A study of mental health consumers' perceptions of access to and satisfaction with integrated behavioral health care services in Metropolitan Atlanta

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ABSTRACT

SCHOOL OF SOCIAL WORK

WRIGHT, DARRIN E. B.S. JOHN JAY COLLEGE OF CRIMINAL JUSTICE, 2000
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A STUDY OF MENTAL HEALTH CONSUMERS’ PERCEPTIONS OF
ACCESS TO AND SATISFACTION WITH INTEGRATED
BEHAVIORAL HEALTH CARE SERVICES
IN METROPOLITAN ATLANTA

Committee Chair: Richard Lyle, Ph.D.

Dissertation dated May 2013

This study examines mental health consumers’ perceptions of access to and satisfaction with integrated behavioral healthcare services in Metropolitan Atlanta. Seventy-five participants (N=75) were selected for this study, utilizing nonprobability convenience sampling. The consumers were current program participants who received services from McIntosh Community Behavioral Health facility over the past 24 months. The research employed a 34-item, six-point Likert scale survey questionnaire to solicit the perceptions of program participants. Frequency distribution, cross-tabulation and statistical test of Phi (ϕ) and chi square were used to analyze the relationships and statistical significance of relationships between the variables. The findings of the study indicated that the majority of mentally ill program participants (97.3%) believed that they
were able to gain access to services and a majority (96.0%) were also satisfied with the services they received.

**Key Terms:** Access, Satisfaction, Behavioral Health and Integrated Behavioral Healthcare.
A STUDY OF MENTAL HEALTH CONSUMERS’ PERCEPTIONS OF ACCESS TO AND SATISFACTION WITH INTEGRATED BEHAVIORAL HEALTH CARE SERVICES IN METROPOLITAN ATLANTA

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
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ATLANTA, GEORGIA
MAY 2013
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CHAPTER I
INTRODUCTION

Uncoordinated care between mental health and primary health care continues to be a major problem faced by individuals with serious mental illness and physical health conditions in the United States. As such there is a need to improve care at the interface of health and mental health among individuals with mental illness (Blount, 1998). In a recent report issued by the New Freedom Commission on Mental Health, a need for better coordination between primary care and mental health care in the United States was identified as a major facilitator towards better care for individuals with mental illness (Freedom Report, 2004). Mental illness impacts all age groups. The National Institute of Mental Health (NIMH) indicated, in its 2008 report, that among an estimated 26.2 percent of Americans ages eighteen and older, about one in four adults suffer from a diagnosable mental disorder in a given year, which translates into 57.7 million people.

Unfortunately, evidence also shows that the current mental health system fails to reach a significant number of people with mental illness, and those it does reach often drop out or get insufficient, uncoordinated care. Likewise, individuals with serious physical health problems also, oftentimes have co-morbid mental health problems. Likewise, nearly half of those with any mental disorder meet the criteria for two or more
medical disorders, with severity strongly linked to co-morbidity (Kessler, Berglund, Demler, et al., 2005).

As many as 70 percent of primary care visits stem from psychosocial issues such as, family problems, depression, anxiety, substance abuse, sexual abuse, and violence (Reiter & Robinson, 2007). Furthermore, individuals living with serious mental illness are dying 25 years earlier than the rest of the population, partly due to unmanaged physical health conditions and a lack of access to care (Manderscheid, 2006). Likewise, findings from a recent study indicated that many of those who continue to experience health disparities occur among racial and ethnic minority groups such as, African Americans and Hispanics populations of lower socioeconomic status (U.S. DHHS, 1999). While patients typically present with a physical health complaint, data from a recent US report suggest that underlying mental health or substance abuse issues are often triggering these visits (Collins, Hewson, Munger, & Wade, 2010). Unfortunately, most primary care doctors are ill-prepared or lack the time to fully address the wide range of psychosocial issues that are presented by their patients (Collins, Hewson, Munger, & Wade, 2010).

These realities may explain why policymakers, planners, and providers of physical and behavioral health care across the United States continue to grapple with how best to deliver quality, effective mental health services within the context of individual well-being and improved community health status. As such, the past several decades have seen various attempts at coordinated care service delivery models, all attempting to connect behavioral and physical health care for a much more holistic approach towards
improved health care experiences and outcomes for consumers with mental illness (Pautler, 2005).

Statement of the Problem

To date most of the evidence supporting the effectiveness and efficiency of integrated behavioral health care models has been done mostly through Randomized Control Treatment (RCT) designs and, in most cases, with populations who suffer primarily from depression (Collins, Hewson, Munger, & Wade, 2010). There is very little research conducted on consumers' with serious mental illness regarding the effectiveness of integrated behavioral health care models with this population (Collins, Hewson, Munger, & Wade, 2010). Secondly, most of the available research findings have focused primarily on the providers' perspective and not the consumers' of these services (Pautler, 2005). As such, the consumers' perspective is often not considered when evaluating the effectiveness of these program models. The success or failure of integrated behavioral health programs which are designed as a means for delivering quality care and improving overall health outcomes is largely dependent upon patients' experience of care from this model (Pautler, 2005). The primary focus of this study was to ascertain the perceptions' of consumers with mental illness, regarding their ability to gain access to and their satisfaction with integrated behavioral health care in metropolitan Georgia.

Purpose of the Study

The purpose of the study was twofold: first, to assess the perceptions of mentally ill consumers regarding their ability to access integrated behavioral health care and
secondly, to ascertain their general satisfaction with integrated behavioral health care in Metropolitan Atlanta for the purpose of addressing any gaps in services and offering policies and service development recommendations to all key stakeholders involved in the implementation of integrated behavioral health care, to help facilitate positive client health outcomes within this model of care.

Research Questions

The research questions addressed in the study are as follows:

1. Do mental health consumers who participate in integrated behavioral healthcare programs have access to care as needed?

2. Are mental health consumers satisfied with services received in integrated behavioral health care?

3. Do mental health consumers follow their healthcare plan when provided with support from care-management coordination in integrated behavioral health care?

4. Is there a relationship between mental health consumers’ perception of access to care and satisfaction with services received in integrated behavioral health care?

5. Is there a relationship between staff interpersonal skills and mental health consumers’ satisfaction with services received in integrated behavioral health care?

6. Is there a relationship between staff interpersonal skills and mental health consumers’ perception of reduced stigmatization in integrated behavioral health care?
Hypotheses

The null hypotheses for the study are as follows:

1. There is no statistical evidence of mental health consumers who participate in integrated behavioral healthcare programs having access to services as needed.

2. There is no statistical evidence of mental health consumers' satisfaction with services received in integrated behavioral health care.

3. There is no statistical evidence of mental health consumers following their healthcare plan when provided with support from care-management coordination in integrated behavioral health care.

4. There is no statistically significant relationship between mental health consumers' perceptions of access to care and satisfaction with services received in integrated behavioral health care.

5. There is no statistically significant relationship between staff interpersonal skills and mental health consumers' satisfaction with services received in integrated behavioral health care.

6. There is no statistically significant relationship between staff interpersonal skills and mental health consumers' perception of reduced stigmatization in integrated behavioral health care.

Significance of the Study

It is becoming manifestly more important for hospital administrators, social services administrators and other key stakeholders involved in primary care and mental health to consider outpatient services as a major component of their overall business
strategy due to the shift towards integrated behavioral healthcare as the preferred method of service delivery for preventive healthcare, as evidenced by the passage of President Obama’s Affordable Care Act of 2010 (Colker, 2011). As such, providers must realize that establishing a foothold in the outpatient services market is critical to their continued survival as viable organizations in the midst of competition for scarce resources and a new business culture, where patients are expecting a more customer oriented and patient centered healthcare system that offers more access points to care (Shi & Singh, 2004).

This study purports to provide invaluable feedback to all key stakeholders involved in the planning, provision and administration of integrated behavioral healthcare services from the consumers’ perspective. One aspect of health care quality that is being increasingly recognized for its importance is the influence of patient’s perception. Even though the patient's perception of quality relies more on the service aspects of health care, it correlates well with objective measures of health care quality. A health care organization's ability to satisfy consumer demand for convenience and information can significantly influence the quality of health care it ultimately delivers. The health care service industry is complex with multiple facets and levels of organization. Health care system management has previously been relatively inefficient, incoherent and supply driven, keeping customers on the outside of the product design, development and the delivery process (McCarthy & Klein, 2010).

Currently, there is a shift to an organization model in which the customer influences every function and managers must adapt and be instrumental in establishing a cultural change within the system to meet the new quality focus. It is believed that the findings from this study could be used as evidence based or best practices, to help
 Administrators and other key stakeholders in their planning efforts towards developing a continuum of care that increases patient access, positive patient experiences and satisfaction for improved health outcomes (McCarthy & Klein, 2010).

Secondly, the passage of President Obama’s Affordable Care Act of 2010 has provided an opportunity for 32 million people with no health insurance to have health coverage by expanding access to care. As such, people in need of long term supports and services will have increased access to care in a health home or community based setting rather than in an institutional setting. As a result, there will be a great need for an increased workforce of trained professionals such as, social workers, primary care physicians, public health practitioners and other paraprofessionals to meet the needs and challenges of this population who will receive care in an integrated model from an already over burdened health care system that is attempting a paradigm shift (Colker, 2011).

Thirdly, it is expected that the findings from this study will add to the growing body of knowledge and discourse on best practices to help meet the needs of individuals with mental illness and other co-occurring health conditions, from a consumers’ perspective. Concomitantly, it is expected that the findings from this study will also add to the body of knowledge as it relates to social work education and social workers’ role in this emerging field of practice. In an effort to better prepare future social workers for these workforce opportunities and how best to work within an integrated organizational healthcare setting while ensuring that social workers’ sense of autonomy and mission of social justice, advocacy and human rights on behalf of their clients’ are not compromised in the process (NASW, 2006).
Definitions

1. Behavioral Health: Behavioral Health is a term used to describe the connection between our behaviors and the health and well-being of the body, mind, and spirit (Boober, 2011).

2. Integrated Behavioral Health: A continuum of care based on the level of collaboration between health care and behavioral health care professionals to meet the needs of a set of defined clients within a care system (Integrated Behavioral Health Project, 2011).

3. Access to care: Access to care refers to the timely use of personal health services to achieve the best possible health outcomes; through the process of gaining entry, getting to the geographic and physical locations where health care is being delivered and finding the appropriate providers for needed care (IOM, 1993).

4. Satisfaction: Satisfaction refers to the degree to which the desired goals of treatment have been achieved (Health Boards Executive, Irish Society for Quality and Safety in Healthcare and Health Services National Partnership Forum, 2003).

5. Perception: Perception refers to the process of organizing and interpreting environmental information into recognizable and meaningful objects and events (Myers, 1998). Perception has three components: a perceiver, a target that is being perceived, and some situational context in which the perception is occurring (Saks & Johns, 2011).
CHAPTER II

REVIEW OF LITERATURE

The purpose of presenting this review of the literature was to lay a scholarly foundation in order to establish a need for the study. This chapter is a review of the current literature on Integrated Behavioral Health Care, its origins and its application in the field of Mental Health. The review covers the background of Behavioral Health concept, Mental Health, Primary Care and examples of Integrated Behavioral Health Care models currently being used in the field. The variables of Access and Client Satisfaction are also presented and related as two important aspects of Integrated Behavioral Health Care. Finally, six conceptual frameworks for this study are presented in which to view, understand and establish an appropriate research methodology towards answering the research questions presented in chapter one.

Behavioral Health

Behavioral health is a component of service systems within healthcare that seek to improve health status while containing healthcare and other costs to society through coordinated care (Substance Abuse and Mental Health Services Administration, 2012). The term Behavioral Health is often used to describe the connection between our behaviors and the health and well-being of the body, mind, and spirit. This includes behaviors such as eating habits, drinking, or exercising that either immediately or over
time impact physical or mental health. As such, it is viewed as a holistic concept and way of viewing health (Boober, 2011). Behavioral health can also include broader factors, such as having to live in an area with high pollution or experiencing high levels of stress over a long period of time. In past decades, the term behavioral health almost entirely referred to behaviors that prevented illness or promoted health. Later, it began to be used to also include behaviors that helped people manage illnesses, especially chronic conditions (Boober, 2011).

Some of these health behaviors are under our individual control; however, oftentimes our choices are limited by factors beyond our immediate control, for example, pollution from a nearby factory. Another example is obesity which is oftentimes attributed to genetics and personal choices of what one eats (Maes, Neale, & Eaves, 1997).

However, a recent study indicates that individuals who live in inner-city neighborhoods oftentimes lack access to grocery stores where they could purchase fresh fruits or vegetables, which, in turn, has a direct impact or make it more difficult for community members to have control over their diet due to a lack of access and choice in the types of food that are available to them (Swinburn, Egger, & Raza, 1999).

More recently, the concept of behavioral health has been expanded to include mental health as well. Many mental health conditions develop largely from biological factors, such as one’s genetic makeup and brain chemistry (NIMH Genetics Workgroup, 1998). Frequently, physical health and mental health issues often occur simultaneously. For example, people with diabetes or cardiac conditions often develop depression as well (World Health Organization, 2008). There is a growing body of literature and evidence-
based studies such as the World Health Organization and the Commission on Social Determinants of Health report that support the link between social determinants of health and other environmental stressors to overall health and mental health status. As such, being able to receive treatment for co-morbid conditions through an integrated behavioral health care setting can be especially helpful because our physical and mental health all interact with each other in complex ways. As such, how we live our lives has a direct impact on our overall health and well-being. Ultimately, the goals of behavioral health interventions are similar to those of other primary care treatment in that, behavioral health strives towards helping people function so they can lead healthier, fuller lives. The ensuing sections in this chapter will examine the function of primary care and mental health, as two key components of behavioral health care.

Primary Care

A key component of Behavioral Health Care is primary care. According to Dr. David Satcher, former Surgeon General and current Director of the Satcher Health Leadership Institute, primary care is the provision of first contact care of the oftentimes undifferentiated patient (Satcher, 2010). Furthermore, primary care is also comprehensive, in that it seeks to respond to most of the health care needs of patients through continuous, coordinated care. By serving as patients’ medical home with recordkeeping, consultation and referral to other allied services as needed. For this reason, integration of services into the context of family and community is seen as the ideal format for this method of care (Satcher, 2010).
The concept of primary care came to preeminence in 1978 with the Alma-Ata Declaration in Kazakhstan, a former nation of the Soviet Union, Russia. The Declaration of Alma-Ata articulated primary healthcare as a set of guiding values and principles for healthcare development and the organization of health services around a range of approaches for addressing priority health needs and the fundamental determinants of health (World Health Organization, 1978). Alma-Ata expressed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world (World Health Organization, 1978).

Alma-Ata was the first international declaration underlining the importance of primary health care. Furthermore, the Declaration of Alma-Ata articulated healthcare as a human right and called for economic and social development as a pre-requisite to the attainment of health for all. It also declared the positive effects of economic and social development on world peace through the promotion and protection of health through the use of individual, group and community participation in planning and implementing their health care (World Health Organization, 1978).

The declaration broadened the medical model to include social and economic factors, and acknowledged that activities in many sectors, including civil society shaped the prospects for improved health. In short, fairness in access to care and efficiency in service delivery were the overarching goals of the declaration of Alma-Ata (World Health Organization, 1978).
Historical Overview of Mental Health Policies and Programs in the U.S.

Mental health care in the United States, sadly, has often been described as a complex patchwork of mental health services that has become so fragmented it is often referred to as the de facto mental health system (Regier, Goldberg, & Taube, 1978). Its structure has been determined by many heterogeneous factors rather than by a single guiding set of organizing principles. As such, services in the United States vary from state to state and are oftentimes predicated on the socio-political culture of that state (Regier, Goldberg, & Taube, 1978).

The origins of the mental health services in the United States coincide with the colonial settlement of America (Grob, 1983). Individuals with mental illness were cared for at home. Mental illness was considered a disease of personal failing or a spiritual disease. Mentally ill patients were often considered possessed by evil spirits or thought to be under the spell of witchcraft, or influenced by the moon, hence the origin of the term lunacy. The insane were seen as incurable, subhuman creatures doomed to a life in shackles and chains at an almshouse (poorhouse) or in jail cells for the mad (Grob, 1983).

The history of mental health policy and programs for individuals with mental health conditions in the United States of America date back to the early 19th century during the Moral Treatment Era. The Moral Treatment Era was introduced to the United States from Europe and it espoused a philosophical belief that mental illness could be treated more humanely by moving the individual to an asylum to receive a mix of somatic and psychosocial treatments in a controlled environment. Dorothea Dix and other social reformers of this era advocated for the use of Moral Treatment as a service
intervention at the state level. For example, the state of New York made the first major attempt to improve care for mentally ill paupers in 1860 (Katz, 1996).

This social policy shift came from the influence of Dr. Sylvester D. Willard, secretary of the Medical Society of the State of New York who began to investigate the conditions of mentally ill paupers in almshouses in New York and found that there was gross negligence in meeting the basic needs of this population; his findings culminated in the State Care Act of 1890. This policy called for taking mentally ill paupers out of almshouses and placing them into state funded mental asylums, where their physical health and comfort would best be met. The State Care Act was used as a model for other states around the nation (Katz, 1996).

**Care for African Americans during the Moral Treatment Era**

An often neglected area of discussion on mental health policy and programs in the United States is care for minority populations, such as African Americans. Most African Americans were enslaved and considered property during the Moral Treatment era. Therefore, African Americans were not afforded any constitutional rights since they were not legally considered citizens but rather property (Lowe, 2006).

However, one of the earliest records dealing with the issue of insanity among African-Americans was in 1745 when the South Carolina Colonial assembly took up the case of Kate, a slave woman, who had been accused of killing a child. After being placed in the local jail, it was determined that Kate was out of her senses and she was not brought to trial (Lowe, 2006).
The problem of how to care for Kate was an issue because her owner was deemed too poor to pay for her confinement and South Carolina had made no provision for the public maintenance of slaves. As a result, the colonial assembly passed the Negro Act of 1751. The Negro Act made each parish in the colony responsible for the public maintenance of lunatic slaves whose owners were unable to care for them (Lowe, 2006).

State institutions continued to be the primary mode for mental health service delivery throughout the Moral Treatment Era up until World War II. World War II created a need for a large number of men for military service; as a result, for the first time the use of psychiatric examinations became a part of the screening process for new recruits. This process saw a huge number of young men rejected from serving due to being found mentally unfit. This alarming revelation brought renewed attention to the field of mental health again (Di Nitto & McNeece, 1990).

As such, this concern resulted in the first federal policy to address mental illness, which resulted in the Mental Health Act of 1946. The Mental Health Act of 1946 established the national Institute of Mental Health (NIMH), a federal mental health agency. The NIMH established programs for mental health training, education and research into mental illness.

However, NIMH scope and program depth did not address the growing concerns of mental health experts around the lack of community based mental health services. As a result, congress established a commission in 1955 to examine the lack of community based mental health services for individuals with mental health conditions and gave recommendations on how to address these gaps in services. The commission released its recommendations in 1961 to the Kennedy administration calling for a federally funded
Community-based mental health services system. To which, President Kennedy enacted the Community Mental Health Act of 1963 (Di Nitto & McNeece, 1990).

**Community Mental Health Era: 1963 to Present**

The Community Mental Health Act of 1963 marked a significant paradigm shift in mental health service provision, from huge centralized state run institutions to federally funded community based mental health service provision through community mental health centers. As such, this policy shift ushered in the deinstitutionalization of mental health care and service provision across the United States. Provisions in The Community Mental Health Act of 1963 (CMHA), emphasized greater federal involvement and reduction in state funded hospital treatment, better coordination between community services and hospitals, more services to individuals with chronic mental illness, more education in mental health, with an emphasis on prevention services, case management and use of paraprofessionals in service provision (Sands, 2012).

According to Di Nitto and McNeese (1990), the CMHA also created a demand for professional social workers who specialized in mental health service provision, psychotherapy and macro practice specialization. However, there was inadequate funding, a lack of coordinated planning and an underestimation on the number of poor Americans in general and African Americans in particular who had been institutionalized for most of their adult lives and the type of supports and resources that would be needed to successfully reintegrate them back into the community (Di Nitto & McNeese, 1990).

The situation was further complicated by returning veterans from the Vietnam War who had multiple disorders of mental health conditions, substance abuse and
addiction. This population soon added to an already stressed, underfunded and disjointed mental health system. This service delivery inefficiency resulted in a huge increase in the number of individuals who were homeless and untreated with multiple disorders across America in major cities and towns (Di Nitto & McNeece, 1990).

In an effort to address this growing dilemma, the Johnson Administration, under the influence of the Ways and Means Committee Chairman, Wilbur Mills, advocated for and established Title XVIII Medicare (A health insurance program for individuals age 65 and over) and Title XIX Medicaid (A federal-state matching means tested medical and health care related program for the poor) under the Social Security Act of 1965 to help address the issue of underfunding and disparity in community mental health services (Jannson, 2008).

Due to the continued bifurcation of community mental health services, Medicaid remained underfunded at the federal level; and many states imposed stringent means-tested measures to restrict the poor and marginalized populations from full access to services. Because of these growing concerns, in 1978, President Jimmy Carter established a Presidential Commission to study the efficacy of the nation’s mental health system in meeting the needs of individuals with mental health conditions. The commission’s report confirmed systemic inadequacy across the mental health system; as it related to programming and service delivery, to include a lack of adequate insurance coverage and community outpatient services for poor and elderly individuals with chronic and severe mental health conditions (Jannson, 2008).

Subsequently, the Mental Health Systems Act of 1980 was enacted in an effort to address these disparities. However, the Mental Health Systems Act was repealed under
the Reagan Administration in 1981. In its place, President Regan introduced the Alcohol, Drug Abuse, and Mental Health (ADMS) block grant in 1981 and in 1986 Congress passed the State Mental Health Planning Act, authorizing small grants to states to develop comprehensive mental health plans for persons with serious mental illness (Jannson, 2008).

Additionally, Congress enacted several amendments to Medicare and Medicaid that made these two programs more accessible to community-based providers. The first of these changes established case management as a distinct benefit under Medicaid. Other Medicaid amendments expanded clinical services to persons with Severe Mental Illness (SMI) who were homeless (Substance Abuse and Mental Health Services Administration, 2002).

In 1990, congress passed the American with Disabilities Act (ADA), which created polices to protect the rights of individuals with disabilities which included individuals with mental health conditions against discrimination in housing, employment and access to public facilities by providing reasonable accommodations (Americans with Disability Act of 1990, 1990). Likewise, in 1996, congress passed the first parity law. This law prohibited insurers or plans serving 50 or more employees from setting lower annual or lifetime dollar caps on mental health benefits than for other health benefits (Hammond, 2003).

In 1999, the U.S. Supreme Court issued its opinion on Olmstead v. L.C., which held that it was a violation of the ADA to keep individuals in restrictive inpatient settings when more appropriate community services are available (Hammond, 2003). In 2002, President George W. Bush formed the President’s New Freedom Commission on Mental
Health. The Commission was charged with focusing on the mental health service system and identify barriers towards service provision and make recommendations on how best to solve these problems (President’s New Freedom Commission on Mental Health, 2003).

The Commission’s final report called for a transformation of the United States healthcare system and identified the need for a coordinated, consumer-centered, recovery-oriented mental health system. Through the establishment of care coordination between primary care and mental health, under an integrated behavioral healthcare model with the goal of increasing access to care and the ultimate elimination of health disparities among vulnerable populations (President’s New Freedom Commission on Mental Health, 2003).

Mental Health and Consumers with Mental Illness

Mental health refers to a broad array of activities directly or indirectly related to the mental well-being component included in an individual’s overall health (World Health Organization, 2006). Concomitantly, health is defined as a state of complete physical, mental and social well-being and not merely the absence of disease (World Health Organization, 1946). Therefore, mental health is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders (World Health Organization, 2003).

Mental health has also been defined as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Moreover,
mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined goals. As such, mental health should be a concern for all individuals in their given communities and countries, rather than only those who suffer from a mental disorder (World Health Organization, 2003).

A mental disorder or mental illness is a psychological or behavioral pattern generally associated with subjective distress or disability that occurs in an individual, and which is not a part of normal development or culture (Insel & Wang, 2010). Such a disorder may consist of a combination of affective, behavioral, cognitive and perceptual components. The recognition and understanding of mental health have changed over time and across cultures, and there are still variations in the definition, assessment, and classification of mental disorders, although standard guideline criteria are widely accepted.

For example, a few mental disorders are diagnosed based on the potential for harm to others, regardless of the subject's perception of distress. Over a third of people in most countries report meeting criteria for the major categories of mental disorders at some point in their lives (Insel & Wang, 2010). The causes of mental disorders are oftentimes explained in terms of a diathesis-stress model which describes the relationship between biology and stress; or biopsychosocial model which describes the relationship between biological, psychological, social and cultural factors (Insel & Wang, 2010).

**Types of Serious Mental Illnesses**

Recent data from the World Health Organization, estimates there are as many as 450 million people across the world who suffers from a mental or behavioral disorder.
Mental health problems are three times more common than cancer (World Health Organization, 2003). For example, findings from the Surgeon General’s mental health report (1999), suggest that, in the United States, mental illness is common. One in 5 American has a diagnosable disorder each year, of which 44 million are adults and 13.7 million are children.

According to the WHO’s Global Burden of Disease (2001), thirty three percent of years lived with a disability (YLD) are due to some type of neuropsychiatric disorder, such as, depression, alcohol-use disorders, schizophrenia and bi-polar disorder. As a result, neuropsychiatric disorders are the fourth leading causes for years lived with a disability (World Health Organization, 2003). Furthermore, neuropsychiatric disorders are also linked to co-morbidity with other physical disorders and diseases, such as, cardiovascular diseases, diabetes, blood pressure, obesity, HIV/AIDS and injuries (World Health Organization, 2003). Neuropsychiatric disorders have a significant impact and burden on the family and consequently on families’ quality of life (World Health Organization, 2003).

**Populations Affected by Serious Mental Illnesses**

Serious mental illnesses can be found among all racial groups, ethnicities, genders, age groups and sexual orientation in a given country’s population. According to the World Mental Health Survey data of 2001, approximately two to three percent of countries general population across the world experience and live with some type of serious mental illness (World Health Consortium, 2004). However, the severity of mental illness is often affected by an individual’s socioeconomic status (SES), their
country's healthcare system and its capacity to provide care (World Health Consortium, 2004). As such, a person’s SES is a social determinant of their ability to access care within their respective countries healthcare system (World Health Organization, 2003). For example, among developed countries like the United States, racial and ethnic minority groups often have higher rates of diagnosis of serious mental illness than their white counterparts. Likewise, African Americans, Hispanics, and some Asians are also less likely than whites to have access to needed care. These health inequalities are attributed to social determinants of race, socioeconomic status and a history of systemic racism embedded within the United States mental health system (Hatloy, 2010).

**Stigma of Having a Mental Illness**

In addition to the health and social costs, those suffering from mental illnesses are oftentimes victims of human rights violations, stigma and discrimination, both inside and outside psychiatric institutions (World Health Organization, 2003). According to the United States former Surgeon General, Dr. David Satcher, the stigmatization of people with mental disorders has persisted throughout history (U.S. Department of Health and Human Services, 2001). It often manifests itself in the form of bias, distrust, stereotyping, fear, embarrassment, anger and avoidance (Mental Health Services Oversight and Accountability Commission, 2007). Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia (Mental Health Services Oversight and Accountability Commission, 2007). It reduces access to resources and opportunities, such as, housing, jobs and healthcare. Ultimately, it leads to low self-esteem, isolation
and hopelessness among individuals who are stigmatized. It deters the public from seeking, and wanting to pay for care. In its more overt and egregious form, stigma can often result in outright discrimination and abuse of individuals with mental illness (Mental Health Services Oversight and Accountability Commission, 2007). More tragically, according to the Mental Health Services Oversight and Accountability Commission (MHOAC), it deprives people of their dignity and interferes with their full participation in society (U.S. DHHS, 1999).

Health Disparities

Health disparities are differences in health status among distinct segments of the population, including differences that occur by gender, race, ethnicity, education, income, disability, or living in various geographic localities (CDC, 2010). In the United States, health disparities related to race, ethnicity, disability and socioeconomic status still pervade the American health care system (Palacio, Reynolds, Drisko, Lucero, Hunt, & Phi, 2009). These disparities exist with respect to quality of health care, access to health care, levels and types of care and many other clinical conditions. Moreover, a combination of vulnerability, social-economic circumstance, and inadequate systems together, help contribute significantly to differences in health status (Palacio, Reynolds, Drisko, Lucero, Hunt, & Phi, 2009).

As stated earlier, one's socioeconomic status (SES) is also a key factor in disparities because of its significant implications for health and health outcomes. Low SES is associated with many health risks as well as lack of access to care (Millman, 1993). Additionally, a lack of appropriate health communication has also been identified
as another cause for health disparities (Thomas, 2004). This is important because health communication in behavioral health care is critical to the practitioner-client relationship and ultimately health outcomes (du Pré, 2004).

While there are many factors which influence health communication, culture and cultural competence has a direct impact on clients' access, satisfaction and efficacy in healthcare. As the racial and ethnic demographics of America continue to change from a white majority to a minority majority, public health Practitioners' and the medical profession must begin to consider patients culture and the need to develop cultural competence skills, in an effort to communicate health related issues that are rooted in their patients' perception of their own personhood (du Pré, 2004).

In an effort to address this issue, the U.S. Department of Health and Human Services developed the National CLAS (culturally and linguistically appropriate service) standards, which define cultural competency in practice to help improve health communication (Thomas, 2004). Tackling health inequities ultimately requires a paradigm shift, to bring into focus the ways in which jobs, working conditions, education, housing, social inclusion, and even political power influence individual and community health (Hunter & Killoran, 2004). As such, integrated behavioral health care is seen as a viable approach towards addressing many of these disparities by improving access to quality services and support (Office of Behavioral Health Equity, 2010).

Integrated Behavioral Health Care

Integrated Behavioral Health Care should not be considered as an all-or-nothing proposition. Rather, it is practiced on a continuum, based on the level of collaboration
between health care and behavioral health care professionals (Integrated Behavioral Health Project, 2011). Historically, innovative programs in collaboration and integration were first developed in settings like the Veterans Health Administration, federally qualified health centers, such as the Cherokee Health Systems in East Tennessee, health maintenance organizations (HMOs), such as Kaiser Permanente; and the Bureau of Primary Health Care within the U.S. Health Resources and Services Administration (HRSA) has also supported a number of initiatives around the country (Collins, Hewson, Munger, & Wade, 2010).

According to Collins, Hewson, Munger, and Wade (2010), collaborative care and integrated care are two terms most often used to describe the interface between primary care and behavioral health care. However, the terms collaborative care and integrated care are not used consistently in the field, and as such, this has led to confusion. In an effort to address this concern, Strosahl (1998) proposed a basic distinction to help clarify the confusion associated with these two terms. Namely, collaborative care involves behavioral health working with primary care. Whereas, integrated care involves behavioral health working within and as a part of primary care (Strosahl, 1998).

A systematic review of the literature supports this idea and further suggests that there are four concepts or frameworks common to all models of integration (Collins, Hewson, Munger, & Wade, 2010). These concepts are: the medical/healthcare home concept, healthcare team concept, stepped care concept, and the four quadrant clinical integration concept (Collins, Hewson, Munger, & Wade, 2010). According to the Milbank Report, the medical/healthcare home concept has become a mainstream theory in primary care. It has also recently gained national attention in recognition of its
importance in caring for the chronically ill. The medical/healthcare home concept is also one of the centerpieces in the Affordable Care Act (ACA) of 2010 as it relates to how behavioral healthcare will be organized and implemented (Rittenhouse & Shortell, 2009).

The National Committee for Quality Assurance (NCQA) has defined some specific criteria for a medical/healthcare home. An important aspect of the criteria includes standards that apply to disease and case management activities that are beneficial to both physical and mental health. These criteria include, but are not limited to the following: patient tracking and registry functions; the use of non-physician staff, such as social workers for case management and care coordination; the adoption of evidence-based guidelines; patient self-management support; tests and screenings; and referral tracking of patients who are in the medical/healthcare home (Collins, Hewson, Munger, & Wade, 2010). Additionally, most medical/healthcare homes are compensated by a per-member, per month (PMPM) fee (Collins, Hewson, Munger, & Wade, 2010).

The second concept, which is a healthcare team, is accepted as a common concept among all integrated behavioral health models. According to Strosahl (2005), a key feature of this concept is the doctor-patient relationship which is replaced with a team-patient relationship. When applied to integrated care, members of the healthcare team share responsibility for a patient’s care, and the message to the patient is that the team is responsible for ensuring care coordination in a patient centered manner. For example, patient visits are coordinated with various members of the team which usually consist of a physician, nurse practitioner or physician’s assistant, nurse, care coordinator who is oftentimes a Master’s level social worker, behavioral health consultant, and other health professionals (Strosahl, 2005). As a result, Blount (1998) noted that in a health
care team approach, each provider learns what the other does and, in some cases, can fill in for one another where appropriate.

The third concept, stepped care, is also widely used in integrated care models. This concept holds that, except for acutely ill patients, health care providers should offer care that causes the least disruption in the person’s life, is the least expensive but needed care for positive results and is cost efficient in terms of staff training required to provide effective services. In stepped care, if the patient’s functioning does not improve through the usual course of care, the intensity of service is customized according to the patient’s response and need (Collins, Hewson, Munger, & Wade, 2010). The final concept, often referred to as the four quadrant clinical integration model, identifies populations to be served in primary care versus specialty behavioral health. Once identified, clients are then placed into one of four services quadrants based on level of behavioral health and physical care needed to function. Once the clients’ needs have been identified, various types of services and organizational models are employed depending on the severity of the clients’ behavioral health needs served in each quadrant (Mauer, 2009). Moreover, this concept may also be used as a template for planning local health care systems based on the target population needs. Figure 1 provides a visual representation of this model (Mauer, 2009).
In addition to these four concepts used in integrated care there are also eight practice models of integration that are currently being used across a variety of practice settings (Collins, Hewson, Munger, & Wade, 2010). These models are improved collaboration, medically provided behavioral health care, co-location, disease management, reverse co-location, unified primary care and behavioral health, primary care behavioral health, and collaborative system of care (Collins, Hewson, Munger, & Wade, 2010).

Likewise, there are five levels of integration along a continuum of care which is used in support of these eight practice models. The first of the five levels is minimal collaboration. This level of integration involves mental health providers and primary care providers work in separate facilities, have separate systems, and communicate sporadically. The second level is basic collaboration at a distance. This level of
integration involves primary care and behavioral health providers who provide care in separate systems at separate sites, but now engage in periodic communication about shared patients. Communication occurs typically by telephone or letter (Collins, Hewson, Munger, & Wade, 2010).

The third level is basic collaboration on-site. This level of integration involves mental health and primary care professionals have separate systems but share the same facility. Proximity allows for more communication, but each provider remains in his or her own professional culture. The fourth level is, partly integrated. This level of integration involves mental health professionals and primary care providers who share the same facility and have some systems in common, such as scheduling appointments or medical records (Collins, Hewson, Munger, & Wade, 2010).

The fifth and final level is physical proximity. This level of integration allows for regular face-to-face communication among behavioral health and physical health providers. At this level, there is a sense of being part of a larger team in which each professional appreciates his or her role in working together to treat a shared patient, and fully integrated care where the mental health provider and primary care provider are part of the same team. The patient experiences the mental health treatment as part of his or her regular primary care (Collins, Hewson, Munger, & Wade, 2010).

Many programs often opt to use one or more of these practice models and levels of integration, which has resulted in a move towards a blended practice model of integration as opposed to a pure integrated practice model. For each of these practice models and levels of integration described, the objective is to achieve greater integration
of health care services along a continuum of care based on the needs of the client population being served (Collins, Hewson, Munger, & Wade, 2010).

Moreover, integrated programs must also consider whether a horizontal or vertical integration service strategy or a combination of both would be best suited for maximum impact as it relates to their behavioral health care business model, goals and objectives (United States Air Force, 2002). According to Shi and Singh (2004), horizontal integration is a growth strategy in which a health care delivery organization extends its core services and products. Horizontal integration is the platform upon which all behavioral healthcare (BHC) services reside, because most members of primary care population can benefit from BHC services delivered in a general service-delivery model (United States Air Force, 2002).

A distinguishing feature of horizontal integration is that it offers a wider catchment for services. Whereas, vertical integration involves providing more targeted, specialized, behavioral health services and interventions to a well-defined, circumscribed group of primary care patients. This approach to care is seen as a paradigm shift in how care is offered in primary care medicine and behavioral health. It is often seen as a best practices approach to care (United States Air Force, 2002). Client populations who are targeted for vertical integration are usually high-frequency or high-cost patient populations, such as those with depression, schizophrenia, and chemical dependency, and certain groups of high medical chronic users of services (United States Air Force, 2002).

Emerging evidence from these care models has stimulated the interest of policymakers in both the public and private sectors to better understand the evidence underpinning integrated healthcare models. The move toward improving the screening
and treatment of mental health and substance abuse problems in primary care settings and improving the medical care of individuals with serious mental health problems and substance abuse in behavioral health settings are some of the drivers behind this growing area of practice and study (Collins, Hewson, Munger, & Wade, 2010).

As explained in the previous paragraph, it is believed that integrating mental health services into a primary care setting or reverse location of primary care into specialty care settings, offers a promising, viable, and efficient way of ensuring that vulnerable populations have access to needed mental health and primary care services. Additionally, mental health care delivered in an integrated setting can help to minimize stigma and discrimination associated with mental illness, while increasing opportunities for improved overall health outcomes (Collins, Hewson, Munger, & Wade, 2010).

According to Shi and Singh (2004), there is some consensus that integrated systems do not necessarily produce internal and external efficiencies. For example, studies in the 1990’s generally did not support the idea of systems that integrated resulted in any marked improvements in organizations’ internal productivity or external efficiencies, as far as better health outcomes for their populations served (Shi & Singh, 2004). On the other hand, more recent studies, such as those conducted by Wang, Wan, Clement, & Begun (2001) and Wan, Yen-Lin, and Ma (2002) have shown a more favorable view of internal organizational performance. For example, Wang et al. (2001) conducted their study for the purpose of examining the association of managed care with hospital vertical integration strategies, as well as to observe the relationships of different types of vertical integration with hospital efficiency and financial performance.
The sample used by Wang et al. (2001) consisted of 363 California short-term acute care hospitals. A linear structure equation modeling was used to test six hypotheses derived from a strategic adaptation model identified by the researchers. Several organizational and market factors were controlled statistically. Results from their findings suggested that managed care was a driving force for hospital vertical integration (Wang et al., 2001). The researchers found in terms of performance, hospitals that are integrated with physician groups and provide outpatient services (backward integration) have better operating margins, returns on assets, and net cash flows at p<0.01 (Wang et al., 2001).

On the other hand, these hospitals were not likely to show greater productivity. Whereas, forward integration with a long-term-care facility, was positively and significantly related to hospital productivity at p<0.05 (Wang et al., 2001). Wang et al. (2001) concluded that forward integration was negatively related to financial performance. Secondly, health executives should be more responsive to the growth of managed care in their local market and should probably consider providing more backward integrated services rather than forward integrated services in order to improve the hospital's financial performance in today's competitive health care market (Wang et al., 2001).

Likewise, in another study, Wan, Yen-Lin, and Ma (2002) analyzed integration mechanisms that affected system performances, measured by indicators of efficiency in integrated delivery systems (IDSs) in the United States, in an effort to answer their research question, do integration mechanisms improve IDSs' efficiency in hospital care? The American Hospital Association's Annual Survey (1998) and Dorenfest's Survey on
Information Systems in Integrated Healthcare Delivery Systems (1998) were used as the instrument to conduct this study (Wan, Yen-Lin, & Ma, 2002).

A covariance structure equation model of the effects of system integration mechanisms on IDS performance was formulated and validated by an empirical examination of IDSs. The study sample included 973 hospital-based integrated health care delivery systems operating in the United States, carried in the list of Dorenfest's Survey on Information Systems in Integrated Health care Delivery Systems. The measurement indicators of system integration mechanisms were categorized into six related domains: informatics integration, case management, hybrid physician-hospital integration, forward integration, backward integration, and high tech medical services (Wan, Yen-Lin, & Ma, 2002).

Wan, Yen-Lin, and Ma (2002) noted that findings from the multivariate analysis revealed that integration mechanisms in system operations were positively correlated and positively affect IDSs' efficiency. The six domains of integration mechanisms accounted for 58.9 percent of the total variance in hospital performance. Furthermore, these findings suggested service differentiation strategy such as having more high tech medical services have much stronger influences on efficiency than other integration mechanisms do. Wan, Yen-Lin, and Ma concluded that the beneficial effects of integration mechanisms have been realized in IDS performance. As such, high efficiency in hospital care can be achieved by employing proper integration strategies in operations (Wan, Yen-Lin, & Ma, 2002).

Additionally, other issues and challenges to be considered in integrated behavioral healthcare are factors such as: clinical, financial and organizational modes of
practice, which often involve entrenched mindsets and resistant behaviors towards embracing an integrated concept. For example, findings from the Singaporean governmental and citizen lead planning board called, Reaching Everyone for Active Citizenry @ Home (REACH), conducted an organization wide needs assessment of their healthcare system in 2008; where they sought feedback from all key stakeholders in their healthcare system to help guide their efforts towards healthcare integration. Findings from the needs assessments revealed that clinical and medical practices are often built around specialization instead of being oriented towards holistic care (REACH, 2008).

Likewise, their current financing framework did not incentivize integration of care, on the part of general practitioners, specialist outpatient clinics and patients alike. Moreover, there was resistance towards a paradigm shift and movement towards integration of care, on the part of some stakeholders who were involved in the Singaporean healthcare system initiative. Furthermore, most organizational processes often lacked the framework for integration, which could be improved by bridging communication and information technology (IT) gaps through coordination across sectors while simultaneously defining the workflow of staff for a smooth transition of patients between caregivers and IT systems, which in turn, would help to facilitate better integration across sectors and allow for the transferability of patient records across an integrated healthcare system (REACH, 2008).

**Examples of Programs’ Efforts in Integration**

A recent study, such as the Triple Aim Initiative, has sought to address those concerns raised in the previous paragraph. In October of 2007, case studies of three
organizations were selected and participated in the Institute for Healthcare Improvement’s Triple Aim initiative: Care Oregon, a nonprofit managed health care plan which served low-income Medicaid enrollees; Genesys Health System, a nonprofit integrated delivery system in Flint, Michigan; and QuadMed, a Wisconsin-based subsidiary of printer Quad/Graphics that developed and managed worksite health clinics and wellness programs. The Triple Aim Initiative sought to demonstrate how they could partner with providers to organize care for the purpose of improving the health of specific population patients' experience of care -- which included domains of quality, access, and reliability -- while seeking to reduce the rate of increase in the per capita cost of care often incurred by these populations (McCarthy & Klein, 2010).

Findings from the Triple Aim Initiative highlighted the importance of local context as a critical factor in implementing the Triple Aim initiative. On the other hand, common concerns and shared elements across Triple Aim organizations illustrated the fact that the approaches could be replicated across care settings with appropriate adaptation (McCarthy & Klein, 2010). For example, all three sites engaged physicians and other providers, whether employed, contracted, or affiliated in new ways of delivering care through extrinsic and intrinsic motivators such as creating learning communities that offered providers continuing education credits and training that helped them internalize the goals of Triple Aim (McCarthy & Klein, 2010).

Additionally, many relied on fostering a culture of mutual accountability through transparency in measurement, applying evidence-based standards to improve the quality of care, improving access to primary care and enhancing coordination of care at the patient level, using payment incentives to support patient and provider behavior changes,
while connecting patients to community resources through a population based approach to meet nonmedical needs, and adapting techniques from other sectors to support more reliable processes (McCarthy & Klein, 2010).

In another study, The Voice of Detroit Initiative (VODI), a five year W.K. Kellogg Foundation funded demonstration project, sought to address the issue of care coordination and cost containment in Detroit Michigan, while concomitantly creating a path to health care reform (Chesney, Mach, Smith, Smitherman, & Taue, 2007). The findings from VODI were presented in a book titled, “Taking Care of the Uninsured: A Path to Reform,” by James D. Chesney, Jennifer Mach, Lucille Smith, Herbert C. Smitherman, and Cynthia Taue, the principle investigators of VODI. Chesney et al. (2007) demonstrated that health care can be improved; and the path to reform has four components: Collaboration, Coordination, Coverage, and Care (4C’s). The authors showed that by collaborating, coordinating, implementing coverage, and organizing care for the uninsured, it is possible to improve primary care utilization and decrease inappropriate ER use and hospitalizations (Chesney et al., 2007).

This approach ultimately produced a more cost-effective health care system and broadened access to care in Detroit (Chesney et al., 2007). Chesney et al. (2007) emphasized the important distinction between having access to care (coverage) and utilization of that access (care). Another key aspect of the initiative which was presented by the authors was the focus on outcomes rather than inputs. Therefore, all work to be done was geared towards creating the same agreed upon outcomes, which were, reduced emergency room use, increased primary care use, decreased specialty care and hospitalization, and reduced cost of care for the uninsured (Chesney et al., 2007).
The authors explained the key drivers of the 4C model were a need for responsibility, accountability, and transparency to occur within the collaboration along with coordination of care in order to reach the desired outcomes. This was done through practices of transparency in monthly enrollment reports, quantitative and qualitative status reports, and reviews of progress made towards goal attainment of stated organizational and clinical goals. Another unique aspect of the program was the VODI program helped organize health coverage for the uninsured population in Detroit through a virtual insurance plan that tracked and managed healthcare. It was designed to provide quality health services to low income, uninsured, and those whom were unable to obtain state or federal assistance (Chesney et al., 2007). VODI used the term virtual insurance primary because there was no payment method established. This program depended only on the willingness of providers to sustain the monetary loss and provide free treatment. The authors considered five questions in measuring the success of the VODI model, which were: What is the enrollment process, who was enrolled in VODI, how were the services provided to enrollees tracked, did VODI provide coverage for enrollees, and what were the characteristics of the uninsured that used VODI coverage (Chesney et al., 2007).

The condition of the Detroit safety net at the beginning of the VODI program was characterized as fragmented, inadequate, and lacking access to a full continuum of health care services prior to the implementation of the VODI model. Furthermore, the safety net had to be changed in order to deliver the VODI goals of: increased access to and utilization of primary care; reduced emergency room utilization, reduced preventable
hospitalizations and specialty care utilizations; and management of patients with chronic conditions (Chesney et al., 2007).

Moreover, the authors recognized that the ability to access care was affected by both individual and community resources, characteristics and need. As such, Chesney et al. (2007) sought to address factors such as: (1) individual resources, by providing coverage and care at no cost or on an ability to pay based on income level; (2) individual characteristics, through community and facility-based outreach to educate and enroll those in need; (3) individual needs through social work services made available to program participants, as well as through care and disease management for prevalent primary care treatable chronic conditions; and (4) community resources by organizing the delivery system into defined networks that emphasized primary care access and utilization (Chesney et al., 2007).

These studies seem to suggest that successful integration of behavioral health requires the support of a strengthened primary care delivery system as well as a long-term commitment from policymakers at the federal, state, local, and private levels (Pautler, 2005). At the center of integrated behavioral health framework is the consumer, the person who faces or is at risk for mental health challenges or mental illness. This focus highlights the purpose and intended outcomes of integrated care, which is to optimize consumers' care by increasing their access to health prevention and promotion, while eliminating health disparities through more intensive levels of care and rehabilitation, according to need, and, thus, to decrease the burden of illness associated with co-morbid conditions (Pautler, 2005).
Access to Care

Millman (1993) asserts that one of the areas that integrated behavioral health care is supposed to address is access to care. Access is a term used for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the medical care system. According to Michael Millman (1993), because of the difficulties in defining and measuring the term access, most people often equate access with insurance coverage and having enough doctors and hospitals in the areas in which they live. But having insurance or nearby health care providers is no guarantee that people who need services will get them. Conversely, many who lack coverage or live in areas that appear to have shortages of health care facilities do, indeed, receive services (Millman, 1993).

The President’s Commission for the Study of Ethical Problems in Medicine and Biomedicine and Behavioral Science Research (1983) was perhaps the most extensive effort to sort out the meanings of access and the related concept of equity. The commission described society's ethical obligation to ensure access as follows: Equitable access to health care requires that all citizens be able to secure an adequate level of care without excessive burdens (President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983). The President’s Commission tried to provide a framework within which debates about health policy might take place, and on the basis of which policymakers could ascertain whether some proposals do a better job than others of securing health care on an equitable basis (President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1983).
According to Millman (1993), the Institute of Medicine (IOM) committee considered ways to resolve these conceptual problems; it became clear that health outcomes are as integral to the concept of access as is the use of services. Furthermore, IOM concluded that with equity of access, the answers to these questions should not be affected by race, ethnic origin, income, geographical location, or insurance status. Based on these considerations, the committee defined access as follows: the timely use of personal health services to achieve the best possible health outcomes. More importantly, this definition relies on both the use of health services and on health outcomes to provide yardsticks for judging whether access has been achieved. The test of equity of access involves determining whether there are systematic differences in use and outcome among groups in society and whether these differences are the result of financial or other barriers to care (Millman, 1993).

**Categories of Access**

Another key consideration in the discussion of access has to do with the pathways to access (Agency of Healthcare Research and Quality, 2004). As such, the National Health Care Disparities Report of 2004 acknowledged that the pathway towards accessing healthcare involves the process of gaining entry, getting to the geographic and physical locations where health care is being delivered and finally, finding appropriate providers who can deliver the much needed care (Agency of Healthcare Research and Quality, 2004). At any point throughout this process, barriers to the pathways to access can occur for an individual as they navigate through these pathways. As a result, AHRQ established three categories on which to measure access, which are: structural measures,
According to Gunner (2007), structural measures of access involve whether or not a health care system has the resources available to enable healthcare. Such as healthcare insurance and health care providers within geographic proximity who can provide services to patients (Gunner, 2007). The second access measure, patient assessment of care, while often viewed as subjective, provides critical feedback from the patient perspective towards the process of seeking and acquiring appropriate care (Gunner, 2007). There is growing evidence of the links between consumer feedback and participation in decision-making in individual care leads to improvements in health outcomes (England & Evans, 1992; Fallowfield, Hall, Maguire, & Baum, 1990). Finally, measures of care utilization provide an objective appraisal on the adequacy of care and the relationship between health risk conditions and the level of health services accessed (Gunner, 2007).

Satisfaction with Behavioral Health Care

Another key aspect of integrated behavioral health care is its patient centered approach to care. As such, patient satisfaction is often cited as a key factor towards patient health outcomes (Imam et al., 2007). Compared with other outcome measures, patient-defined outcomes emphasize the importance and uniqueness of the individual’s experience (Slade, Leese, & Cahill, 2005; Hammond, 2003). Conversely, the credibility of patient evaluations does not necessarily rely on any agreement about professionally
defined outcome measures, or measures with a definite relationship to external realities (Edlund, Young, & Kung, 2003).

According to Davies, Leese, Parkman, Phelan, and Thornicrof (2005), two persons given exactly the same treatment and stimuli will not necessarily perceive these services as being exactly similar. Several researchers have called attention to the lack of conceptual agreement in the field of patient satisfaction research (Slade, Leese, & Cahill, 2005).

However, according to a report from the Health Boards Executive (2003), satisfaction, like many other psychological concepts, is easy to understand but hard to define. The concept of satisfaction overlaps with similar themes such as happiness, contentment, and quality of life (Health Boards Executive, 2003). Satisfaction, according to the Health Boards' Executive committee, is not some pre-existing phenomenon waiting to be measured, but a judgment people form over time as they reflect on their experience. For this reason, a simple and practical definition of satisfaction is the degree to which the desired goals of treatment have been achieved (Health Boards Executive, 2003).

For example, in 2010, the Kentucky Cabinet for Health and Family Services, Department for Behavioral Health Developmental and Intellectual Disabilities (BHDID) conducted a survey to evaluate consumers' satisfaction with services delivered at Community Mental Health Centers (CMHCs) in Kentucky (Sohn, 2011). The purpose of this study was to identify factors that predict clients' perception on General Satisfaction via responses from the survey. Two separate logistic regression analysis were performed for adult and youth survey respondents, respectively (Sohn, 2011).
For the adult survey, respondents' characteristics and their responses about several aspects of services were included as potential explanatory variables. For the youth survey, since caregivers participated in the survey also, their responses about several aspects of services that their children received, the youth patients' characteristics, medical and social backgrounds were used as explanatory variables (Sohn, 2011).

Findings from the adult survey responses, as it pertains to the domains of access, quality and participation in treatment planning, indicated a significant relationship between those domains and clients' perception on General Satisfaction. Conversely, in the youth survey, the domains of access, cultural sensitivity, participation in treatment planning and social connectedness were found to be significantly associated with responses to General Satisfaction (Sohn, 2011).

Hence, Sohn (2011) found that respondents who positively indicated those domains of services are more likely to answer positively as generally satisfied. As a result, Sohn argued that in the areas of services, especially access, quality, cultural sensitivity, participation in treatment planning were shown to be related with General Satisfaction; and, as a result, could increase the level of positive responses in behavioral health care services (Sohn, 2011).

Perception

As stated earlier on in this chapter, at the centre of integrated behavioral health’s framework is the client. As such, the clients’ perception as it relates to access to care and satisfaction with the care received, are important factors in clients’ health outcomes. Perception is a term used to describe the process of organizing and interpreting
environmental information into recognizable and meaningful objects and events (Myers, 1998). Perception involves the human mind engaged in an ongoing process of filtering sensory information into what makes sense (Myers, 1998). Perception involves top-down effects as well as bottom-up process of processing sensory inputs (Myers, 1998). The bottom-up processing is considered low-level information that is used to build up higher-level information, for example, shapes for object recognition. The top-down processing refers to a person's concept and expectations, i.e., knowledge that influences perception (Myers, 1998).

**Components of Perception**

Perception has three components, these components are: a perceiver, a target that is being perceived, and some situational context in which the perception is occurring (Saks & Johns, 2011). According to Saks and Johns (2011), the perceiver's experience, needs, and emotions can affect his or her perceptions of a target. An important characteristic of the perceiver that influences his or her impressions of a target is experience. Past experiences lead the perceiver to develop expectations, and these expectations affect current perceptions. One of the most important influences on perception is experience. Individuals' past experiences lead them to develop expectations that affect their current perceptions (Saks & Johns, 2011).

Individuals' perceptions are also influenced by the target's social status and ambiguity. Ambiguity or lack of information about a target leads to a greater need for interpretation and understanding of what is being experienced. Moreover, every occurrence of perception occurs within some situational context, and this context can
oftentimes affect what one perceives. The most important effect that the situation can have is to add information about the target (Saks & Johns, 2011); hence, resulting in the synthesis of these three components of perceiver, target and situational context. Thus, leading to the development of perceptual sets, which are mental predispositions used to perceive one thing and not the other based on one's experiences, assumptions, and expectations of a given object or task (Myers, 1998).

Theoretical Framework

The following six conceptual frameworks were used to gain a better understanding of this study, the problem presented and the best methodological approach to be used in an effort to answer the research questions presented in this study. The Bio-psychosocial Model, Population Health Model, Chronic Disease Model and the Recovery Model were used to understand the clinical and practice underpinnings of this descriptive and explanatory study; whereas, the Afrocentric Perspective was utilized as a lens in which to view and better understand populations who have been or maybe at risk for oppression, marginalization or being undervalued. Concomitantly, the Open Systems Theory of organizations was used as a framework in which to understand the organizational process, systems, climate and culture of the organization associated with this study.

Biopsychosocial Model

The biopsychosocial model (BPS) is a general model or approach which suggests that biological, psychological, which entails thoughts, emotions, and behaviors, and social factors, all play a significant role in human functioning in the context of disease or
illness (Engel, 1977). The biopsychosocial model, according to Pautler (2005), examines the relationship between psychosocial experiences and biomedical diseases. Over the last two decades emerging evidence has indicated that there are relationships between psychosocial, environmental and biomedical factors in the origin and treatment of disease (Pautler, 2005).

As a result, this new body of knowledge and way of conceptualizing health and well-being has played a significant role in forming a considerable portion of the case for integrative behavioral healthcare; as opposed to the medical model which only considers the biological factors at the expense of social determinants and their impact on a person’s well-being and how we think about health and illness (Pautler, 2005). The biopsychosocial model is appropriate for this study because it provides a framework to think about how care is organized and delivered and how to conduct research and evaluate outcomes in coordinated care systems (Pautler, 2005). Furthermore, the biopsychosocial model is fundamental to family practice, because it places emphasis on the three spheres of a person which are the biological, psychological, and socio-cultural determinants and the interplay among these three elements in a person’s life as the best suited approach towards addressing any type or combination of client problems within primary care medicine (Engel, 1977).

The biopsychosocial model is not without its critics, for example, Dr. Niall McLaren, professor, psychiatrist and author of several books on psychiatry and the BPS model, argues that the BPS model is not grounded in the principles of scientific method which requires the gathering empirical and measurable evidence subject to specific principles of reasoning (McLaren, 2004). As such, the continued use of BPS model as
the determination for the role of illness and disease proves to be problematic since it
cannot be measured (McLaren, 2004). Therefore, Dr. McLaren (2004) contends that the
biopsychosocial becomes one more disingenuous panacea for psychosomatic illness.
McLaren argues that while sociology, psychology, and biology are factors in mental
illness, simply stating this obvious fact does not make it a proven model in the tradition
of the scientific inquiry method. As such, conclusions drawn from the BPS model could
be exploited by medical insurance companies or government welfare departments to
determine who gains access to medical care and social services (McLaren, 2004).

Similarly, some psychiatrists see the BPS model as flawed, in either its
formulation or application (Epstein & Borrell-Carrio, 2005). In their study, Epstein and
Borrell-Carrio (2005) described six conflicting interpretations of what the model might
be, and proposed that habits of mind may be the missing link between a biopsychosocial
intent and clinical reality. Likewise, psychiatrist Hamid R. Tavakoli (2009) argues that
the BPS model should be avoided because it unintentionally promotes an artificial
distinction between biology and psychology, and merely causes confusion in psychiatric
assessments and training programs, and ultimately it has not helped the cause of trying to
de-stigmatize mental health (Tavakoli, 2009).

This is evidenced by medical students and residents who often have trouble trying
to categorize conditions like bipolar disorder and schizophrenia, in the biological versus
the psychological sphere, when such a separation is arbitrary. Also, this can lead to the
implication that perhaps such disorders of the brain can be controlled and manipulated by
patients, which is clinically inaccurate and can lead to misguided treatments with
potential for suboptimal outcomes (Tavakoli, 2009). As such, a necessary sense of
pragmatism and a form of mutual tolerance has forced a co-existence of perspectives, between medical and mental health sectors, rather than a genuine theoretical integration of a shared BPS paradigm (Pilgrim, 2002). Furthermore, Pilgrim (2002) suggested that despite the scientific and ethical virtues of the BPS model, it has not been properly realized. As a result, it seems to have been pushed into the background by a return to medicine and the re-ascendancy of a biomedical model.

**Population Health Approach**

According to Saskatchewan Health Population Branch of Canada (1999), the goal of a population health approach is to maintain and improve the health status of the entire population and to reduce inequalities in health status between groups and subgroups. Many factors significantly affect and impact the health and health status of individuals. These factors are called determinants of health (World Health Organization, 2008). Determinants of health include factors such as: income and social status, social support networks, education, employment and working conditions, physical environments, social environments, biology and genetic predispositions, personal health practices and coping skills, healthy child development, health services, gender and culture (World Health Organization, 2008). In a population health approach, the entire range of individual and collective determinants, and the ways in which they interact, is considered. An important feature in the approach is the necessity to collect and use evidence which shows how these determinants affect population health status (Saskatchewan Health, 1999).

A population health approach is a conceptual framework for thinking about health. It helps to identify the determinants that influence health, to analyze them and to
assess their relative importance in determining health (Saskatchewan Health, 1999).

This approach includes decisions about priorities, investment and policy changes which are guided by the evidence about the relative contribution to population health status to the determinants of health and their interactions. Population Health is a framework for taking action, through policies, programs and services, on health issues that comprehensively address health issues of a population, in ways that take into account the multiple determinants of health (Saskatchewan Health, 1999).

It involves actions primarily targeted at the micro, mezzo and macro level, in order to have an impact on health status at the population or group level. It also requires collaboration between multiple sectors at the community, local and government levels; business and voluntary organizations in the field on health. This framework is best suited for my study because it provides a framework on which to assess the outcomes of the organizations efforts towards integrated behavioral healthcare (Saskatchewan Health, 1999).

Conversely, the effectiveness of the model as it relates towards addressing population health and its approach is still relatively young and evolving. As such, the effectiveness of the model and its outcomes are still being determined as it is put into action and its impact and outcomes are evaluated for best practices and adoption across populations (Tanner, 2004).

**Chronic Care Model**

According to Wagner et al. (2001), the Chronic Care Model (CCM) identifies the essential facilitators of a health care system that encourages high-quality chronic disease
care and ultimately better client outcomes. These facilitators are the community, the health system, self-management support, delivery system design, decision support and clinical information systems (Wagner et al., 2001). The Chronic Care Model is a proposal for reorganizing primary medical care to better address the needs of patients with chronic illnesses. For these reasons the model is appropriate for this study because it proposes a new clinical paradigm for delivering chronic disease care, with a major emphasis on patient self-management and secondary prevention (Wagner, Austin, & Von Korff, 1996). The ideas behind the CCM were outlined in a series of landmark articles published in 2002 in the Journal of the American Medical Association that described a number of attempts to implement various aspects of the model in diverse healthcare delivery systems across the United States (Bodenheimer, Wagner, & Grumbach, 2002).

According to Wagner, Austin, and Von Korff (1996), the Model is applicable to a variety of chronic illnesses such as mental illness and health care settings that treat populations with chronic illness. CCM suggests that in the long run, healthier patients’ translates to more satisfied providers, improved cost-effectiveness in health care provision and overall improved outcomes for patients (Wagner, Austin, & Von Korff, 1996).

The most frequently asked question about chronic care management is, does it work? As such, there are still many skeptics about the effectiveness of chronic care model (Norris, Nichols, Caspersen, & Glasgow, 2002). The body of research evaluating chronic care models over the past ten years has grown. A number of published studies demonstrate positive financial and clinical outcomes (Norris et al., 2002). Norris, Nichols, Caspersen, and Glasgow (2002) reviewed 27 studies that measured the impact of
disease management programs on cost and found there was evidence of cost savings in three of five chronic care management programs, eight of thirteen asthma management programs, and seven of nine diabetes management programs but few in the area of substance abuse, addictions and mental health programs. Yet, the majority of published studies report on individual programs with relatively small patient populations. Many do not examine economic aspects of the programs under study (Norris et al., 2002).

Furthermore, according to Norris et al. (2002), early outcome evaluations have frequently contained flawed assumptions leading to biased or suspect results. Randomized controlled trials have been the gold standard for evaluating chronic care model programs, but often these trials are impractical in a health plan environment. Most evaluations are based on pre-post test methodologies – which try to assess what costs, would have been if the program being studied were not in place. Pre-post analyses can substantially overstate care management program savings if not properly designed (Norris et al., 2002).

**Recovery Model**

The Recovery Model as it applies to mental health is an approach to mental disorders or substance dependence that emphasizes and supports each individual's potential for recovery. Recovery is seen within the model as a personal journey that may involve developing hope, a secure base and sense of self, supportive relationships, empowerment, social inclusion, coping skills, and meaning (Deegan, 1988). Originating from the 12-Step Program of Alcoholics Anonymous and the Civil Rights Movement, the use of the concept in mental health emerged as deinstitutionalization resulted in more
individuals living in the community. It gained impetus due to a perceived failure by services or wider society to adequately support social inclusion, and by studies demonstrating that many can recover (Deegan, 1988).

The Recovery Model has now been explicitly adopted as the guiding principle of the mental health systems of a number of countries and states (Mental Health: A Report of the Surgeon General, 1999). In many cases practical steps are being taken to base services on the recovery model, although there are a variety of obstacles and concerns raised. A number of standardized measures have been developed to assess aspects of recovery, although there is some variation between professionalized models and those originating in the psychiatric survivor movement (Mental Health: A Report of the Surgeon General, 1999).

Some concerns have been raised about recovery models, according to Davidson, O’Connell, Tondora, Lawless, & Evans (2005). Recovery is an old concept and, therefore, a focus on recovery adds to the burden of already stretched providers in that, recovery is a process. As such, it is neither something providers can do to or for people with mental illness, nor is it something that can be promoted after or separate from treatment and other clinical services (Davidson, O’Connell, Tondora, Lawless, & Evans, 2005). Furthermore, recovery must involve cure first before a discussion of recovery can occur. Another criticism is that recovery happens to very few people, and as such, recovery represents an irresponsible fad.

Another concern pointed out by Davidson et al. (2005) is recovery-oriented care can only be implemented through the addition of new resources, and recovery-oriented
care is neither reimbursable nor evidence based; additionally, recovery-oriented care devalues the role of professional intervention.

Furthermore, there have been tensions between recovery models and particular evidence-based practice models in the transformation of US mental health services, based on recommendations from the New Freedom Commission to promote recovery-oriented care in the treatment of mental illness (Davidson et al., 2005). As such, opponents of the recovery movement believe this will increases providers' exposure to risk and liability in the use of the recovery model due to the lack of evidence to support the efficacy of the model (Davidson et al., 2005). The New Freedom Commission's emphasis on the recovery model has been interpreted by some critics as saying that everyone can fully recover through sheer will power, and therefore may give a false hope to those judged unable to recover and implicitly blame those people judged unable to recover (Davidson et al., 2005).

Afrocentric Perspective

The Afrocentric perspective in social work was developed at Atlanta University School of Social Work during the civil rights era, in response to what was seen by the school’s social work student body and faculty, as an overwhelming preponderance of Eurocentric oriented theories and paradigms being used to address social problems experienced by diverse populations who were often times not of European origin (Adams, 1981). The Afrocentric perspective grounded as it is in humanistic values sought to transcend the conventional pathological view that African Americans, poor or oppressed groups due to race, ethnicity, gender or sexual orientation, experience social
dysfunctioning, primarily due to internal deficits and character disorders. It places primacy on the strengths and uniqueness of differential population groups and dictates service response patterns which respect the cultural integrity of affected populations as well as their ethos, talents and creative cores. Thus, the Afrocentric Perspective defines and portrays some of these differences and their implications for social work education, human behavior, research, policy and practice (Clark Atlanta University School of Social Work, 1999).

The Afrocentric perspective attempts to establish a mindset within the evolutionary historical development of African Americans before and after their dispersal from Africa and nourishes a belief in the concept of prevailment. As such, it emphasizes the need for social work practitioners to understand and appreciate the significance of history; from an Afrocentric perspective, it is believed that it is virtually impossible to take an effective social history of an individual in the absence of a socio-cultural history of his or her social group. To do so, according to Afrocentric perspective is to run the risk of misinterpreting objective reality or the conditions being experienced, in favor of the practitioner’s subjective reality or understanding of those conditions (Clark Atlanta University School of Social Work, 1999).

As such, the Afrocentric perspective seeks to bring about an understanding that human beings are not separate from their experiences or cultures. The Afrocentric perspective holds the position that one’s heritage forms the basis for developing an understanding and appreciation for diversity and heritage of others.

As such, being mindful of this social fact while attempting to assist your client system is critical towards developing an authentic therapeutic relationship, by
understanding issues of populations who have experienced or are experiencing various forms of oppression, discrimination or marginalization, aids in the process of developing authenticity. Therefore, understanding that your client system is the expert in interpreting their problem. The clinician's role is to facilitate the process towards empowerment, self actualization and spiritual realignment (Clark Atlanta University, School of Social Work, 1999).

However, there are critics of the Afrocentric perspective, such as Kwame Anthony Appiah. Appiah, in his essay, Europe Upside Down: Fallacies of the New Afrocentrism, argues that current Afrocentricism is nothing more than folk or ethnic philosophy which does not include any serious critique or analysis expected in serious philosophical discourse. Furthermore, Appiah argues that Afrocentricism uses a paradigm which is a mirror image to Eurocentric constructions of race and a preoccupation with the ancient world of Africa that no longer exist as its bases on which to develop its frame of reference (Appiah, 1992).

**Systems Theory**

Open systems theory refers to the concept that organizations are strongly influenced by their environment. The environment consists of other organizations that exert various forces of an economic, political, or social nature. The environment also provides key resources that sustain the organization and lead to change and survival. Open systems theory was developed after World War II in reaction to earlier theories of organizations development, such as the human relations perspective of Elton Mayo and
the administrative theories of Henri Fayola, which treated organizations largely as a self-contained entity (Morgan, 1997).

Open Systems theory was started with the research of Ludwig Von Bertalanffy in the field of biology. Open systems theory is unique, in part as stated earlier, because it considers the organization as part of the unique environment in which they operate and as such, should be structured to accommodate unique problems and opportunities that are presented within their environmental context (Hofkirchner & Schafranek, 2011).

Environmental influences that affect open systems can be described as either specific or general. The specific environmental factors often refer to the network of suppliers, distributors, government agencies, and competitors with which a business enterprise interacts. Whereas, the general environment encompasses four factors that emanate from the geographic area in which the organization operates, such as cultural values, which shape views about ethics and determine the relative importance of various issues faced by the organization (Hofkirchner & Schafranek, 2011).

A second factor is economic conditions, which include economic upswings, recessions, regional unemployment, and many other regional factors that affect an organization's ability to grow and prosper. A third factor is the legal and political environment, which effectively helps to allocate power within a society and to enforce laws. Moreover, the legal and political systems in which an open system operates can play a key role in determining the long-term stability and security of the organization's future. The fourth and final factor is quality of education, which is an important factor in high technology, medical or other industries that require an educated work force (Morgan, 1997).
The open-systems theory also assumes that all large organizations are comprised of multiple subsystems, each of which receives inputs and throughputs from other subsystems and turns them into outputs for use by other subsystems. The subsystems are not necessarily represented by departments in an organization, but might instead resemble patterns of activity (Cummings & Worley, 2009).

The model suggests that organizations operate within an external environment which takes specific inputs from the environment and transform those inputs into throughputs, by using social and technical processes. The outputs from the transformation process of the throughputs are then returned into the environment, which can then be used as feedback to inform the organization as it pertains to its functioning (Cummings & Worley, 2009).

An important distinction between open-systems theory and more traditional organizational theories is that the former theory assumes a subsystem hierarchy, meaning that not all of the subsystems are equally essential. Furthermore, a failure in one subsystem will not necessarily thwart the entire system. By contrast, traditional mechanistic theories implied that a malfunction in any part of a system would have an equally debilitating impact (Cummings & Worley, 2009). For these reasons the Open Systems Theory is appropriate for this study because it provides a framework in which to examine and understand the interaction between the organization and its multilevel subsystems that are involved in providing integrated behavioral care to clients' within integrated behavioral healthcare model.

Conversely, the open systems theory is often cited as being overly complex and as such, requires an enormous amount of training and willingness by an organization's
leadership and all its involved stakeholders in the organization to embrace an ideology of continuous feedback and improvement which can often be perceived as additional work for organizations that are often underfunded and over worked to begin with (Bell, 2012).

In summary, this chapter provided a review of the current literature on integrated behavioral health care, its origins and its application in the field of mental health. The literature review covered behavioral health, mental health, and primary care and health disparities. Additionally, examples of integrated behavioral health care models currently being used in the field were also discussed. The dependent variable of perception was defined and discussed as it relates to this study. Whereas, the independent variables of access and client satisfaction were discussed as important factors associated with clients’ perception of integrated behavioral healthcare. Six conceptual models were presented as a lens in which to further examine and understand this study.

Furthermore, this literature review is relevant to this study as it purports to shed light on the current discussion on best practices for social workers who are or who will be practicing in an integrated behavioral health care setting; and their role in such settings. The literature suggests social workers must first; learn more about the physical health issues that mental health clients often face. Secondly, obtain a strong understanding of the psychiatric diagnoses necessary to confidently do assessments in a fast-paced environment of hospitals and primary care settings. Thirdly, recognize interviewing as a bedrock social work skill and asset; and as such, use it to obtain an understanding of the interface between physical and mental health issues faced by patients. Finally, social workers must be willing to cooperate with client’s medical providers by seeing them as partners and not as competitors in the treatment process (Reardon, 2010).
CHAPTER III

METHODOLOGY

This chapter provides an explanation of the research method that was used in the study and the appropriateness of a descriptive and explanatory research method for this study. This chapter provides a detailed discussion of the study population, sampling technique, data collection procedures and rationale employed. This chapter also addresses the issue of internal and external validity and discusses descriptive analysis as the appropriate procedure for data analysis and presentation of findings from this study. The chapter ends with a summary of the overall information presented in the chapter.

Research Design

A descriptive and explanatory research design was employed in this study. The study was designed to ascertain data in order to describe and explain the perceptions' of consumers with mental illness; regarding their ability to gain access to and satisfaction with integrated behavioral health care in Metropolitan Atlanta. The descriptive and explanatory research design allowed for the descriptive analysis of the demographic characteristics of the respondents. Furthermore, this research design also facilitated the explanation of the statistical relationships between the research questions presented in chapter one of this study.
Description of Site

This research was conducted in Atlanta, Georgia. Atlanta is the largest urban Metropolitan city in the state of Georgia. The surveys were administered at one of Metropolitan Atlanta’s Community Service Boards. Community Service Boards are a public entity created by the Georgia Legislature in 1993 to provide mental health, developmental disability and addictive disease services to various counties throughout Metropolitan Atlanta (House Bill 100, 1993).

Sample and Population

The target population for this study was composed of current participants with serious mental illness, served within a Metro Atlanta Integrated Behavioral Health Facility. The participants must have been served within the facility over the past 24 months and not have had a psychotic episode within the last three months of when the data was collected. A baseline was established in an attempt to include only individuals’ who were in the recovery phase within their treatment, alert and oriented times 3 to place, time and person in order to participate in completing the survey. A purposive sample of 75 participants was selected utilizing a nonprobability convenience sampling from among the participants of the selected site for this study.

Instrumentation

The research study employed a survey questionnaire format. The Agency for Healthcare Research and Quality, Experience of Care and Health Outcomes (ECHO) survey was employed. This instrument consisted of 34 items. ECHO surveys are a part of AHRQ’s Consumer Assessment of Healthcare Providers and Systems surveys. The
The survey has been tested for reliability and validity and is seen as an evidenced based survey in the field of behavioral health and healthcare. The survey was divided into three sections. Section I solicited questions from respondents regarding whether or not they were screened for medical conditions at the behavioral health center. This information was deemed as important to the agency/stakeholder who had received a demonstration grant to screen and monitor their clients in their integrated behavioral healthcare program.

Section II of the survey solicited the perceptions of the participants regarding their ability to gain access to behavioral healthcare at the center and their satisfaction with the care received. Section II consisted of sixteen items that asked questions regarding access, adherence to treatment, satisfaction and stigma associated with having a mental health condition. Of the sixteen questions, selected questions were used as independent variables for the study. The questions employed a likert scale format utilizing a rating scale of 1 through 6 in the following manner: 1 = Strongly Agree; 2 = Agree; 3 = Agree Somewhat; 4 = Undecided; 5 Disagree and 6 = Strongly Disagree.

Section III of the survey solicited demographic information regarding the characteristics of the survey respondents, such as respondents' overall health and mental health status, age, race, ethnicity, gender, education level; and did someone help the respondent to complete the survey and if so, how.

Treatment of Data

Statistical treatment of data employed was descriptive statistics, which included measures of central tendency, frequency distribution and cross tabulation. The test
statistics for the study was phi and chi square. Frequency distribution was used to analyze each of the variables of the study in order to summarize the basic measurements. A frequency distribution of independent variables was used to develop a demographic profile and gain insights about the respondents from the study. Cross tabulations were utilized to demonstrate the statistical relationship between independent variables and the dependent variable in this study. Cross tabulation were conducted between access to integrated behavioral health, and satisfaction with care. Two test statistics were employed. The first test was Phi (\(\Phi\)) which is a symmetric measure of associations that is used to demonstrate the strength of relationships between two or more variables (Knoke & Bohnsteadt, 1995). The following are the values associated with Phi (\(\Phi\)):

- .00 to .24 “no relationship”
- .25 to .49 “weak relationship”
- .50 to .74 “moderate relationship”
- .75 to 1.00 “strong relationship”

The second test statistic employed in this research study was chi square. Chi square was used to test whether or not there was a statistical significance at the .05 probability among the variables in the study.

Limitations of the Study

There were two basic limitations of the study. First, the study was delimited to the agency selected; and second, the size of the sample (\(N=75\)) utilized for the purpose of the study. As such, the findings from this study are only relevant to this sample and may not be replicable to other or similar populations as described in this study.
CHAPTER IV
PRESENTATION OF FINDINGS

The purpose of this chapter was to present the findings of the study in order to describe and explain the perceptions of consumers with mental illness: regarding their ability to gain access to and general satisfaction with integrated behavioral healthcare in Metropolitan Atlanta. This chapter presents the findings of the study. The findings are organized into two sections: demographic data and research questions and hypotheses.

Demographic Data

This section provides a profile of the study respondents. Descriptive statistics were used to analyze the following: respondents overall health, overall emotional health, age group, gender, education, whether respondents were of Hispanic or Latino descent, their race, did someone help with completing the survey and if so, how did that person help.

Target population for the research was composed of current program participants with serious mental illness, served within McIntosh Community Service Board Behavioral Health facility in Metropolitan Atlanta, over the past 24 months; excluding those who had a psychotic episode within the last three months. Seventy-five program participants (N=75) were selected utilizing purposive and non probability convenience sampling from among participants of the selected site.
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<tr>
<td>High school grad-GED</td>
<td>33</td>
<td>44.0</td>
</tr>
<tr>
<td>Some college or 2yr degree</td>
<td>15</td>
<td>20.0</td>
</tr>
<tr>
<td>4 yr college grad</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>More than 4yrs college degree</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td><strong>Descent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Not Hispanic or Latino</td>
<td>74</td>
<td>98.7</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>40</td>
<td>53.3</td>
</tr>
<tr>
<td>Black or African American</td>
<td>34</td>
<td>45.3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>
Table 1 (continued)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did someone help you with survey?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>18.7</td>
</tr>
<tr>
<td>No</td>
<td>61</td>
<td>81.3</td>
</tr>
<tr>
<td>How did that person help you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Read the questions to me</td>
<td>8</td>
<td>10.7</td>
</tr>
<tr>
<td>Wrote down the answers I gave</td>
<td>6</td>
<td>8.0</td>
</tr>
</tbody>
</table>

As indicated in Table 1, forty-two of the respondents of the study were female, whereas thirty-three was male. The average age range of the typical respondent of the study was between 25-55 years old. The typical respondent also had some form of formal education. Twenty-three had some high school education whilst thirty-three graduated from high school and two respondents had two or more years of college education. The typical respondent was not Hispanic or Latino; Forty where white whereas 34 were African American and one was other. The typical respondent felt that their overall health was good whereas their overall emotional health was fair.

Research Questions and Hypotheses

There were six research questions and six null hypotheses in the study. This section provides an analysis of the research questions and a testing of the null hypotheses.
Research Question 1: Do mental health consumers who participate in integrated behavioral healthcare programs have access to care as needed?

Hypothesis 1: There is no statistical evidence of mental health consumers who participate in integrated behavioral healthcare programs having access to care as needed.

In this study, access to care was defined as the timely use of personal health services to achieve the best possible health outcomes; through the process of gaining entry, getting to the geographic and physical locations where health care is being delivered and finding the appropriate providers for needed care.

To answer this research question consumers had to rate in likert scale format their opinions concerning statements regarding their ability to gain access to behavioral healthcare services as needed, using the following scale: 1) Strongly agree, 2) Agree, 3) Agree somewhat, 4) Undecided, 5) Disagree, 6) Strongly disagree.

The statistical method of recoding was employed in order to make a better interpretation of the data being presented, by grouping the following variables: Strongly Agree, Agree somewhat and Agree were recoded as the variable, Agree; Strongly Disagree and Disagree were recoded as the variable Disagree. The variable, Undecided remained the same. As such the new variables were 1) Agree, 2) Disagree, 3) Undecided.

Table 2 is a frequency distribution of the computed variable access. In order to determine the true arithmetic mean of the variable, four items from the survey identified as access items, were aggregated and recoded as access in order to determine the true arithmetic mean of the variable access.
Table 2

ACCESS: Access among consumers with mental illness to integrated health care services

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Agree</td>
<td>73</td>
<td>97.3</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.08  Std. Dev .487

As shown in Table 2, the consumers with mental illness receiving services at an integrated health behavioral health care provider in Metropolitan Atlanta indicated that they believe they have access to care at the integrated behavioral health care facility. Of the 75 respondents, 97.3% indicated that they agreed that they have access to care. Only 2.7% indicated that they disagreed that they have access to care.

Research Question 2: Are mental health consumers satisfied with services received in integrated behavioral health care?

Hypothesis 2: There is no statistical evidence of mental health consumers' satisfaction with services received in integrated behavioral health care.

In this study, satisfaction was defined as the degree to which the desired goals of treatment have been achieved. Table 3 is a frequency distribution of the computed variable satisfaction. In order to determine the true arithmetic mean of the variable, the values (1 thru 3) from the three sub-facets were recoded.
Table 3

SATIS3: Satisfaction among consumers with mental illness with the services received

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Undecided</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Agree</td>
<td>72</td>
<td>96.0</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.09  Std. Dev .470

As shown in Table 3, the consumers with mental illness receiving services at an integrated health behavioral health care provider in Metropolitan Atlanta indicated that they were satisfied with the services received at the integrated behavioral health care facility. Of the 75 respondents, 96.0% indicated that they agreed that they were satisfied with the services they received. Only 1.3% of the respondents indicated that they were not satisfied with the services they received, and 2.7% indicated that they were undecided.

Research Question 3: Do mental health consumers follow their healthcare plan when provided with support from care-management coordination in integrated behavioral health care?

Hypothesis 3: There is no statistical evidence of mental health consumers following their healthcare plan when provided with support from
care-management coordination in integrated behavioral health care.

In this study, care-management coordination was defined as patient tracking and clinical case-management through the use of non-physician staff, such as social workers, counselors, and other allied professional (Collins, Hewson, Munger, & Wade, 2010). Table 4 is a frequency distribution of the computed variable social support and encouragement from care-management coordination.

Table 4
COORD4: Social support and encouragement from care-management coordination helped me to follow my healthcare plan

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>Undecided</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Agree</td>
<td>72</td>
<td>96.0</td>
</tr>
<tr>
<td>Total</td>
<td>75</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Mean 2.09  Std. Dev .470

As shown in Table 4, the majority of mental health consumers receiving services at an integrated health behavioral healthcare provider in Metropolitan Atlanta indicated that social support and encouragement from care-coordination (counselor, social worker, and community support individual) helped them to follow their healthcare plan as prescribed by their medical provider. Of the 75 respondents, 96.0% indicated that they
agreed that social support and encouragement from care-management coordination helped them to follow their healthcare plan as prescribed; whereas, 2.7% of the respondents disagreed that social support and encouragement from care-management coordination helped them to follow their healthcare plan as prescribed. Only 1.3% of the respondents indicated that they were undecided whether or not social support and encouragement from care-management coordination helped them to follow their healthcare plan as prescribed by their provider.

Research Question 4: Is there a relationship between mental health consumers’ perception of access to care and satisfaction with services received in integrated behavioral healthcare?

Hypothesis 4: There is no statistically significant relationship between mental health consumers’ perception of access to care and satisfaction with services received in integrated behavioral healthcare.

Table 5 is a cross-tabulation of the aggregated variables consumers' perception of access by satisfaction with services received. Table 5 shows the association of consumers' perception of access to care and satisfaction with services received by respondents of the integrated behavioral health care facility and indicates whether or not there was a statistically significant relationship between the two variables.
Table 5

Cross-tabulation of consumers' access by satisfaction with services received

<table>
<thead>
<tr>
<th>Satisfaction with services received</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Access</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1.3</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Agree</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>1.3</td>
<td>2</td>
<td>2.7</td>
</tr>
</tbody>
</table>

$\phi = .862$  \hspace{2cm}  df = 2  \hspace{2cm}  \rho = .000

As indicated in Table 5, 1.3% of the respondents who disagreed that they had access to care were also dissatisfied with services received from the integrated behavioral health provider. There was one respondent (1.3%) who disagreed that they had access to care, but was undecided on whether or not they were satisfied with services received from the integrated behavioral health provider. However, the majority (97.3%) of respondents indicated that they believed they had access to care and were satisfied with the services received from the integrated behavioral health provider.

As shown in Table 5, the statistical measurement phi ($\phi$) was employed to test for the strength of association between consumer perception of access to care and satisfaction with services received. As indicated, there was a strong relationship ($\phi = .862$) between the two variables. When chi-square statistical test for significance
was applied, the null hypothesis was rejected \((p = .000)\) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 5: Is there a relationship between staff interpersonal skills and mental health consumers' satisfaction with services received in integrated behavioral health care?

Hypothesis 5: There is no statistically significant relationship between staff interpersonal skills and mental health consumers' satisfaction with services received in integrated behavioral health care?

Table 6 is a cross-tabulation of the aggregated variables identified as staff interpersonal skills by satisfaction with services provided. Table 6 shows the association of staff interpersonal skills with the satisfaction with the services received by respondents in the integrated behavioral health care facility and indicates whether or not there was a statistically significant relationship between the two variables.
Table 6

Cross-tabulation of staff interpersonal skills by satisfaction with services

<table>
<thead>
<tr>
<th>Satisfaction with services provided</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1.3</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Undecided</td>
<td>1</td>
<td>1.3</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Agree</td>
<td>0</td>
<td>0.0</td>
<td>71</td>
<td>94.7</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>2.7</td>
<td>72</td>
<td>96.0</td>
</tr>
</tbody>
</table>

\[
\phi = .696 \quad df = 2 \quad \rho = .003
\]

As indicated in Table 6, only 1.3% of the respondents that were undecided in the level of staff interpersonal skills also reported they were unsatisfied with integrated behavioral health services. There was one respondent (1.3%) who was undecided on both the staff interpersonal skills and level of satisfaction. However, a majority (94.7%) of the respondents indicated that they believed that the staff had good interpersonal skills and believed that they were generally satisfied with services received at the integrated behavioral health facility.

As shown in Table 6 the statistical measurement phi (\(\phi\)) was employed to test for the strength of association between staff satisfaction with services provided and staff interpersonal skills. As indicated, there was a moderate relationship (\(\phi = .696\)) between
the two variables. When the chi-square statistical test for significance was applied, the null hypothesis was rejected (p = .003) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

Research Question 6: Is there a relationship between staff interpersonal skills and mental health consumers' perception of reduced stigmatization in integrated behavioral health services?

Hypothesis 6: There is no statistically significant relationship between staff interpersonal skills and mental health consumers' perception of reduced stigmatization in integrated behavioral health services.

Table 7 is a cross-tabulation of the aggregated variables identified as staff interpersonal skills by perceptions of reduced stigmatization in integrated behavioral health care. It shows the association of staff interpersonal skills with the perception of reduced stigmatization in integrated behavioral health care and indicates whether or not there was a statistically significant relationship between the two variables.
Table 7

Cross-tabulation of staff interpersonal skills by perceptions of reduced stigma

<table>
<thead>
<tr>
<th>Staff Interpersonal Skills</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undecided</td>
<td>1 (1.3%)</td>
<td>0 (0.0%)</td>
<td>2 (2.7%)</td>
<td>3 (4.0%)</td>
</tr>
<tr>
<td>Agree</td>
<td>2 (2.7%)</td>
<td>0 (0.0%)</td>
<td>70 (93.3%)</td>
<td>72 (96.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>3 (4.0%)</td>
<td>0 (0.0%)</td>
<td>72 (96.0%)</td>
<td>75 (100.0%)</td>
</tr>
</tbody>
</table>

\[ \phi = .306 \quad \text{df} = 1 \quad \rho = .008 \]

As indicated in Table 7, only 2.7% of the respondents believed that the staff did not have good interpersonal skills, and also did not have a perception of reduced stigmatization in seeking integrated behavioral health services. However, a majority (93.3%) of the respondents indicated that they believed staff had good interpersonal skills and believed that there was reduced stigmatization in seeking integrated behavioral health services. There was one respondent (1.3%) that was undecided whether or not staff interpersonal skills had reduced stigmatization in seeking integrated behavioral health services. One respondent (1.3%) who was undecided on the level of staff's interpersonal skills agreed that there is reduced stigmatization in seeking integrated behavioral health services.

As shown in Table 7, the statistical measurement phi (\( \phi \)) was employed to test for the strength of association between staff interpersonal skills and perceptions of reduced...
stigma. As indicated, there was a weak relationship ($\phi = .306$) between the two variables. When chi-square statistical test for significance was applied, the null hypothesis was rejected ($p = .008$) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability.

In sum, 75 program consumers with mental illness responded to the survey which solicited their perceptions, regarding their ability to gain access to and satisfaction with integrated behavioral health care in Metropolitan Atlanta, by indicating that they agreed with all of the sub facets which composed the definition of access and satisfaction on the survey. It is concluded that the majority (97.3%) of mental health consumers believed that they were able to gain access to services at the behavioral health care facility, and a majority (96.0%) were also satisfied with the services they received. Furthermore, 93.3% of the respondents indicated that they believed there was reduced stigmatization in seeking integrated behavioral health services at the facility, and a majority (96%) of program consumers agreed that care-management coordination helped them to follow their healthcare plan as prescribed.
CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

This chapter discusses the findings of the study and concludes with a discussion as it relates to the implications for social work policy and practice and proposes some recommendations for future discussions for policy makers, social work practitioners and administrators. The research study was designed to answer seven questions concerning the perceptions of consumers with mental illness: regarding their ability to gain access to and general satisfaction with integrated behavioral health care in Metropolitan Atlanta. Each research question is presented in order to summarize the significant findings of interest as identified in Chapter IV.

Research Question 1: Do mental health consumers who participate in integrated behavioral healthcare programs have access to care as needed?

In order to determine the true arithmetic mean of the variable access, the values identified as access variables were aggregated and recoded as access. Likewise, the following variables, Strongly Agree, Agree somewhat and Agree, were recoded as the variable Agree; Strongly Disagree and Disagree were recoded as the variable Disagree. The variable Undecided remained the same. As such the new variables were 1) Agree, 2) Disagree, 3) Undecided.
Of the 75 respondents surveyed, 97.3% agreed that they had access to integrated behavioral health care at the facility (See Table 2).

Research Question 2: Are mental health consumers satisfied with services they receive in integrated behavioral health care?

In order to determine the true arithmetic mean of the variable satisfaction, the values identified as satisfaction variables were aggregated and recoded as satisfaction. Likewise, the following variables, Strongly Agree, Agree somewhat and Agree, were recoded as the variable Agree; Strongly Disagree and Disagree were recoded as the variable Disagree. The variable Undecided remained the same.

Of the 75 respondents, ninety-six percent (96.0%) of the program participants indicated that they agreed that they were satisfied with the services they received. One respondent or 1.3% indicated that he or she was not satisfied with the services received, and 2.7% indicated that they were undecided (See Table 3).

Research Question 3: Do mental health consumers follow their healthcare plan when provided with support from care-management coordination in integrated behavioral health care?

Of the 75 respondents surveyed, 96.0% indicated that they agreed that social support and encouragement from care-management coordination helped them to follow their healthcare plan as prescribed; whereas, 2.7% of the respondents disagreed that social support and encouragement from care-management coordination helped them to follow their healthcare plan as prescribed. Only 1.3% of the respondents indicated that they were undecided whether or not social support and encouragement from
care-management coordination helped them to follow their healthcare plan as prescribed by their provider.

Research Question 4: Is there a relationship between mental health consumers’ perception of access to care and satisfaction with services received in integrated behavioral healthcare?

The study indicated that 1.3% of the respondents who disagreed that they had access to care were also dissatisfied with services received from the integrated behavioral health provider. There was one respondent (1.3%) who disagreed that he or she had access to care, but was undecided on whether or not he or she was satisfied with services received from the integrated behavioral health provider. However, the majority (97.3%) of respondents indicated that they believed they had access to care and were satisfied with the services received from the integrated behavioral health provider.

The statistical measurement phi (φ) was employed to test for the strength of association between consumer perception of access to care and satisfaction with services received. As indicated, there was a strong relationship (φ = .862) between the two variables. When chi-square statistical test for significance was applied, the null hypothesis was rejected (p = .000) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability (See Table 5).

Research Question 5: Is there a relationship between staff interpersonal skills and mental health consumers’ satisfaction with services received in integrated behavioral health care?

The study indicated that one (1.3%) of the respondents that was undecided in the level of staff interpersonal skills also reported that he or she was unsatisfied with
integrated behavioral health services. There was one respondent (1.3%) who was undecided on both the staff interpersonal skills and level of satisfaction. However, a majority (94.7%) of the respondents indicated that they believed the staff had good interpersonal skills and believed that they were generally satisfied with services received at the integrated behavioral health facility.

The statistical measurement phi (ϕ) was employed to test for the strength of association between staff satisfaction with services provided and staff interpersonal skills. As indicated, there was a moderate relationship (ϕ = .696) between the two variables. The statistical measurement of chi-square was employed to test for the strength of the relationship between staff interpersonal skills and satisfaction of services received. When chi-square statistical test for significance was applied, the null hypothesis was rejected (p = .003) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability (See Table 6).

Research Question 6: Is there a relationship between staff interpersonal skills and mentally ill program consumers' perception of reduced stigmatization in integrated behavioral health services?

The study indicated that 2.7% of the respondents believed that the staff did not have good interpersonal skills, also did not have a perception of reduced stigmatization in seeking integrated behavioral health services. However, a majority (93.3%) of the respondents indicated that they believed staff had good interpersonal skills and believed that there was reduced stigmatization in seeking integrated behavioral health services. There was one respondent (1.3%) that was undecided whether or not staff interpersonal skills had reduced stigmatization in seeking integrated behavioral health services. One
respondent (1.3%) who was undecided in the level staff's interpersonal skills agreed that there is reduced stigmatization in seeking integrated behavioral health services (See Table 7).

The statistical measurement phi (\(\phi\)) was employed to test for the strength of association between staff interpersonal skills and perceptions of reduced stigma. As indicated, there was a weak relationship (\(\phi = .306\)) between the two variables. The statistical measurement of chi-square was employed to test for the strength of the relationship between staff interpersonal skills and perceptions of reduced stigma. When chi-square statistical test for significance was applied, the null hypothesis was rejected (\(p = .008\)) indicating that there was a statistically significant relationship between the two variables at the .05 level of probability (See Table 7).

In sum, 75 program consumers with mental illness responded to the survey which solicited their perceptions, regarding their ability to gain access to and satisfaction with integrated behavioral health care in Metropolitan Atlanta, by indicating that they agreed with all of the sub facets which composed the definition of access and satisfaction on the survey. It is concluded that the majority (97.3%) of mentally ill program consumers believed that they were able to gain access to services at the behavioral health care facility, and a majority (96.0%) were also satisfied with the services they received. Furthermore, 93.3% of the respondents indicated that they believed there was reduced stigmatization in seeking integrated behavioral health services at the facility and a majority (96%) of program consumers agreed that care-management coordination helped them to follow their healthcare plan as prescribed.
Implications for Social Work Practice

Findings from the study suggest that social work and social work practitioners have a crucial role in the provision of integrated behavioral health care. As such, social work professionals should consider the following when working within this model of care:

1. Learn more about the physical health issues that clients with serious mental illness often face;

2. Understand the importance of care coordination and case-management as key factors towards helping individuals with serious mental illness address any systemic barriers to patient access and positive consumer experiences with integrated behavioral health care services;

3. Consider the importance of clients' help seeking and health behaviors as it relates to the various pathways to access, adherence to treatment and utilization of services, by becoming more culturally competent in both of those areas; and

4. Utilize an autonomous social work practice model to ensure social work's core competencies and practices behaviors are practiced with clients' who seek services within a multidisciplinary integrated behavioral healthcare model.

Recommendations

Studies concerning the effectiveness and efficiency of integrated behavioral health care programs have focused primarily on the providers' perspective and not the consumers of these services. The success or failure of integrated behavioral health care as a model in which to coordinate care for individuals with serious mental illness relies
on patient experience and perception of services within this model of care. As a result of the findings from this study, the researcher is recommending the following:

1. Further research that employs a mix method approach that includes focus groups should be employed to give voice and context to multifaceted issues that clients with mental illness may present, in an effort to gain a better understanding of what works and what doesn’t from the clients’ perspective.

2. Policy makers at the federal, state, and local levels should encourage the use of findings from those research endeavors, as drivers towards continuous improvement and assurance of patient centeredness within this model of care, through ample funding of selected sites to overcome barriers, such as having an appropriate mix of professional and Para-professional individuals in the workforce to meet the needs of this population.

3. Social work administrators and program managers should ensure that their organizations and programs embrace policies and practices both implicitly and explicitly that foster learning communities and shared ownership with the consumers. By investing in training, technical support, best practices and continuous evaluation of systems and programs through the employment of process and outcome evaluations to address any organizational or programmatic barriers towards achieving organizational and program objectives and goals.

4. Social work education and schools of social work should identify and develop course offerings that incorporate integrated behavioral health into their curriculum content and field placements. Course content should focus on the following:
a. The role of the social worker within an multidisciplinary treatment model of care;

b. Screening, rapid assessments, brief interventions, group work;

c. Substance use counseling, addictions counseling, and clinical case-management;

d. The concept of intersectionality of social work and public health interventions, behavioral health issues and health practices among diverse populations; and

e. Field placements that offer opportunities for students to complete their field work in integrated behavioral health settings while receiving credit and training hours necessary to apply for Master's in Addiction Counselor (MAC) certification upon graduation from their social work programs.
APPENDICES
APPENDIX A

LETTER OF CONSENT TO PARTICIPATE IN STUDY

CLARK ATLANTA UNIVERSITY

Dear Research Participant,

I am a doctoral student at the Whitney M. Young, Jr., School of Social Work and I am conducting a research to examine Clients' perspective on Integrated Behavioral Healthcare.

Your perspective is very important and valuable to further the development of research experiences and needs of clients who receive care in integrated behavioral healthcare. This study is being conducted in partial fulfillment of doctoral research requirements and for future presentation and publication on Clients' perception about their ability to gain access to and satisfaction with integrated behavioral health care. You are being asked to participate in this study because of your unique perspective as a client who received these services. As such your perspective is valuable towards helping to improve care for future clients at McIntosh Community Service Board. If you choose to participate in this study, please complete the attached survey. The survey will inquire about opinions regarding your services you received from McIntosh Community Services Board and other providers over the course of the last 2 years.

All responses will remain confidential and anonymous. DO NOT write your name on the survey. There is no identifiable information on the survey, aside from some very general demographic questions. All surveys will be held in locked files by the Doctoral Program Chair for a period of three years, consistent with federal regulations. After this time, all data will either remain locked or will be destroyed. Locked data may be used for future publications or research only and no identifiable data on individual participants will be retained.

There are no risks to your participation in this study. There are no consequences should you choose to participate. You can discontinue completing the survey at anytime if you choose to do so. In addition, if you wish to speak with someone about this study or your voluntary participation in it, please feel free to contact Dr. Richard Lyle, Chair of the WMYJSSW Doctoral Program at the address, phone number or email address below. Please note there is no compensation for your participation.

BY COMPLETING AND RETURNING THIS SURVEY, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS. RETURNING THIS QUESTIONNAIRE INDICATES THAT YOU VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

Darrin E. Wright, Doctoral Candidate
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dwright@cau.edu

Dr. Richard Lyle, Chair
WMYJSSW Doctoral Program
223 James P. Brawley Drive, SW
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Rlyle@cau.edu
APPENDIX B

SURVEY QUESTIONNAIRE

Survey Instructions
On section I of this survey, please answer each question by marking the box below the question with your answer.

You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

■ Yes → If Yes, go to #1 on page 1
□ No

On section II of this survey, please share your opinion on the statements made by checking the box next to the statement you agree with the most.

1 □ Strongly agree 2 □ Agree 3 □ Agree somewhat
4 □ Undecided 5 □ Disagree 6 □ Strongly disagree

Section I: During the past two years, McIntosh Trail CSB has strived to screen individuals, who receive services at the counseling center, for medical conditions. Please check one of the boxes concerning the questions below:

1. Were you screened at the counseling center for medical disorders (blood drawn from your finger) in the past 2 years?
   1 □ Yes if YES, go to question # 2
   2 □ No if NO, go to section II of this survey

2. Were you given information about the results?
   1 □ Yes
   2 □ No

3. Was the information presented in a way that you could understand?
   1 □ Yes
   2 □ No
APPENDIX B (continued)

4. Were all of your questions answered in a way that you could understand?
   □ Yes  
   □ No

5. Did you have a primary health care provider at the time of the screen?
   □ Yes  
   □ No

6. If yes, were the results sent to your provider?
   □ Yes    If YES, go to question #8
   □ No

7. If no, were you given a referral to a provider?
   □ Yes  
   □ No

8. Did you follow up with a primary care provider after the screening?
   □ Yes  
   □ No

9. Did you make any changes after being provided the results of the screening:
   Take your medication as prescribed?
   □ Yes  □ No
   Changed your diet?
   □ Yes  □ No
   Increased your exercise?
   □ Yes  □ No
   Talked more with your medical provider?
   □ Yes  □ No

Section II: Please answer the following questions regarding your opinion concerning the statements below. Please answer all questions by only checking one box for each statement that you agree with the most.

10. My medical condition has improved as a result of the information I’ve received.
    □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
    □ Disagree  □ Strongly disagree

11. Social support and encouragement from my counselor, social worker and community support individual helped me to follow my health care plan as prescribed by my medical provider.
    □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
    □ Disagree  □ Strongly disagree

12. I like the services that I received.
    □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
    □ Disagree  □ Strongly disagree
13. If I had other choices, I would still get services from this agency.
   □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
   □ Disagree       □ Strongly disagree

14. I would recommend this agency to a family member or friend.
   □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
   □ Disagree       □ Strongly disagree

15. The location of services was convenient (such as parking, public transportation and distance).
   □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
   □ Disagree       □ Strongly disagree

16. Staff was willing to see me as often as I felt it was necessary.
   □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
   □ Disagree       □ Strongly disagree

17. Staff returned my calls within one day of my call to McIntosh Trail CSB.
   □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
   □ Disagree       □ Strongly disagree

18. Services were available at times that were good for me.
   □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
   □ Disagree       □ Strongly disagree

19. I was able to get all the services I thought I needed.
   □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
   □ Disagree       □ Strongly disagree

20. I was able to see a psychiatrist, social worker or counselor, when I wanted to.
    □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
    □ Disagree       □ Strongly disagree

21. Staff treated me with respect and courtesy.
    □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
    □ Disagree       □ Strongly disagree

22. Staff here believe that I can grow, change and recover from my mental health condition.
    □ Strongly agree  □ Agree  □ Agree somewhat  □ Undecided
    □ Disagree       □ Strongly disagree
APPENDIX B (continued)

23. I felt comfortable asking questions about my treatment and medication(s).
   □ Strongly agree  □ Agree  □ Agree somewhat □ Undecided
   □ Disagree       □ Strongly disagree

24. I felt I could trust staff with my mental health care.
   □ Strongly agree  □ Agree  □ Agree somewhat □ Undecided
   □ Disagree       □ Strongly disagree

25. I felt staff made every effort to understand my opinions concerning my mental
    health condition.
   □ Strongly agree  □ Agree  □ Agree somewhat □ Undecided
   □ Disagree       □ Strongly disagree

Section III: About You

26. In general, how would you rate your overall health?
   □ Excellent
   □ Very good
   □ Good
   □ Fair
   □ Poor

27. In general, how would you rate your overall mental or emotional health?
   □ Excellent
   □ Very good
   □ Good
   □ Fair
   □ Poor

28. What is your age?
   □ 18 to 24
   □ 25 to 34
   □ 35 to 44
   □ 45 to 54
   □ 55 to 64
   □ 65 to 74
   □ 75 or older

29. Are you male or female?
   □ Male
   □ Female
APPENDIX B (continued)

30. What is the highest grade or level of school that you have completed?
   1□ 8th grade or less
   2□ Some high school, but did not graduate
   3□ High school graduate or GED
   4□ Some college or 2-year degree
   5□ 4-year college graduate
   6□ More than 4-year college degree

31. Are you of Hispanic or Latino descent?
   1□ Yes, Hispanic or Latino
   2□ No, not Hispanic or Latino

32. What is your race? Mark one.
   1□ White
   2□ Black or African American
   3□ Asian
   4□ Native Hawaiian or Other Pacific Islander
   5□ American Indian or Alaskan Native
   6□ Other

33. Did someone help you complete this survey?
   1□ Yes → If Yes, go to question #34
   2□ No → Thank you.

34. How did that person help you? Mark one or more.
   1□ Read the questions to me
   2□ Wrote down the answers I gave
   3□ Answered the questions for me
   4□ Translated the questions into my language
   5□ Helped in some other way

Please print: ______________________
______________________________

Please return the completed survey in the envelope
APPENDIX C

SPSS PROGRAM ANALYSIS

SUBTITLE 'DARRIN WRIGHT CAU School of Social Work PhD Program'.

DATA LIST FIXED/
ID 1-3
SCREEN 4
RESULTS 5
INFORMA 6
QUESTION 7
PROVIDER 8
SENTTO 9
REFERRAL 10
PRIMARY 11
CHANGES 12
MEDICAT 13
DIET 14
EXERCISE 15
TALKED 16
MEDICAL 17
SUPPORT 18
SERVICE 19
CHOICES 20
AGENCY 21
LOCATION 22
WILLING 23
RETURN 24
AVAIL 25
WASABLE 26
PSYCHI 27
STAFF 28
CHANGE 29
COMFORT 30
Mental 31
EFFORT 32
OVERALL 33
EMOTION 34
APPENDIX C (continued)

AGEGRP 35
GENDER 36
EDUCAT 37
DESCENT 38
ETHNIC 39
HELPYOU 40
HOWHELP 41.

VARIABLE LABELS
ID 'Case numbers'
SCREEN 'Q1 Were you screened at the counseling center for medical disorders in the past 2 years'
RESULTS 'Q2 Were you given information about the results'
INFORMA 'Q3 Was the information presented in a way that you could understand'
QUESTION 'Q4 Were all of your questions answered in a way that you could understand'
PROVIDER 'Q5 Did you have a primary health care provider at the time of the screen'
SENTTO 'Q6 If yes - were the results sent to your provider'
REFERRAL 'Q7 If no - were you given a referral to a provider'
PRIMARY 'Q8 Did you follow up with a primary care provider after the screening'
CHANGES 'Q9a - Did you make any changes after being provided the results of the screening'
MEDICAT 'Q9b - Did you take your medication as prescribed'
DIET 'Q9c - Did you changed your diet'
EXERCISE 'Q9d - Did you increased your exercise'
TALKED '9e - Did you talked more with your medical provider'
MEDICAL '10 My medical condition has improved as a result of the information I have received'
SUPPORT 'Q11 Social support and encouragement from my counselor, social worker and community support individual helped me to follow my health care plan as prescribed by my medical provider'
SERVICE 'Q12 I like the services that I received'
CHOICES 'Q13 If I had other choices I would still get services from this agency'
AGENCY 'Q14 I would recommend this agency to a family member or friend'
LOCATION 'Q15 The location of services was convenient'
WILLING 'Q16 Staff was willing to see me as often as I felt it was necessary'
RETURN 'Q17 Staff returned my calls within one day of my call to McIntosh Trail CSB'
AVAIL 'Q18 Services were available at times that were good for me'
WASABLE 'Q19 I was able to get all the services I thought I needed'
PSYCHI 'Q20 I was able to see a psychiatrist social worker or counselor when I wanted to'
STAFF 'Q21 Staff treated me with respect and courtesy'
CHANGE 'Q22 Staff here believe that I can grow change and recover from my mental health condition'
APPENDIX C (continued)

COMFORT 'Q23 I felt comfortable asking questions about my treatment and medication'
MENTAL 'Q24 I felt I could trust staff with my mental health care'
EFFORT 'Q25 I felt staff made every effort to understand my opinions concerning my mental health condition'
OVERALL 'Q26 In general how would you rate your overall health'
EMOTION 'Q27 In general how would you rate your overall mental and emotional health'
AGEGRP 'Q28 What is your age'
GENDER 'Q29 Are you male or female'
EDUCAT 'Q30 What is the highest grade or level of school that you have completed'
DESCENT 'Q31 Are you of Hispanic or Latino descent'
ETHNIC 'Q32 What is your race'
HELPYOU 'Q33 Did someone help you complete this survey'
HOWHELP 'Q34 How did that person help you complete this survey'

VALUE LABELS
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RESULTS
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2 'No/
REFERRAL
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CHANGES
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**APPENDIX C (continued)**

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APPENDIX C (continued)

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4 'Undecided'
5 'Disagree'
6 'Strongly Disagree'/

STAFF
1 'Strongly agree'
2 'Agree'
3 'Agree somewhat'
4 'Undecided'
5 'Disagree'
6 'Strongly Disagree'/

CHANGE
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2 'Agree'
3 'Agree somewhat'
4 'Undecided'
5 'Disagree'
6 'Strongly Disagree'/

COMFORT
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4 'Undecided'
5 'Disagree'
6 'Strongly Disagree'/

MENTAL
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2 'Agree'
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4 'Undecided'
5 'Disagree'
6 'Strongly Disagree'/

EFFORT
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6 'Strongly Disagree'/
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</table>
APPENDIX C (continued)

HOWHELP
1 'Read the questions to me'
2 'Wrote down the answers I gave'
3 'Answered the questions for me'
4 'Translated the questions into my language'
5 'Helped in some other way'.

MISSING VALUES
SCREEN RESULTS INFORMA QUESTION PROVIDER SENTTO REFERRAL
PRIMARY CHANGES MEDICAT DIET EXERCISE TALKED MEDICAL
SUPPORTSERVICE CHOICES
AGENCY LOCATION WILLING RETURN AVAIL WASABLE PSYCHI
STAFFCHANGE COMFORT MENTAL
EFFORT OVERALL EMOTION AGEGRP GENDER EDUCAT DESCENT ETHNIC
HELPYOU HOWHELP (0).

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APPENDIX C (continued)

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APPENDIX C (continued)

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FREQUENCIES
/VARIABLES SCREEN RESULTS INFORMA QUESTION PROVIDER SENTTO REFERRAL
PRIMARY CHANGES MEDICAT DIET EXERCISE TALKED MEDICAL SUPPORT SERVICE CHOICES
AGENCY LOCATION WILLING RETURN AVAIL WASABLE PSYCHI STAFF
CHANGE COMFORT MENTAL EFFORT OVERALL EMOTION AGEGRP GENDER EDUCAT
DESCENT ETHNIC HELPYOU HOWHELP
/STATISTICS = DEFAULT.
REFERENCES


Mason, OH: South-Western Cengage Learning.


House Bill 100, HB 100 (April 1, 1993).


