive, and many patients in this region can't afford to pay for these services.

FAMILY MEDICINE CENTER
731 North Taylor Suite 300 • Amarillo, TX 79107 • 806-378-6939
Administrative Contact: Charles Wright, MD, Regional Chair
Clinical Contact: Joe V. Garms, Psychologist

Family Medicine Center is one of four satellite family practice residency sites affiliated with the medical school at Texas Tech. The residents are actively involved in treating patient mental health needs, guided by the assistant chair for family medicine, a PhD psychologist who also practices in the clinics. The program has contracts with the local schools to treat children with attention deficit disorder and the state Department of Criminal Justice to provide court-mandated evaluations of inmates at the state prison. Its two psychologists also evaluate inpatients on the psychiatric ward at the local hospital, and teach residents to use cognitive therapy with patients.

SANDY RIVER MEDICAL CENTER
Rt. 2 Box 412-B • Axton, VA 24054 • 804-685-7095
Administrative Contact: M. Jo Brogan, Administrator
Clinical Contact: Katherine Garrett, NP, Clinical Director

This small community health center refers patients with mental health needs to specialty mental health providers, including private practitioners and a community mental health center. These services are located approximately twenty miles from the health center. The receptionist at the health center makes appointments with the mental health providers.

STONE MOUNTAIN HEALTH SERVICES
Drawer S • St. Charles, VA **24282** • 703-383-4428
Administrative Contact: Tony Lawson, Administrator
Clinical Contact: Art Van Zee, MD, Clinic Director

St. Charles Health Council is the grantee for Stone Mountain Health Services, which operates community health center satellites at three locations in western Virginia. Two of the satellites provide services to victims of black lung disease. The clinics provide space for workers from Central Appalachian Services, a community mental health center. The current director of the CHCs initiated these arrangements recognizing his patients needs and the limited space available to the mental health agency in the communities they proposed to serve. The clinic also employs a pediatrician who provides services to children with attention deficit disorder.

FAMILY MEDICAL CLINIC
P0 Box 368 • Drakes Branch, VA 23937 • 804-568-4281
Administrative Contact: Lee Copeland, Administrator
Clinical Contact: Charles S. Davis, PhD, MD, Medical Director

This FQHC look-alike facility employs a full-time master's level counselor to provide basic mental health services to its patients. Because this individual is not yet licensed, he works under the supervision of one of the facility's primary care physicians. Patients must be referred to him by a physician. In fact, much of the care is handled using a team approach, with the physician and counselor collaborating. Individuals with more complex mental health needs are referred to specialty mental health providers about 80 miles away. The practitioners at Family Medical Clinic prefer not to do this, since their patients have a fundamental distrust of mental health services, may be unable to pay for them, and are often reluctant to make the long trip.

CENTRAL VIRGINIA COMMUNITY HEALTH CENTER
P0 Box 220 • New Canton, VA 23123 • 804-581-3271
Administrative Contact: Rod Manifold, Administrator
Clinical Contact: Randall Bashore, MD, Medical Director

This facility currently offers mental health and substance abuse treatment services by referral only, although primary care physicians on site do provide services such as alcoholism, counseling, family counseling, and screening in preparation for referral to specialty care. Most referrals are made to practitioners affiliated with the University of Virginia or Blue Ridge Hospital. About 11 years ago, an area mental health provider used space at Central Virginia CHC to offer services; referrals are also still made to this provider.

SALTVILLE MEDICAL CENTER
P0 Box 729 • Saltville, VA 24370 • 703-496-4433
Administrative Contact: Howard Chapman, Administrator
Clinical Contact: Walter Evenhauis, MD, Medical Director

This community health center currently offers no on-site mental health services, referring all patients with mental health needs to area specialty mental health providers. Referral arrangements are informal. Primary care physicians at the health center perform the initial assessments and determine the most appropriate referral. Several years ago, one of the specialty providers offered on-site counseling services, but that arrangement was discontinued, primarily due to lack of space. The center director who responded to the survey noted that patients seem to be more compliant and willing to keep appointments when services are provided on site.

YAKIMA VALLEY FARMWORKERS CLINIC
32 N. 3rd Street Suite 410 • Yakima, WA 98901 • 509-453-1344
Administrative Contact: Janice Luvas, Director of MH Services
Clinical Contact: Mary O'Brien, Clinical Director/Mental Health Services

Yakima Valley Farmworkers Clinic is a community and migrant health center operating five primary care sites in south central Washington and northern Oregon. The organization also receives state and county funding to run a licensed mental health clinic in Yakima and to provide substance abuse treatment services at various locations. The mental health agency provides a wide range of services to individuals with diagnosed mental health problems, including psychiatric evaluation, on-going psychotherapy and medication management, individual, family and group therapy, case management, foster care, and crisis intervention.

SHENANDOAH COMMUNITY HEALTH CENTER
P0 Box 3236 • Martinsburg, WV 25401 • 304-263-4956 or 267-8299
Administrative Contact: Susan B. Walter, Administrator
Clinical Contact: C. David Spencer, MD

The director of this community health center has an MSW and strongly supports the idea of linking primary care with mental health and substance abuse treatment services. Shenandoah piloted a case management
services program for children and adults which handled about 1 5,000 visits a year. That service ended in July 1993 because it was not reimbursable. At present, the health center offers on-site case management and counseling for pregnant women. The two MSWs who provide these services are funded by a state maternity program. In September 1 994, Shenandoah contracted with the local mental health center to place a case manager on-site. Patients with chronic mental health problems are referred to that mental health center. Those with situational problems have difficulty finding care.

MONROE HEALTH CENTER
P0 Box 590 • Union, WV 24983-0590 • 304-772-3064
Administrative Contact: Shirley C. Neel, Administrator
Clinical Contact: Dudley Crawford, Medical Director

Monroe Health Center is an FQHC/CHC located in the same multi-purpose building as a satellite office of the area's community mental health center. A strong, completely informal, referral relationship between the two agencies has been in place since they both moved into the building eighteen years ago. Patients are referred "across the hall" for mental health and substance abuse treatment services. The physicians at the CHC write prescriptions for psychotherapeutic medications when the counselor at the CMHC requests them for a patient. Shared nursing staff help to facilitate communication between the two providers.

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EDMUND S. MUSKIE SCHOOL OF PUBLIC SERVICE
96 Falmouth Street
PO Box 9300
Portland, ME 04101-9300

TELEPHONE (207) 780-4430
TTY (207) 780-5646
FAX (207) 780-4417
www.muskie.usm.maine.edu